CBT: Teaching and Measuring Competency

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Case Conceptualized

CBT
Case Conceptualization

- Situation specific thoughts, feelings, and behaviors
- History, pervasive negative beliefs, assumptions, and behavioral strategies

Problem Conceptualization

- Problem in thinking associated with specific psychological problems
Structure of the Therapeutic Interview

1. Brief Update (rating of mood, med check)
2. Bridge from last session
3. Setting the agenda
4. Discussion of today’s agenda items and review of homework
5. Capsule summaries plus summarization of session
6. Setting new homework
7. Feedback from patient
Structure

**Beginning**
- Establish the problem(s)

**Middle**
- Work on the problem, goal-directed, key cognitions/behaviors, strategy, application of skills, capsule summary, homework
- Repeat for each problem

**End**
- Feedback, overall summary, homework
Check In

- Provides opportunity for therapist to build and maintain a solid therapeutic alliance
- May lead to relevant agenda items
- Provides opportunity to observe mental status that may be worth commenting on and may lead to an agenda item.
Set the Agenda

Agenda is a short list of topics which the client and therapist agree will be the focus of the session

- The agenda comes from the goal list which comes from the problem list

PROBLEM-GOAL-AGENDA
Example

PROBLEM LIST
1. Feel less sad
2. Isolating self
3. Avoid work
4. Over eating
5. Insecure

GOALS
Improve mood
Engage with others
Stop avoiding
Improve eating
Raise Confidence
Guidelines for Successful Agenda Setting

- Be collaborative
- Prioritize Agenda Items
- Always review homework
- Be realistic (Try to keep it to 1-2 items)
- Keep treatment goals in mind
  - Common problem: Failing to complete a thorough assessment before jumping into the agenda.
- Just because something comes up in the check-in doesn’t mean it is the most pressing/distressing issue
- Use therapeutic judgment: suicide/homicide ideation
Cognitive Therapy Rating Scale

- Agenda
- Feedback
- Understanding
- Interpersonal Effectiveness
- Collaboration
Cognitive Therapy Rating Scale

- Pacing and Efficient Use of Time
- Guided Discovery
- Focusing on Key Cognitions/Behaviors
- Strategy for Change
- Application of techniques
- Homework
CTRS: References

Dobson, K.S. et al. (1985)
Shaw, B.F. et al. (1999)
Strunk, D.R. et al. (2002)
Vallis, T.M. et al. (1986)
Williams, R.M. et al. (1991)
Cognitive Therapy Rating Scale

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<th>Poor</th>
<th>Barely Adequate</th>
<th>Mediocre</th>
<th>Satisfactory</th>
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Part 1. General Therapeutic Skills

___1. AGENDA

0 Therapist did not set agenda

2 Therapist set agenda that was vague or incomplete

4 Therapist worked with patient to set a mutually satisfactory agenda that included specific target problems (e.g., anxiety at work, dissatisfaction with marriage.)

6 Therapist worked with patient to set an appropriate agenda with target problems, suitable for the available time. Established priorities and then followed agenda.
2. FEEDBACK (SUMMARY)

0  Therapist did not ask for feedback to determine patient’s understanding of, or response to, the session.

2  Therapist elicited some feedback from the patient, but did not ask enough questions to be sure the patient understood the therapist’s line of reasoning during the session or to ascertain whether the patient was satisfied with the session.

4  Therapist asked enough questions to be sure that the patient understood the therapist’s line of reasoning throughout the session and to determine the patient’s reactions to the session. The therapist adjusted his/her behavior in response to the feedback, when appropriate.

6  Therapist was especially adept at eliciting and responding to verbal and non-verbal feedback throughout the session (e.g., elicited reactions to session, regularly checked for understanding, helped summarize main points at end of session.)
3. UNDERSTANDING

0 Therapist repeatedly failed to understand what the patient explicitly said and this consistently missed the point. Poor empathetic skills.

2 Therapist was usually able to reflect or rephrase what the patient explicitly said, but repeatedly failed to respond to more subtle communication. Limited ability to listen and empathize.

4 Therapist generally seemed to grasp the patient’s “internal reality” as reflected by both what the patient explicitly said and what the patient communicated in more subtle ways. Good ability to listen and empathize.

6 Therapist seemed to understand the patient’s “internal reality” thoroughly and was adept at communication this understanding through appropriate verbal and non-verbal responses to the patient (e.g., the tone of the therapist’s response conveyed a sympathetic understanding of the patient’s “message”). Excellent listening and empathic skills.
4. INTERPERSONAL EFFECTIVENESS

0  Therapist had poor interpersonal skills. Seemed hostile, demeaning, or in some other way destructive to the patient.

2  Therapist did not seem destructive, but had significant interpersonal problems. At times, therapist appeared unnecessarily inpatient, aloof, insincere or had difficulty conveying confidence and competence.

4  Therapist displayed a satisfactory degree of warmth, concern, confidence, genuineness, and professionalism. No significant interpersonal problems.

6  Therapist displayed optimal levels of warmth, concern, confidence, genuineness, and professionalism, appropriate for this particular patient in this session.
5. COLLABORATION

0 Therapist did not attempt to set up a collaboration with patient

2 Therapist attempted to collaborate with patient, but had difficulty either defining a problem that the patient considered important, or establishing rapport.

4 Therapist was able to collaborate with patient, focus on a problem that both patient and therapist considered important, and establish rapport.

6 Collaboration seemed excellent; therapist encouraged patient as much as possible to take an active role during the session (e.g. by offering choices) so they could function as a “team”.

6. PACING AND EFFICIENT USE OF TIME

0 Therapist made no effort to structure therapy time. Session seemed aimless.

2 Session had some direction, but the therapist had significant problems with structuring or pacing (e.g., too little structure, inflexible about structure, too slowly paced, too rapidly paced).

4 Therapist was reasonably successful at using time efficiently. Therapist maintained appropriate control over flow of discussion and pacing.

6 Therapist used time efficiently by tactfully limiting peripheral and unproductive discussion and by pacing the session as rapidly as was appropriate for the patient.
7. GUIDED DISCOVERY

0 Therapist relied primarily on debate, persuasion, or "lecturing". Therapist seemed to be "cross-examining" patient, putting the patient on the defensive, or forcing his/her point of view on the patient.  

2 Therapist relied too heavily on persuasion and debate, rather than guided discovery. However, therapist’s style was supportive that patient did not seem to feel attacked or defensive.  

4 Therapist, for the most part, helped patient see new perspectives through guided discovery (e.g., examining evidence, considering alternatives, weighing advantages and disadvantages) rather than through debate. Used questioning appropriately.  

6 Therapist was especially adept at using guided discovery during the session to explore problems and help patient draw his/her own conclusions. Achieved an excellent balance between skillful questioning and other modes of intervention.
8. FOCUSING ON KEY COGNITIONS OR BEHAVIORS

0 Therapist did not attempt to elicit specific thoughts, assumptions, images, meanings, or behaviors.

2 Therapist used appropriate techniques to elicit cognitions or behaviors; however, therapist had difficulty finding a focus or focused on cognitions/behaviors that were irrelevant to the patients key problems.

4 Therapist focused on specific cognitions or behaviors relevant to the target problem. However, therapist could have focused on more central cognitions or behaviors that offered greater promise for progress.

6 Therapist very skillfully focused on key thoughts, assumptions, behaviors, etc. that were most relevant to the problem area offered considerable promise for progress.
9. STRATEGY FOR CHANGE (Note: For this item, focus on the quality of the therapist’s strategy for change, not on how effectively the strategy was implemented or whether change actually occurred.)

0 Therapist did not select cognitive-behavioral techniques.

2 Therapist selected cognitive-behavioral techniques; however, either the overall strategy for bringing about change seemed vague or did not seem promising in helping the patient.

4 Therapist seemed to have a generally coherent strategy for change that showed reasonable promise and incorporated cognitive-behavioral techniques.

6 Therapist followed a consistent strategy for change that seemed very promising and incorporated the most appropriate cognitive-behavioral techniques.
10. APPLICATION OF COGNITIVE-BEHAVIORAL TECHNIQUES
(Note: For this item, focus on how skillfully the techniques were applied, not on how appropriate they were for the target problem or whether change actually occurred.)

0 Therapist did not apply any cognitive-behavioral techniques.

2 Therapist used cognitive-behavioral techniques, but there were significant flaws in the way they were applied.

4 Therapist applied cognitive-behavioral techniques with modern skill.

6 Therapist very skillfully and resourcefully employed cognitive-behavioral techniques.
11. HOMEWORK

0 Therapist did not attempt to incorporate homework relevant to cognitive therapy.

2 Therapist had significant difficulties incorporating homework (e.g., did not review previous homework in sufficient detail, assigned inappropriate homework).

4 Therapist reviewed previous homework and assigned “standard” cognitive therapy homework generally relevant to issues dealt with in session. Homework was explained in sufficient detail.

6 Therapist reviewed previous homework and carefully assigned homework drawn from cognitive therapy for the coming week. Assignment seemed “custom tailored” to help patient incorporate new perspectives, test hypotheses, experiment with new behaviors discussed during sessions, etc.
CTRS MANUAL

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Candidate handbook
Appendix CTRS Manual
Training Model 1

- Focus on competency (CTRS score of 40 or higher)
- Subsidized in-person training, 3-day introductory CBT course (offered twice a year in varying locations, clinician pays reduced fee)
- Free one-hour telephonic training on CTRS

Process:
- Clinician pursues own training, with state-subsidized options
- Clinician records an actual therapy session and then submits it to the Academy for evaluation
- Clinician must receive a CTRS score of 40 or higher. Failure to do so results in required additional training (hybrid certification)
- Clinician who has not verified competency in CBT, cannot bill DSHS for EPB services
Training Model 2

- Focus on training and providing adequate resources to clinicians
- More central/administrative control of training—with clinician feedback
- Sustainability efforts involve certification and customized 1-day in-person training

Process:
- 3-day in-person training on CBT fundamentals. Followed by 12 weeks of telephonic group supervision. Sustained with topic-specific 1 or 2-day in-person training
- Employer pays for Academy certification (a component of sustainability efforts)
Training Model 3

Focus on training, competency, and providing adequate resources to clinicians

More central/administrative control of training—with clinician feedback

Process:
- 3-day in-person training on CBT fundamentals. Followed by 16 weeks of telephonic group supervision. During 16-week period, all trainees submit 3 audio recordings and 3 case conceptualizations to supervisor for evaluation.
- Trainees must demonstrate competency before 1-day in-person booster (competency a criteria of training protocol)
Training Model 4

Focus on training, providing adequate resources to clinicians, and integration of CBT throughout entity (holistic approach)

- Systematic approach, grant funded, and developed within academia

Process:
- In-person training for administrators, clinical staff, and non-clinical support staff
- One-on-one supervision (6 to 9 months)
- Optional certification program made available to clinical staff
ACT Consultation Services

- Training program design.
- Outcome measures and data collection
- Strategies to cultivate employee buy in
- Guidance and facilitation of remote training
- Data analysis and ROI reporting
- Development of promotional materials
- Assist in search for program funding (grant writing)
- Construct feasible and lasting sustainability initiatives
Why Choose to Work with ACT

- Data driven, evidence-based
- Only employ certified CBT trainer consultants
- Proven track record
- Scalability
- Intense focus on client satisfaction
- Committed to lasting and sustainable results
VIDEO DEMONSTRATION

Cognitive Therapy
Rating Scale Observed
Questions & Answers
Cognitive Therapy Organizations

- Academy of Cognitive Therapy (ACT)
  - Certifies Cognitive Therapists
  - Referrals
  - Listserv
  - Newsletter
  www.academyofct.org
  Email: info@academyofct.org

- Association of Behavioral Cognitive Therapies (ABCT)
  - National Membership Organization
  - Annual Conference
  www.abct.org
  Email: membership@aabt.org

- International Association for Cognitive Psychotherapy
  - International Membership Association
  - Triannual World Congress
  - Journal
  http://iaccp.asu.edu/