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Teaching and Supervising Cognitive Behavioral Therapy

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Derek Milne: I hope that the materials I've provided will support supervisors and be a suitable recompense for all

those in England who helped me develop them; thanks to them for their commitment to clinical supervision.

FOREWORD

Teaching and Supervising Cognitive Behavioral Therapy is the first comprehensive text to provide empirically validated, effective training and supervisory approaches to teachers and supervisors from a variety of disciplines that use a cognitive behavior therapy (CBT) approach. Despite the substantial interest in the practice of cognitive behavioral therapy, until recently there has not been a corresponding pursuit of evidence-informed training and dissemination methods. For example, it took more than twenty years from the publication of *Cognitive Therapy of Depression* in 1979 for CBT training to be required in psychiatry residencies. Likewise, dissemination of CBT remains poor in other disciplines, including psychology. In addition to broader uptake, there is a need for the field to develop more effective training programs and to deepen CBT's impact across multiple disciplines of caregivers, which will be assisted by effective supervision.

The authors of this book are expert CBT practitioners, supervisors, and teachers whose experiences enrich their review of the available evidence on effective training and supervision. In addition, this book provides an approachable framework for using technological aids to teaching and supervision in an accessible manner. The learning exercises and practical understanding of different trainee groups, along with the online resources provided with this book, will undoubtedly contribute to the effort to develop more robust CBT training. As such, I believe this book will be an excellent tool for individual trainers and educational programs alike.

—A. T. Beck, MD,
University Professor of Psychiatry
Emeritus

and author of *Cognitive Therapy and the Emotional Disorders*

ABOUT THE AUTHORS

Donna M. Sudak, MD, is professor, senior associate training director, and director of psychotherapy training in the Department of Psychiatry at the Drexel University College of Medicine. She is a clinician-educator with a wealth of national and international experience in teaching and patient care, and she has received numerous teaching awards. She has made a number of significant contributions to the literature in CBT education and has played a major role in developing suggested curricula and guidelines for resident competency in cognitive behavior therapy. She also has authored multiple publications regarding combining treatment with medication and CBT.

In addition to her teaching responsibilities at Drexel University College of Medicine, Dr. Sudak is an adjunct faculty member at the Beck Institute for Cognitive Therapy and Research. She is past president of the Academy of Cognitive Therapy, the editor of the PIPE examination, and serves on multiple national committees in Association of Behavioral and Cognitive Therapies and American Association of Directors of Psychiatric Residency Training (AADPRT), including having been named the incoming program chair for the 2016 Annual Meeting at AADPRT.

R. Trent Codd III, EdS, is the president and founder of the Cognitive-Behavioral Therapy Center of WNC, P.A., an interdisciplinary group practice located in Asheville, North Carolina. In addition to rendering clinical services at the center, he provides clinical consultation and training in CBT locally and nationally. He codirects an intensive training program in CBT each year and is on the clinical faculty of Lenoir-Rhyne University. Additionally, he is a licensed professional counselor as well as a fellow, certified

trainer/consultant, and credentialing committee member of the Academy of Cognitive Therapy.

John Ludgate, PhD, is a licensed psychologist who has worked as a psychotherapist for nearly thirty years. He currently works at the Cognitive-Behavioral Therapy Center of Western North Carolina. In addition to having an active clinical practice, he is involved extensively in training and supervision in CBT, locally and nationally. He trained at the Center for Cognitive Therapy in Philadelphia, obtaining a postdoctoral fellowship in cognitive therapy from the University of Pennsylvania. He subsequently became assistant director of training at the center. In the early 1990s he was a research clinical psychologist at the University of Oxford in England and served as a protocol therapist in several outcome studies of panic disorder, agoraphobia, social phobia, and hypochondriasis. He has written a number of books on CBT, including *Heal Yourself: A CBT Approach to Reducing Therapist Distress and Increasing Therapeutic Effectiveness* (2012), *Cognitive Behavior Therapy and Relapse Prevention in Depression and Anxiety* (2009), and *Maximizing Psychotherapeutic Gains and Preventing Relapse in Emotionally Distressed Clients* (1990). He cowrote *Overcoming Compassion Fatigue: A Practical Resilience Workbook* (2014) with Martha Teater and was coeditor with Jesse Wright, Michael Thase, and Aaron T. Beck of *Cognitive Therapy with Inpatients: Developing a Cognitive Milieu* (1992). He is a founding fellow of the Academy of Cognitive Therapy and serves on the credentialing committee of the academy.

Leslie Sokol, PhD, is a licensed psychologist, expert in cognitive behavior therapy, internationally recognized speaker, and coauthor of *Think Confident, Be Confident* (2009). She is a distinguished founding fellow, past president, and credentialing chair of the Academy of Cognitive Therapy. She was the director of education at the

Beck Institute for Cognitive Behavior Therapy for nearly fifteen years. Her private practice is in the Philadelphia suburbs.

Marci G. Fox, PhD, is a licensed psychologist and has been in private practice for nearly twenty years. She has worked closely with Dr. Sokol, Dr. Judith Beck, and Dr. Aaron T. Beck at the Beck Institute for Cognitive Behavior Therapy in Philadelphia for almost the same amount of time. As an Academy of Cognitive Therapy certified trainer/consultant and former adjunct Faculty Member at the Beck Institute, she trains individuals in cognitive therapy both nationally and internationally, and helps mental health professionals to improve their clinical skills and pinpoint specific areas of remediation. Dr. Fox has a founding fellow distinction as well as an invited placement on the board of examiners and credentials committee of the Academy of Cognitive Therapy. Dr. Fox has lectured for years on cognitive therapy as well as confidence and self-esteem. She has coauthored the books *Think Confident, Be Confident: A Four-Step Program to Eliminate Doubt and Achieve Lifelong Self-Esteem* (2009) and *Think Confident, Be Confident for Teens: A Cognitive Therapy Guide to Overcoming Self-Doubt and Creating Unshakable Self-Esteem* (2011). Dr. Fox has published in peer-reviewed journals and diverse publications in the area of cognitive behavior therapy.

Robert Reiser, PhD, is a licensed psychologist and a fellow of the Academy of Cognitive Therapy. Since 2006, he has collaborated with Derek Milne on a series of research projects involving the development of an instrument (*SAGE*) to assess competence in supervision. He has written and coauthored journal articles and has contributed book chapters with Derek Milne focusing on evidence-based approaches to clinical supervision, including the *International Handbook of Clinical Supervision* (edited by Ed Watkins and Derek Milne, 2014). After ten years of teaching

a graduate-level CBT course, he is now actively engaged in supervision and training in a CBT for psychosis implementation and dissemination project. Over several years he has served as a consulting supervisor for the CBT-D national training program with the Veterans Administration.

Derek L. Milne is a clinical psychologist and a fellow of the British Psychological Society, with extensive experience as a supervisor, supervisor trainer, and supervision researcher. Since 1996, he has led the first ever systematic R&D program on clinical supervision, developing our understanding and seeking to enhance practice within the field of mental health (especially CBT supervision). This research program has followed the evidence-based practice rationale and has included extensive collaboration within the National Health Service. This started with theory-building work (systematic reviews), then involved a series of $n = 1$ studies (including the development of an instrument to assess competence in supervision), and related efforts to foster an evidence-based practice (for example, a national pilot study of a supervisor training manual). This program is summarized in *Evidence-Based Clinical Supervision* (2009). In 2010 he retired as director of The Doctorate in Clinical Psychology at Newcastle University, but he continues to teach and research supervision. His latest work is *The International Handbook of Clinical Supervision* (2014), coedited with Ed Watkins.

CHAPTER 1
CBT TRAINING AND SUPERVISION
AN OVERVIEW

John Ludgate

To help readers understand the current recommendations for cognitive behavioral therapy (CBT) training and supervision, this chapter begins with a review of the historical roots and subsequent development of CBT training and supervision worldwide. In addition, the chapter describes the advantages and disadvantages of existing formats for training and briefly reviews the literature on the effectiveness and benefits of CBT training. Last, future directions regarding research and practice in the field of CBT training and supervision are outlined.

Historical Roots of CT Training and Supervision

The evolution of a cognitive model and the development of Beck's cognitive therapy has been described in several texts (Weishaar, 1993; Wills, 2009). The development of training in cognitive therapy (CT) is closely linked with the history of cognitive therapy itself. In the 1960s Aaron Beck, a psychiatrist in Philadelphia, now widely regarded as the father of cognitive behavioral therapy, became interested in determining the factors involved in the development and maintenance of depression. He formulated his initial cognitive model of depression in papers in 1963 and 1964 (Beck, 1963, 1964). The theory was elaborated in his book *Depression: Clinical, Experimental, and Theoretical Aspects* (1967).

Thereafter, along with the subsequent publication of Beck's *Cognitive Therapy and the Emotional Disorders* (1976), a number of case studies were conducted in single-case design in which therapy derived from the model was applied to depressed outpatients (Rush, Khatami, & Beck, 1975; Shaw, 1977).

John Rush, a psychiatry resident at University of Pennsylvania from 1972 to 1975, and other residents became interested in both the clinical and research applications of cognitive therapy for depression. Beck provided supervision to the residents at the Mood Clinic at

Philadelphia General Hospital and, as well, taught a psychotherapy course (Weishaar, 1993). After the successful clinical outcome achieved in the single-case studies previously mentioned, a study was designed to test cognitive therapy in a randomized controlled trial compared with antidepressant medication, at that time considered the gold standard for treating depression. Beck and Rush were joined by Gary Emery, Marika Kovacs, and Steve Hollon in planning and conducting this study, which, according to Weishaar (1993), resulted in notes on each patient's progress and details on the effectiveness of techniques being used compiled initially into a twelve-page manual on conducting cognitive therapy. This manual eventually grew to two-hundred pages and evolved into the book *Cognitive Therapy for Depression* (Beck, Shaw, Rush, & Emery, 1979).

The earlier brief manual was used to guide research therapists; recruited subjects were randomly assigned to cognitive therapy or pharmacotherapy. The therapists were psychiatry residents who received weekly supervision from Beck based on audio recordings of actual therapy sessions, a highly influential, and unusual for the time, model of supervision that has continued to date. Beck's emphasis on supervision and feedback on actual therapy practice to ensure skill development, and experiential, active learning as part of initial training, are key contributions to psychotherapy education.

The subsequent paper (Rush, Beck, Kovacs, & Hollon, 1977) was the first to show the efficacy of cognitive therapy, and a follow-up study of this patient cohort (Kovacs, Rush, Beck, & Hollon, 1981) showed that cognitive therapy was as effective as medication in the short term and fared better at one-year follow-up, findings that have been confirmed in numerous subsequent studies. As well as the training and supervision of therapists for this outcome study, another seminal event was the development of the Cognitive Therapy Rating Scale (CTS; Young & Beck, 1980) to ensure fidelity, which has become a key measure of competence for training and supervision, and, in addition, an Index of Cognitive Therapy Fidelity in outcome studies. Chapter 4 illustrates the use of the rating scale and other methods of evaluating competency in trainees.

In 1979 the National Institute of Mental Health (NIMH) elected to conduct a multicenter outcome study comparing cognitive therapy, interpersonal psychotherapy (Klerman, Weisman, Rounsaville, & Chevron, 1984), and medication for unipolar depression. Cognitive therapists were trained by the Philadelphia group at a number of

sites to participate in the study. By the study design, only three months of training was provided to these novice therapists because the NIMH stipulated that it should represent the therapy provided by the “average practitioner,” who presumably would have received only short-term training.

According to Weishaar (1993), therapists' ratings indicated that the majority failed to reach the established competency criteria for cognitive therapists. Beck, apparently, strongly suggested that it would take one year of training and supervision to produce adequately trained cognitive therapists. The somewhat poorer outcome for cognitive therapy with severe depression found in this study (Elkin et al., 1989) relative to interpersonal psychotherapy and medication may have been due to inadequate training. Even in these early days in the evolution of cognitive therapy and CT training, an essential for effective training was thought to be an adequate dosage of training and the provision of supervision over a significant time period, which has been validated by subsequent research. This idea is discussed in greater detail in chapter 10.

Another important contribution to training and dissemination in cognitive therapy was the development of a one-year postdoctoral fellowship in cognitive therapy at the University of Pennsylvania in 1979. The objective was to provide intensive training and supervision in CT. Trainees also provided therapy to a range of clients at the Center for Cognitive Therapy, an outpatient clinic under the University of Pennsylvania's Department of Psychiatry. As the program grew, approximately six to seven full-time fellows were accepted into this program per year, including some key figures in the development of CBT.

Although this program is no longer in existence in its original form, the model of training has endured, and fellowships in CBT are currently offered at several centers, including the Beck Institute for Cognitive Behavior Therapy, the Cognitive-Behavioral Institute of Albuquerque, Harbor-UCLA, and the Depression and Anxiety Specialty Clinic in Chicago. An extramural training program started at the Center for Cognitive Therapy in Philadelphia to allow clinicians who were employed to travel to the center for didactic training several times a year and to also receive case supervision, often by telephone, when geographical location made this more feasible than face-to-face supervision, a model that has been continued by the Beck Institute for Cognitive Behavior Therapy.

As CBT training evolved, the Center for Cognitive Therapy and the Beck Institute offered visiting professionals brief or longer trainings customized and designed for their particular needs. Individuals who had spent time training in Philadelphia returned to their home countries or home locations within the United States and started training, therapy, or research programs in the field of CBT.

For example, several training courses were set up in Oxford, London, and Newcastle in the United Kingdom as a result of training directors at these locations receiving training from Beck and colleagues in Philadelphia. Thus, CBT education spread worldwide.

In the late 1970s and early 1980s there were still few trainings opportunities for professional development available in the United States outside of Philadelphia, except for a small number of workshops at the Association for the Advancement of Behavior Therapy (AABT) conferences (now ABCT—the Association for Behavioral and Cognitive Therapies) and other events offered by continuing education groups. In Europe there were some one-time workshops usually organized during annual conferences of organizations such as the British Association for Behavioural and Cognitive Psychotherapy (BABCP) and the European Association for Behavioral and Cognitive Therapy (EABCT). Similarly, in other parts of the world, brief training was usually the sole vehicle for dissemination, most often associated with events like the World Congress of Cognitive Therapy.

Following the Rush et al. (1977) study, several centers, such as at Washington University in St. Louis and, later, Vanderbilt University in Nashville, provided CBT training for therapists to conduct research utilizing a small group of established, proficient, and experienced therapist trainers. Such training is described in several early articles (Shaw & Dobson, 1988; Shaw & Wilson-Smith 1988), and the many studies carried out subsequently evaluating training provided as part of research trials have recently been reviewed (Rakovshik & McManus, 2010). This literature provides significant help in designing therapist training.

The first postgraduate intensive training for professionals outside Philadelphia was offered at the Cleveland Center for Cognitive Therapy in 1982 under the direction of Jim Pretzer and Barbara Fleming, two former fellows at the Center for Cognitive Therapy in Philadelphia. This ten-month systematic training in the theory and

applications of CBT, involving once-monthly one-day training workshops, has been offered from 1982 to the present and can now be completed online. In 1985 the Atlanta Center for Cognitive Therapy began to offer a nine-month, one-day-a-month CBT training with supervision. Their didactic program included guest trainers such as David Burns, Edna Foa, and Art Freeman. Subsequently other agencies and organizations in the United States, usually clinical practice CBT centers, started to offer this intensive type of training.

Training in the United States during the 1980s and 1990s lagged behind that of the United Kingdom. Windy Dryden in 1982–1983 at Goldsmith College at University of London offered the first time-intensive CBT training in Britain, which led to a diploma in Cognitive Approaches to Counseling and Psychotherapy. By the mid-1990s, postgraduate diploma courses for professionals in the field existed at the Institute of Psychiatry in London, at Oxford, and at Newcastle. These were usually one year in duration and involved didactic instruction and supervision, often with rating of audio recordings included to assess and monitor competency and guide supervision.

Other countries, including Japan, Turkey, Hong Kong, Saudi Arabia, Brazil, Australia, and New Zealand, have developed comprehensive home-based training programs, often with the initial assistance of US- or UK-based CBT trainers.

Several initiatives by US states (for example, Michigan and Texas) have instituted statewide evidence-based therapy training, which includes CBT. In Britain, the publication of the National Institute of Health and Clinical Excellence (NICE) guidelines on creating access to evidence-based psychological interventions in 2004 and the subsequent provision of funding by the British government in 2007 for this initiative (see chapter 2 for further descriptions of this initiative) have resulted in a major CBT training effort and a large number of mental health workers, often from nontraditional groups as regards therapy and counseling, have been, and are being, trained to deliver low-intensity CBT (Bennett-Levy, Richards, et al., 2010) to depressed and anxious patients in the community. Training approaches for maximally effective training in CBT for nontraditional trainees are described in chapter 11.

Public health policy clearly will continue to greatly affect the growth of CBT training and dissemination. A welcome development in many countries has been the provision of public funding for CBT trainings.

Several European countries have been funded for this through the European Union and the World Health Organization. Some Scandinavian countries receive government assistance with such training, and in South Africa an educational council helps with the training process.

Such efforts have a major focus in the CBT community on the issue of dissemination from a theoretical and research perspective, including practical guidelines (McHugh & Barlow, 2012).

Although supervision was a recommended part of the training for cognitive therapists, no systematic descriptions of CBT supervision practice appeared in the literature until the mid- to late 1990s (Liese & Alford, 1998; Liese & Beck, 1997; Newman, 1998; Padesky, 1996; Perris, 1994). Subsequently, Milne and James (2000) provided a very systematic review of effective cognitive behavioral supervision. These practical resources (the seminal articles mentioned previously), along with the advent of training workshops for CBT supervisors offered at national and international CBT conferences, and through other forums in the past decade, have resulted in a much more elaborate, comprehensive, evidence-based approach to supervision in the field of CBT.

Recommendations concerning “good” CBT supervision practice, which includes agenda setting, provision of feedback, concrete goal setting, practice opportunities, a focus on both core skills (conceptualization and intervention) and the client-therapist relationship, attention to the supervisory process, and the use of different learning modalities for the supervisee (Liese & Beck, 1997; Padesky, 1996) have emerged. Currently, in addition to those just mentioned, many resources now exist for supervisors attempting to develop CBT supervisory skills, including two books (Milne, 2009; Scott, 2013) and a number of recent book chapters and articles (Gordon, 2012; Kennerley & Clohessy, 2010; Milne & Dunkerley, 2010). This is a part of the field that has grown rapidly and holds rich promise, as does the important work on measuring supervision adherence and competency (Kennerley & Clohessy, 2010; Milne, 2009) and attempts to describe and operationalize core competencies for CBT trainees and supervisees (Newman, 2012; Roth & Pillings, 2008). In this volume, chapters are devoted to evidence-based supervisory practices in CBT (chapter 12) and to training CBT supervisors (chapter 13).

Current Training Opportunities

Currently, individuals can receive training in CBT in a number of different ways.

CBT Training within Existing Professional Training

Professional training programs often provide opportunities for initial CBT exposure.

Clinical Psychology and Counseling Psychology Training Programs

Many psychology programs have a strong CBT component. Klepac et al. (2012) offered guidelines for CBT teaching based on the findings of an ABCT task force created to examine cognitive and behavioral psychology doctoral education. This report gives detailed recommendations on competencies expected from such training, but actual practice may not yet reflect these recommendations. Clinical psychology training in other countries, such as England, may well include a greater focus on CBT because this model of treatment is more widely espoused there. Weissman et al. (2006) reported that 100 percent of PhD programs in the United States offered CBT didactic training, while only 89 percent required this training. An examination of PsyD courses showed that CBT didactic training was offered in 100 percent of courses and required in 96 percent, but "gold standard" training, which includes both didactic and supervision components, was included in only 20 percent of PsyD, and PhD courses were only somewhat better in this regard. CBT training at graduate level for psychologists is fully discussed in chapter 8.

Residency Training in Psychiatry

An initiative taken by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Psychiatry in 2001 required competence in CBT for graduating psychiatry residents as defined by each individual program. Weissman et al. (2006) found that the vast majority of residency programs reported compliance with this. In addition, in a survey comparing training courses for different professionals, psychiatry had a higher percentage of programs meeting the "gold standard". This training is described in a number of articles (Sudak, 2009) and is fully discussed in chapter 9.

Social Work Training

Many training programs available in the field of social work include a major CBT didactic training component. Weissman et al. (2006) reported that 93 percent offered CBT training and 80 percent required this. However, only 21 percent of these courses involved supervision as well as didactic instruction.

Postgraduate Training for Professionals

Postgraduate training may lie on a spectrum of training intensity from stand-alone seminars and workshops available at conferences or continuing education groups through intensive training often leading to certification (such as the Cleveland or Atlanta programs) to, at the most intensive level, postgraduate degree or diploma courses such as those offered in the United Kingdom and other countries, and postdoctoral fellowships in CBT offered at several centers in the United States.

Another avenue to obtaining CBT training is to serve as a therapist in a randomized controlled CBT outcome study, which usually involves training to a designated criterion of competency. Currently, a practicing professional wishing to receive training in CBT has a number of specific options.

- General CBT workshops or CBT for Specific Disorder workshops at conferences held by groups such as ABCT, BABCP, and IACP (International Association of Cognitive Psychotherapy), or through continuing education groups such as PESI (Provider Education System Incorporated) Education or Cross Country Education.
- On-site trainings organized by agencies, which are usually of brief duration and may involve a heterogeneous professional group (counselors, in-home workers, case managers).
- Weekend or multiple-day workshops and training on specific CBT topics, for example, depression, anxiety, or personality disorders, such as those organized by the American Institute of Cognitive Therapy or the Beck Institute. These can be sequential, with beginner-level and advanced workshops offered. Supervision may be offered. In some cases general certification is provided. In addition to this, professionals may receive certification in specific applications of CBT (for example, trauma-focused CBT; Cohen,