Cognitive Behavioral Therapy: A Blueprint for Attaining and Assessing Psychiatry Resident Competency

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Background: The Residency Review Committee (RRC) for Psychiatry of the Accreditation Council on Graduate Medical Education (ACGME) now requires that all psychiatric residency programs demonstrate competency for all psychiatric residents in cognitive behavior therapy (CBT). Objective: To increase awareness about specific knowledge, skills, and attitudes necessary to perform competent CBT, optimal teaching methods available to insure competency, and valid assessment tools and resources available to training programs. Methods: Literature review and discussion of common features of successful training programs. Results and Conclusions: Training programs have resources and standardized methods of training, supervision, and assessment available to help residents meet the ACGME mandated competency requirements in CBT. (Academic Psychiatry 2003; 27:154–159)

Cognitive behavioral therapy (CBT) is a form of psychological treatment with a comprehensive theory of psychopathology and personality and specific models for various disorders. The therapy requires an empathic, active clinician, who collaborates with patients in order to define specific treatment goals. Sessions are structured with the purpose of reducing symptoms and learning disorder-specific cognitive and behavioral skills. Cognitive therapy has been found to be effective in working with individuals, groups, couples, and families (1).

Although CBT was initially developed as a treatment for depression, it has been adapted for a wide range of psychiatric disorders and continues to be distinguished by substantial empirical support for its effectiveness in more than 325 outcome trials (2,3). This treatment approach has a long history of standardizing methods for therapist training, supervision, and assessment (4,5). Treatment manuals for the use of CBT in major psychiatric disorders have been developed, validated, and published (6–19).

The purpose of this article is to provide training directors with the critical elements necessary for teaching psychiatry residents about CBT, methods for assessing the skills necessary to perform competent CBT, and resources available for developing robust CBT training programs for residents.
ESSENTIAL INGREDIENTS OF COGNITIVE THERAPY

To obtain basic competency in cognitive therapy, residents must be able to do the following:

1. Formulate cases according to the cognitive model for various disorders
2. Develop a strong, active, collaborative therapeutic alliance
3. Use a cognitive conceptualization to plan treatment within sessions and across sessions
4. Continuously monitor progress
5. Structure sessions to maximize progress
6. Focus on helping patients solve or cope with current problems and achieve their goals, using a variety of techniques (20)
7. Identify and help patients modify their key dysfunctional cognitions
8. Facilitate behavioral change
9. Work directly on treatment compliance
10. Emphasize relapse prevention

Certain basic values and attitudes are important in becoming proficient in cognitive therapy and achieving competency. Cognitive therapists place a high priority on helping patients reduce symptoms quickly. They demonstrate the characteristics of any good therapist: genuine empathy, caring, regard, and accurate understanding. They value a collaborative working relationship and fine-tune their style and the process of therapy to suit individual patients (7). Many of the references that follow this article are beneficial resources for training directors to help residents become skilled practitioners.

CURRICULAR ELEMENTS

Effective, focused CBT training results in improved therapist competence and patient outcomes (21,22,23). For adequate training to occur, a substantial period of theoretical (didactic) training and supervised clinical experience is needed. Because studies vary with respect to the sophistication and prior therapy experience of trainees, it is difficult to directly generalize to the education of psychiatric residents. Most studies of advanced trainees emphasize a minimum of 6 months (24–30 hours) of didactic lecture, along with at least 2 hours per week of clinical work with patients and 2 hours per week of supervision for a 6- to 12-month period of time (21,24,25,26). Brief training carries the danger of inadequately preparing trainees. One study found that trainees overestimated their knowledge and competence in CBT when training length was insufficient to produce competence (26).

Competence in CBT involves both adherence to the model as well as skillful application of treatment methods in caring for patients. Therefore, residents first should be taught general psychotherapy skills (27), then the model of cognitive psychopathology and conceptualization, and finally the tools and techniques of treatment, including guided discovery, Socratic questioning, collaborative empiricism, and behavioral techniques (28). Case conceptualization is a key part of the educational process (29,30). Focused and sufficiently supervised, clinical practice must accompany teaching, since knowledge without application rarely changes skill development (31). Application of the treatment techniques without conceptualization further the misconception of CBT as a “bag of tricks” (29) or a rigid, manual-driven approach suitable only for a very narrow group of patients.

Training can also be enhanced by self-practice and self-reflection (32). When residents use CBT tools and techniques on themselves, they develop a more complete understanding of implementation and motivational strategies. When residents are successful in reducing anxiety or solving problems, they become more enthusiastic in recommending CBT techniques to their patients. Practicing with their own thought records, activity schedules, and data logs help residents increase their self-knowledge, and thereby, increase internal reflection about therapeutic conceptualization, progress, and outcome.

Role playing and observation of master clinicians performing therapy via audiotape, videotape, or live patient interviews are also crucial methods of educating residents. The most effective teaching process involves using the techniques of the treatment—that is, an active, collaborative instructor who uses an agenda, guided discovery, feedback, and homework to help residents attain proficiency.

The need for systematic and thorough training for residents in CBT is underscored by the ACGME competency requirements. One danger of proposing this requirement, however, is that residents who are graduated as competent practitioners may actually be inadequately prepared, unless they are involved in
robust CBT training programs with close supervision and assessment. Training programs must adequately supervise written examples of case conceptualization and treatment planning and carefully evaluate audio or video tapes of residents’ sessions with patients. Such evaluation should include, at a minimum, an assessment of how well the resident maintains a collaborative therapeutic relationship, sets a satisfactory agenda, develops an efficient and effective cognitive or behavioral intervention within the session, summarizes, obtains and addresses feedback, and assigns relevant homework (33).

**Assessment Tools**

There are several different assessment tools available for evaluating the performance of residents who are learning cognitive therapy. We describe four of these measures here: The Cognitive Therapy Scale (34,35,36), The Academy of Cognitive Therapy Case Formulation Rating (37), The Cognitive Therapy Awareness Scale (38), and the Cognitive Therapy Supervision Checklist (39). Each of these tools has unique features that can assist educators in assessing the knowledge and skills of psychiatry residents.

The **Cognitive Therapy Scale (CTS)** (34,35,36) has been the standard measure of competence in cognitive therapy for more than 20 years. This scale is used widely in training programs in cognitive therapy as a structured method of rating therapy sessions and providing feedback. It is also used extensively in cognitive therapy outcome studies to measure the competence of research therapists. The Academy of Cognitive Therapy, a multidisciplinary certifying organization, uses the CTS as a primary measure for certifying clinicians in cognitive therapy.

The Cognitive Therapy Scale has 11 items divided into two domains: General Therapeutic Skills (e.g., agenda setting, interpersonal effectiveness, collaboration); Conceptualization, Strategy, and Technique (e.g., guided discovery, focusing on key cognitions and behaviors, strategy for change, and homework). Each item is rated on a 0–6 scale. The highest possible score on the CTS is 66. A score of 40 is the usual cutoff for defining competency for cognitive therapists who participate in outcome research studies, and the passing score for certification by the Academy of Cognitive Therapy is 40. In our training programs we have found that the CTS is most useful as a tool for giving residents specific instruction in the key elements of effective cognitive therapy sessions. The actual numerical score is of less value than detailed feedback on performance in each of the rating categories. However, we generally recommend that residents score at least 40 on one or more CTS ratings before completing their training in CBT.

The **Cognitive Formulation Rating Scale (CFRS)** was developed by the Academy of Cognitive Therapy as a method of assessing a clinician's ability to conceptualize a case based on the cognitive behavioral model and to plan treatment. Ratings on the CFRS are conducted in three main areas: Case History (2 items), Case Formulation (5 items), and Treatment Plan and Course of Therapy (5 items). Each item is rated on a 3-point scale (0 = not present, 1 = present but inadequate, 2 = present and adequate).

In the Formulation section of the CFRS, clinicians are asked to describe precipitants of the disorder, current cognitions and behaviors that are contributing to the problem, developmental considerations in symptom production, the patient’s strengths and assets, and a summary of the case conceptualization. The treatment plan and course of therapy include ratings on items such as treatment goals, interventions planned and practiced, and how the clinician approached obstacles to the treatment plan. The Academy of Cognitive Therapy criterion for a passing score on the CFRS is 20 out of 24 total possible points. We have been using this case formulation write-up format in our cognitive therapy training programs and have found that residents usually appreciate the structured methods, examples, and feedback that this system provides. We have found that most residents are able to attain a score of 20 on the CFRS after completing a basic didactic course of 16–20 hours and treating 2–5 patients with CBT.

The **Cognitive Therapy Awareness Scale (CTAS)** (38) was originally designed as a method of measuring the acquisition of basic knowledge of cognitive therapy concepts and methods in patients who are being treated with this approach. However, it is also being used in residency training programs as a standardized pre- and postmeasure for changes in knowledge associated with participation in cognitive therapy courses. The CTAS has 40 true/ false questions on topics such as definitions of automatic thoughts and schemas; description of thought records, activity schedules, and other commonly used treatment
methods; and identification of maladaptive thinking in case illustrations.

The maximum score on the CTAS is 40. A score of about 20 would be expected if one knew nothing about cognitive therapy. A study of 96 patients who used a computer program to help them learn cognitive therapy skills found an increase from a mean score of 24.2 before using the software to 32.5 after completing the computer training (38). The CTAS has not been studied systematically in psychiatry training programs. However, our experience to date indicates that residents typically have mean CTAS scores in the mid-20s to lower 30s before starting formal training in cognitive therapy. Most residents have a substantially higher CTAS score after completing a comprehensive course in cognitive behavior theory and methods.

The fourth assessment tool, the Cognitive Behavior Therapy Supervision Checklist (39), can be used to track resident progress in achieving specific competencies. As with the other measures, the CBT Supervision Checklist serves its most important function in coaching residents on the critical elements of effective therapy. It also can serve as a record of the resident's fulfillment of training goals.

The items on the CBT Supervision Checklist are based on those recommended by the AADPRF task force on psychotherapy competencies. They include evaluations of general therapy skills in addition to specific cognitive therapy interventions, such as setting agendas and structuring therapy, modifying automatic thoughts and beliefs, and assigning useful homework.

Sources for the assessment tools described here are (1) Cognitive Therapy Scale and Manual: Academy of Cognitive Therapy Web site (http://academyofct.org); (2) Cognitive Therapy Formulation Rating Scale (plus instructions for developing case conceptualization and an example of a formulation), Academy of Cognitive Therapy Web site; (3) Cognitive Therapy Awareness Scale, Wright et al., 2002 (38); (4) Cognitive Therapy Supervision Checklist—Donna Sudak, M.D. (donna.sudak@drexel.edu).

**OBSTACLES TO EFFECTIVE TRAINING**

The most significant obstacle in teaching residents CBT is a lack of faculty expertise in some academic departments of psychiatry. Psychiatrists are not well represented in specialty organizations that certify CBT competence (ACT, ABPP) and have not traditionally sought further training in this method of psychotherapy, as compared to psychodynamic psychotherapy. There are also fewer specialty training institutes of CBT, as compared to psychoanalysis, which can be used as sources for paid or volunteer faculty.

Programs can creatively increase faculty expertise in several ways:

1. Providing faculty members with comprehensive training in CBT at a specialized institute (e.g., an extramural fellowship at a recognized institute for cognitive therapy training) for one or two faculty members who can teach both faculty and residents.
2. Acquiring psychoeducational materials such as videotapes of master therapists, CBT books, and computer programs that teach basic CBT methods (40,41).
3. Arranging supervision of faculty trainees by telephone or teleconference with experts in CBT.
4. Coordinating a series of workshops for faculty and residents led by experienced cognitive therapists.
5. Recruiting trained community practitioners who could serve as paid or volunteer faculty.
6. Affiliating with university departments of psychology, psychology internships, nursing, social work, or other allied health fields with faculty expertise in CBT. These departments may require some teaching by psychiatrists (i.e., in psychopharmacology) so that a "trade" for faculty time can be made.

Other obstacles to effective training are the faulty beliefs that many residents and faculty have about CBT or psychotherapy in general. These can include beliefs that cognitive therapy is mechanical and suitable only for a narrow range of patients, lacks value for the therapeutic relationship, and discounts any exploration of development in working with patients. Such beliefs can be modified by educating an entire department as well as by adopting an empirical approach to the implementation of the treatment and training. Scheduled departmental conferences and grand rounds focusing on CBT related topics can increase faculty comfort and familiarity with this approach. A commonly related problem is the need to
directly address the concern that residents and faculty have about tape sessions. Again, adopting an empirical approach is helpful, as well as teaching residents to evaluate their automatic thoughts, generally about performance or close supervision. Noticeably, the connotation of competency implies the need to directly observe resident performance to ensure skillful application of treatment.

Departments will also need to face the challenge of finding time in the didactic schedule for teaching. The mandate for competency will assist program directors in this regard, but it is preferable to do so without infringing on other didactic requirements. Additionally, residents commonly believe that there are few or no suitable CBT patients in the available resident outpatient caseload. A number of approaches can be helpful in this situation. First, the resident didactic training can emphasize working with the patients the resident is most likely to encounter (e.g., CBT for depression, anxiety disorders, personality disorders, or bipolar disorder). Second, CBT does not need to be taught as an exclusively outpatient discipline. Many models exist for implementing training in inpatient settings (15,42), with patients with severe mental disorders (8,43,44,45), and medically ill patients (46,47,48). Third, in medication clinics, residents can learn how to use CBT techniques to enhance medication compliance with any patient (8,49). This venue should not take the place of conducting a full course of psychotherapy with other patients, but it has the added advantage of meeting the competency requirement for combined medication and psychotherapy cases. The widespread efficacy of CBT, along with the existence of models for multiple types of patients, allows training directors to be flexible in implementation.

**RESOURCES**

Several specialty organizations exist that can be resources for training directors. The Academy of Cognitive Therapy (www.academyofct.org) is an organization that can provide credentialing, a geographic list of trained practitioners, formats for case write-ups and the CTS and manual via the Internet. The American Board of Professional Psychology (www.ABPP.org) has specific credentialing in behavioral psychology as well as a geographic listing of practitioners. Cognitive therapy institutes in the United States include the Beck Institute for Cognitive Therapy and Research (www.beckinstitute.org), which has a specific extramural training program for residency training directors and faculty, as well as one for residents. Several other centers offer didactic training and seminars in CT, including the San Francisco Bay Area Center for Cognitive Therapy (www.sfbacct.com), the Cleveland Center for Cognitive Therapy (www.behavioralhealthbassoc.com), the Atlanta Center for Cognitive Therapy (www.cognitiveatlanta.com), and the Center for Cognitive Therapy in Huntington Beach (padesky@aol.com). Videotapes of master cognitive therapists are available from the Beck Institute, and a DVD-ROM multimedia computer program, developed by Drs. Jesse H. Wright, Andrew S. Wright, and Aaron T. Beck, is available from Mindstreet (http://mindstreet.com).

**References**