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).

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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, Mannarino, & Deblinger, 2006) or CBT-based extended models (Schema therapy; Young, Klosko, & Weishaar, 2003).
- Intensive nine-month to one-year trainings (which often involve supervision) such as those in Cleveland, Atlanta, San Diego, Chicago, and Asheville, among others.
- Postdoctoral fellowships that involve full-time training and work in a dedicated CBT center for one or two years, such as those offered in the Depression and Anxiety Specialty Clinic in Chicago, the Cognitive Behavioral Institute in Albuquerque, and Harbor-UCLA in Los Angeles.

Training through participation as a therapist in research trials of CBT in which therapists are trained to a predesignated level of competency. This training is quite intensive but may be focused only on the treatment of a particular problem or disorder. Candidates selected usually have backgrounds in general CBT skills.

In the United Kingdom, thirty-seven universities offer CBT postgraduate training courses. It is now possible in Britain to obtain both master's and doctor

of philosophy degrees in the field of CBT, which is not yet possible in the United States.

Although the Academy of Cognitive Therapy (ACT) (www.academyofct.org) provides excellent information on training courses, there is no body in the United States that accredits training, although ACT and several other organizations provide certification to individuals, which is further described in chapter 4.

The British Association for Behavioural and Cognitive Psychotherapies approves trainings and provides different levels of credentialing for British and Irish courses. Other countries have robust local postgraduate training and credentialing initiatives.

Appendix VI, Training Opportunities (www.wiley.com/go/sudak), contains information on training opportunities available in the United States and overseas for individuals and agencies considering training or supervision in CBT.

CLASSIFICATION AND REVIEW OF TRAINING PROGRAMS

Recent literature is helpful when considering the type of training to pursue, as there are pros and cons to each. Rakovshik and McManus (2010), in a comprehensive review of evidence-based training in CBT, describe training programs as (1) brief (60 hours or less of CBT training), (2) intermediate (61–137 hours of CBT training), and (3) extensive (137 hours or more of CBT Training). They did not make a distinction between courses offering supervision as well as didactic training but noted in their review that almost all the studies they examined included supervision. They reported that supervision plus an adequate dosage of didactic training appeared to be the important component in training that results in favorable outcomes. Using this classification, it is likely that most trainings available throughout the world for practitioners are in the brief category, some in the intermediate category when ongoing supervision hours are included, and only a few in the extensive category.

Using a number of different criteria (duration, presence or absence of a systematic step-up approach, presence or absence of supervision), CBT training programs might be classified as follows.

Limited-Exposure CBT Training

These are usually of brief duration (no more than one day) and may offer a general introduction to CBT, more advanced applications of CBT, or CBT for specific disorders. Such training is often delivered to mixed and heterogeneous audiences or, in some cases, may be presented to an entire agency.

Advantages Such trainings are offered frequently, do not involve a significant financial or time commitment, and for practitioners familiar with the model may provide a "tune-up" or extension of their skills and knowledge.

Disadvantages Brief training of this sort usually is largely didactic and, though there may be some experiential components, without practice or supervision components. Real-life skill development beyond an increase in knowledge is limited. The quality of training or trainer in fidelity to the model can be extremely variable and hard for trainees to assess in advance.

More Systematic CBT Training Programs of Longer Duration

This type of training is often offered for several days, over a weekend or in a series, with a more systematic approach to knowledge (of theory, research, and practice) and skill acquisition.

Advantages Compared with limited-exposure training, this type of training is longer, more in-depth, and may have built-in opportunities for practice within the training. Also, a number of areas of application of CBT or one application (for example, depression) can be focused on in greater detail with more trainee involvement.

Disadvantages Again, such training is unlikely to involve supervision of actual practice and, subsequently, changes in actual therapy behavior may not ensue following such training. Similarly, the quality of training may be more variable than the next two types of training described.

More Intensive CBT Training Involving Supervision or Case Consultation

This form of training usually is geared toward therapists in practice who attend part time for six months to one year with a significant number of hours (forty or greater) of didactic instruction. The training is usually progressive and systematic in nature. Supervision is usually provided on an individual or group basis either during or after the training.

Advantages The range and time spent in didactic instruction gives a good grounding in the theory and application of CBT. Trainers are more likely to be adequately credentialed and trained. This type of training may be particularly helpful for CBT "novices" who have opportunities for practice, both within the training and in supervised patient care between training sessions. Such trainings usually have built-in assessment of skills and competence (CTS ratings, for example), and supervision also provides a check on skill development. This form of training may provide internal certification when a defined level of competence is achieved and may meet the requirements for external and peer-reviewed credentialing, as described in chapter 4.

Disadvantages For economic and practical reasons, the amount of supervision provided may not be sufficient to ensure continued best practice of CBT. Rating samples of trainees' therapy sessions may not occur. In addition, although the CBT trainers conducting such trainings may encourage this, trainees may not pursue credentialing. Last, such training may be costly and involve a time commitment that may be difficult or impossible to sustain when trainees are employed full time.

Intensive CBT Training Leading to Certification or a Diploma or Degree

This type of CBT training involves either a part-time master's or doctoral degree program associated with a university department, such as those in existence in the United Kingdom, or a full-time postdoctoral fellowship organized through a university department, or a clinic, or center with links to a university who award the fellowship, which is possible in the United States. This training may be of significant duration, usually from one to two years.

Advantages This is the most extensive from of CBT training, both in teaching input and supervised practice. Trainees are evaluated in many different ways to ensure competency (CTS plus other methods) and have numerous opportunities to deliver CBT in a practice setting under supervision to be evaluated on their skill level and receive corrective feedback, often from a number of different supervisors over the duration of the training. Individuals completing such training receive an award (diploma, degree, fellowship) from an institution with credentialing authority and are, in this way, set apart in terms of training and expertise.

Disadvantages Such training is very time intensive and can be expensive. As a result it involves a self-selected, favorably disposed group of trainees who possibly do not represent the providers who most need intensive evidence-based training. In addition, such training, as pointed out by Muse and McManus (2013), is very labor intensive for trainers and supervisors and may not be the optimal use of resources for dissemination of CBT.

A detailed description of different training routes for continued education for therapists in practice can be found in chapter 10, in the section titled "Current CBT Training Options."

Table 1.1 summarizes training options and their advantages and disadvantages, as described previously.

For a professional considering training options, some important questions to be asked include:

- What is the length of training?
- How is the training organized (time blocks, consistency with job requirements)?

Table 1.1 Summary of Alternatives for CBT Training

Type of Training	Characteristics	Training Methods	Positives/Negatives
Limited-exposure workshops	Brief (1 day or less). Usually sponsored by agencies or associations. Introductory or specialized.	Usually didactic and demonstration only. Little or no experiential focus. No supervision or practice components.	High availability. Online versions readily available. Inexpensive. Brief time commitment. Trainer and training quality variable. No practice or supervision. Behavior change as a practitioner unlikely.
Brief CBT programs	Several-day programs or spaced over time. Progressive approach and more in-depth focus possible. Sponsored by agencies or associations.	Can include experiential, practice, and consultative components, as well as didactic and demonstration.	More in-depth. More nondidactic components. Quality of training and trainer variable. No supervision. No assessment of competency. Behavior change may not occur.
Intensive programs	Usually 6 months to 1 year duration. Part-time program. Systematic progressive training for professional practice. Sponsored often by CBT centers.	Includes comprehensive didactic and demonstration component. Opportunities for experiential and self-reflective elements. Supervised clinical practice encouraged. Case consultation or supervision usually provided.	More likely to result in behavior change as well as knowledge acquisition. Competence often assessed. May provide certification and often meets criteria for credentialing. Trainers more likely to be credentialed. Costly.
Intensive programs culminating in a diploma,	Duration of one to two years. Diploma.	All training methods are utilized. Supervision (individual or	Likely to result in behavior change. Competence assessed.

(*continued*)

Table 1.1 (*Continued*)

degree, or fellowship award	Master's, doctorate, and fellowship awards. The most comprehensive, both in time involved and content of training. Sponsored by CBT center in association with universities or through university clinics.	group) is a major component of training. Use of CBT in actual patient care targeted, monitored, and fine-tuned through supervision. Competency assessed often at several intervals during training.	Trainers usually credentialed. Training itself can be credentialed through organizations. Results in the award of degree, diploma, or fellowship acknowledging training and competence. Often costly and involves a significant time commitment. May mean giving up current employment, if full time.

- What is the content of training?
- What is the supervision or practice component?
- What training methods are employed (didactic, experiential, online)?
- What is the trainer's background and expertise?
- Is certification and credentialing part of training?
- What is the cost and time commitment?

Most systematic CBT training programs offer certification from the agency providing the training and may also offer continuing education credits. In addition some assist in the process of credentialing through the Academy of Cognitive Therapy or other credentialing bodies.

Currently in the United States there are three routes toward certification:

1. *The Academy of Cognitive Therapy* offers different forms of membership. Becoming a diplomate entails peer credentialing based on CBT experience, CBT training hours accumulated, and ratings of work samples. The academy also credentials individuals in training and consultation, who receive the designation ACT Trainer/Consultant. These individuals have reached a desired level of competence as CBT trainers, CBT supervisors, or CBT consultants; this can assist individuals and agencies in setting up good-quality training and supervision.
2. *The American Board of Professional Psychology (ABPP)*, which is affiliated with the American Psychological Association, provides certification in

cognitive behavioral psychology that involves an exam, professional experience, and an evaluation of work samples. Unlike the Academy of Cognitive Therapy, which is open to all professionals, this is restricted to psychologists.

3. *The National Association of Cognitive-Behavioral Therapy (NACBT)* certifies members at two levels: Diplomate in Cognitive-Behavioral Therapy and Certified Cognitive Behavior Therapist. Both are based on training and length of experience. There are no requirements regarding work samples or evaluation of skills or practice for certification with this organization.

In the United Kingdom, the British Association for Cognitive and Behavioural Psychotherapy has certification at the level of Cognitive Behavioral Psychotherapist (Full), Cognitive Behavioral Psychotherapist (Provisional), and Supervisor and Trainer and Psychological Wellbeing Practitioner (linked to receiving training through the Improving Access to Psychological Therapies Courses). Accreditation procedures are also reviewed in chapter 4. See "Accreditation as a CBT Provider."

Individuals or agencies considering instituting training or supervision should seek out CBT trainers and supervisors accredited by some of the listed organizations.

EFFECTIVENESS OF TRAINING

Not a great deal of research has been conducted about CBT training to allow us to provide training based on evidence for effectiveness. As Milne (2009) argues, it is important that we establish a good evidence base and have research support for CBT supervisory and training practice. This is emerging with increasing vigor. Very little evaluative research on the effects of training therapists for practice, as distinct from studies evaluating training for research trials, has been conducted in the United States. Most of the existing literature on the effects of training and supervision originates from the United Kingdom and other countries. The existing research is reviewed in Tables 10.1 and 10.2 in chapter 10.

A recent review article by Rakovshik and McManus (2010) located forty-one published studies up to the year 2009 that evaluated CBT training and met criteria for inclusion in the review. Of these, only seven studies were *not* linked to a research trial of CBT. Nineteen studies (approximately 46 percent) showed clear competence enhancement, measured in an acceptable fashion, thirteen studies (approximately 32 percent) showed positive effects of training but not necessarily meeting the criteria of competence, and five (approximately 12 percent) showed no significant effects of training. However, a more general systematic review of training for evidence-based practice (many studies of CBT training were included) carried out by Beidas and Kendall (2010) concluded that "perceived and declarative knowledge increased following training in evidence-based

practice" but cautioned that "generally speaking, therapists trained in the current format (workshop, manual, and brief supervision) do not reach proficiency in treatment adherence, competence and skill" (p. 25). The authors went on to outline methods of maximizing training through active learning. Empirically supported educational methods that maximize learning in CBT training are described in chapter 3 of this volume.

It is difficult to draw definitive conclusions across studies because of the very different outcome measures and indices of competency. The problem of differing outcome measures in CBT training research has been noted by several commentators (Beidas & Kendall, 2010; Fairburn & Cooper, 2011; Muse & McManus, 2013). These and other authors have suggested ways to remedy this situation.

Many existing training studies have used multiple measures and, most important, included the Cognitive Therapy Rating Scale (CTS) or a revision of this (CTS-R; Blackburn et al., 2001) with ratings made (often by independent observers) on recorded work samples. Some writers (Fairburn & Cooper, 2011) favor a measure of therapist skill in real-life settings, a trainee conducting therapy with a standardized "patient" (an actor), a method of evaluation used in medical training, while others favor role plays and behavioral rehearsal as a way to assess competency (Beidas, Cross, & Dorsey, 2014). Most training studies used measures of knowledge and self-perceived skill without any measure of observed skill.

Unfortunately, self-reported behavior change does not match actual behavior change (Beidas & Kendall, 2010). Some studies include patient outcome as a measure of the effectiveness of training, but this may be less than ideal because other factors, in addition to therapist competency, may be instrumental in determining therapeutic outcome. Muse and McManus (2013) provide an excellent review and evaluation of measures of competency for CBT training. In addition, chapter 4 describes different methods of evaluating trainee competency. Chapter 10 also includes a more detailed analysis of the research on the effectiveness of CBT training.

However, a brief summary of the findings of the training research indicates that

- Dosage is predictive of outcome. More extensive training leads to greater competence and better patient outcomes (Ravoshik & McManus, 2010).
- Supervision added to didactic instruction is more effective than didactic instruction alone (Sholomskas et al., 2005).
- Relatively inexperienced therapists (CBT "novices") can be successfully trained, especially when the training is lengthier and more extensive and includes a supervision component (Barnfield, Mathison, & Beaumont, 2007; Keen & Freeston, 2008).
- Nontraditional providers such as nurses, occupational therapists, case managers, and palliative care workers can be trained to competence in CBT (Westbrook, Sedgewick-Taylor, Bennett-Levy, Butler, & McManus, 2008).

- Employing different training modes, including experiential learning, clinical practice (including self-practice), self-reflection, and supervision is important to attain competence in CBT (Beidas & Kendall, 2010; Bennett-Levy, Lee, Travers, Pohlman, & Hamernik, 2003).

BEST PRACTICES FOR TRAINING

Later chapters (8, 9, 10, and 11) elaborate on best training practices from both a review of existing research and the experience of trainers. At this point, several suggestions and guidelines are briefly outlined:

- Training should be tailored to the specific needs of those being trained.
- Training should include different modalities of learning, including experiential components that foster active learning and skill development rather than the acquisition of knowledge alone.
- Online versions of training are needed for maximum dissemination of training.
- Brief training, including some supervisory or consultative component, should be made easily available to those who are providing low-intensity CBT.
- Follow-up or ongoing practice of skills with supervision is critical.
- Assessment of core competencies and skills, not only knowledge, is essential.
- Trainers must receive training in best training practices.

BEST PRACTICES FOR SUPERVISION

Evidence-based supervision in CBT is described in later chapters (12 and 13). The following is a summary from the existing literature (Milne, 2009; Milne & James, 2000) regarding best practices in optimizing CBT supervision:

- Use of different training modes in a targeted and conceptually driven way (didactic, observational, experiential)
- Use of training manuals and disorder-specific evidence-based protocols
- Structuring supervision in a manner that mirrors cognitive behavioral therapy practice (agenda setting, problem definition, use of feedback and homework)
- Developing a good supervisory alliance that involves collaborative empiricism
- Providing corrective feedback to supervisees and eliciting and responding to trainee feedback regarding supervision (see chapter 5)
- Use of self-practice and self-reflection to foster learning
- Focus on the supervisory process

- Ensuring supervisors have ongoing supervision and training to fine-tune their supervisory skills (see chapter 13)

WATCH. Go to www.wiley.com/go/sudak, *Appendix VII, Video Library*, and View Videos:

- Goal Setting for Supervisors
- Frustration

SOME DISTINCTIVE FEATURES OF CBT TRAINING AND SUPERVISION

Key features in the development of CBT training and supervision include:

Range of professionals trained CBT training has been notably inclusive of professional groups trained. Beck supervised, trained, and collaborated with psychiatrists, psychologists, and social workers in the early development of CBT. Training courses currently offered are open to professionals from all disciplines. Professional organizations representing cognitive behavior therapists in the United States (ABCT, Academy of Cognitive Therapy) and internationally are solidly multidisciplinary. Studies describing and evaluating training for a wide range of mental health, nursing, medical, and other professional groups exist in the literature. CBT has been more widely disseminated as a result. Behavior therapists need to be given great credit for implementing this ecumenical training stance. Isaac Marks implemented behavior therapy training for nurses in the 1970s and clearly demonstrated that this group could produce outcomes comparable to other professionals (Marks, 1985). Multidisciplinary teamwork related to the delivery of CBT is unique among psychotherapies. Such open-mindedness to maximizing services to clients by widespread training of many disciplines is well represented in the low-intensity CBT movement, which has gained tremendous support (Bennett-Levy et al., 2010) and has considerable potential to help a larger number of suffering patients.

Range of applications of CBT training A hallmark of the evolution of CBT has been the continuous momentum and progression of new applications to clinical problems and populations. In the 1980s and 1990s, CBT was largely a treatment for mood and anxiety disorders; now evidence-based CBT protocols exist for a wide variety of conditions ranging from medical conditions such as irritable bowel syndrome (Toner, Segal, Emmott, & Myran, 2000) and Tourette's Syndrome (Woods et al., 2008) to psychiatric symptoms previously thought to be untreatable by psychotherapy, such as hallucinations and delusions (Chadwick, Birchwood, & Trower, 1996).

Very specialized training in CBT exists for such specific areas of interest as trauma-focused CBT (Cohen et al., 2006) or CBT-I for insomnia (Perlis, Jungquist, Smith, & Posner, 2005).

Reflexivity One of the hallmarks of the CBT approach is that key elements of therapy (structure, collaboration, feedback) are reproduced in training and supervision, which is unique among psychotherapies. These similarities are described in Table 1.2. In CBT, this practice models the key components of the therapy by implementing them in supervision and training (Liese & Beck, 1997; Padesky, 1996). In addition Bennett-Levy, Thwaites, Haarhoff, and Perry (2015) describe how CBT can be practiced "from the inside out"; that is, by trainees using CBT methods on themselves utilizing self-refection and self-practice to improve skill development.

Regarding supervisory practice, Milne (2008) has noted this "reflexivity" and its advantages but has also pointed out that (1) it is not always adhered to and (2) it may not be sufficient. Milne recommends a more specialized approach with the inclusion of other elements from the wider field of supervision and also from the applied psychology of learning. This practice is described in chapter 12.

Table 1.2 Commonalities between CBT Therapy and CBT Supervision and Training

Therapy Elements	Present in Supervision	Present in Training
Structure	Yes	Yes
Agenda setting	Yes	Trainer directed but can include trainees's needs
Prioritizing agenda	Yes	Most often trainer determined
Collaboration	Yes	In more active learning modules and in seeking feedback
Guided discovery	Yes	In more active learning
Interpersonal effectiveness	Yes	Yes
Efficient use of time/ pacing	Yes	Yes
Problem definition/ goal setting	Yes (for patient and supervisee)	Yes, in stated training objectives
Problem solving	Yes (for patient and supervisee)	Yes, in meeting training objectives
Capsule summaries	Yes	Yes
Homework	Yes	Usually present in ongoing training, not in one-time training
Feedback	Yes (to and from supervisee)	Yes, on clarity of and reactions to the material presented

Face validity of the CBT model The CBT model has a coherence, clarity, and commonsense quality that can be easily explained and demonstrated. Trainees and clients resonate with the high face validity of the model. Its universality is represented in proverbs ("One man's trash is another man's treasure"), widely read quotations (Shakespeare noted, "There is nothing either bad or good but thinking makes it so"), and Oscar Wilde concluded, "We are all in the gutter but some of us are looking at the stars"), and in the commonsense analysis of day-to-day situations (It is not the noise in your house during the night that makes you anxious but your assumption about what is causing it).

The emergence of models for training and supervision The development of models for training and supervision in CBT in general (Bennett-Levy, 2006; Bennett-Levy et al., 2015) and for training in specific skills such as case conceptualization (Kuyken, Padesky, & Dudley, 2009) may guide trainers in a manner quite different from the earlier "train and hope" approach (Stokes & Baer, 1977). Similarly, the development of evidence-based supervision approaches with a clear guiding model (Milne, 2008) ensures more effective supervision. See chapter 12 for more information.

Delineating core competencies and improved measurement of competency The general move toward delineating the competencies required for psychotherapy and other areas of professional practice (Kaslow, 2004) has extended to CBT. Of great value to trainers and supervisors, trainees, and therapists alike has been the defining CBT competencies (Newman, 2012; Roth & Pilling 2008). Just as therapy is generally more successful when clear goals and targets are established, operationalizing clear competencies and skill sets expected of a therapist delivering CBT with fidelity is likely to make CBT training and supervision maximally effective. Chapter 2 describes core competencies in CBT training. As mentioned previously, research regarding training outcomes has been hampered by the use of differing measures of competency (Muse & McManus, 2013). There are encouraging signs of improved measures of competency of trainees, supervisees, and supervisors. Chapter 4 reviews methods of evaluating competency in trainees, and chapter 12 describes practical ways of measuring elements of supervision.

Training for supervisors and trainers Ongoing supervision and consultation for supervisors and trainers is widely recommended. It ensures that the cycle of training and supervision is optimized with and optimizes both continued professional development and faithful, skillful patient care improving the probability of positive clinical outcomes. This is described in detail in chapter 13.

FUTURE DIRECTIONS FOR CBT TRAINING AND SUPERVISION

There is a significant need for greater availability of effective training programs (intensive with a strong didactic, experiential, practice-and-supervision component) both at the graduate and postgraduate levels. The quality and content of training should be assessed by credentialing bodies. CBT national and international organizations could devote attention to this issue to ensure that training programs offered meet adequate standards.

Clearer and more specific descriptions of training and supervision are needed. Such needs inspired this text. Access to training in CBT supervision and training should be improved and more continual education and supervision for trainers and supervisors required. The initiative by the Academy of Cognitive Therapy to credential individuals with the required competence to be "consultant trainers" will, we hope, lead to a continuing improvement in the quality of supervision. The effort to prevent "drift" from the model ultimately affects patient outcomes.

As Clark (2004) points out, there is a need for a theory to guide training research to inform the practice of CBT training and supervision. At the present time, despite some advances in this field we are still not sure, based on empirical data, what works best and for whom in training and supervision. Unfortunately, in reality training that is currently available is often a "one size fits all" approach.

Consensus is needed about the goals of training and how we define competence or desired outcomes so that we may design training in a systematic way. Setting benchmarks regarding competencies at different stages of a therapist's development may help this (Newman, 2012). Sharpless and Barber (2009) have suggested that therapists may pass through five developmental stages:

1. Novice
2. Advanced beginner
3. Competent
4. Proficient
5. Expert (paralleling the Dreyfus competency model; see Sudak, chapter 5)

A formulation of expectations for each stage is required rather than a one-time definition of competence (a specific cut-off score on the Cognitive Therapy Scale, for example). We also need unanimity on what defines competency, which makes comparison of training studies possible. Muse and McManus (2013) identified ten methods of assessing competence in a review of studies that measure different skills on Miller's Pyramid (Miller, 1990), such as knowledge ("knows"), practical understanding ("knows how"), practical application of knowledge and skill ("shows how"), and clinical practice ("does"). Chapter 4 discusses the different methods of evaluating competency.

Well-designed evaluative research must answer some of the following questions:

- What is the optimal length, content, and form of training for different trainee groups (for example, low-intensity providers, individuals with little knowledge of counseling in general, therapists working with highly complex and challenging cases)?
- Which mode or modes of training (didactic, experiential, observational, self-reflective) produce the best outcomes? Effective training may involve a two-stage process in which first theoretical knowledge is acquired via didactic presentations, guided reading and the use of Internet and Web-based resources followed by continuing skills development via practice cases, experiential work, observation of sessions, and supervision (Rakovshik & McManus, 2010). (Different teaching methods applicable to CBT are discussed in chapter 3.)
- How much CBT training can be done online without the expense of providing trainers and supervisors? Fairburn and Cooper (2011) argue that all aspects of training should be done through the Internet and other technologies since traditional training is both cost-ineffective and unlikely to lead to the degree of dissemination required given the public health needs.
- How much can training use nontraditional methods such as computer programs (similar to those designed to assist patients), CBT "apps," research-based manuals, and self-help materials? (The use of technology in training is discussed in chapter 7.) Such research needs to be a priority to ensure that we train and supervise in the most effective way (Milne, 2009).

Several writers have emphasized the importance of organizational factors in maximizing the effectiveness of CBT training and supervision. Beidas and Kendall (2010) have proposed a systems-contextual model to optimize training stressing the role and interaction of therapist factors, client variables, and organizational support. They argue that each factor needs to be addressed to create effective training. Stirman et al. (2013) offer guidelines to facilitate training looking at the role of organizational factors. Chapter 11 provides suggestions for motivating organizations to support initiating and maintaining CBT training and supervision efforts.

More training courses for supervisors and trainers should be developed. Professional organizations and individuals in the training and supervision community must provide such opportunities and stress the importance of continued training and supervision.

SUMMARY

Significant progress has been made to refine and optimize the dissemination of CBT. This is an exciting time for trainers and supervisors. Subsequent chapters in

this volume provide guidelines to optimize the practice of CBT training and supervision from the existing knowledge base and on the extensive practical experience of the contributors.

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