Candidate Handbook

Revised May 2013

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Appendixes

This Candidate Handbook was created to inform potential Academy of Cognitive Therapy (ACT) applicants of the current standards, policies and practices related to ACT Certification and the Certification Process. ACT reserves the right to revise this Candidate Handbook and the policies contained herein as deemed appropriate. To ensure that you have the most current version of this handbook, please refer to the ACT website or contact the ACT Administrative Office.

1. Certification Skill Requirements

ACT recognizes as a Certified Cognitive Therapist one who, according to the standards set forth by the Academy of Cognitive Therapy, possesses demonstrable skill in case formulation, conceptualization and treatment plan design. Also, within the context of a therapy session, the therapist must demonstrate effectiveness in the following areas: agenda-setting, proper elicitation of feedback, empathy and understanding, interpersonal effectiveness, patient-therapist collaboration, pacing and appropriate use of time, use of guided discovery, focus on key cognitions and/or behaviors, development of a strategy for change, application of cognitive-behavioral techniques, and homework assignments.

2. Eligibility

To be eligible to receive certification from ACT, the applicant must meet the following minimum requirements:

(1) The applicant must hold a graduate degree in the field of mental health (or the equivalent, as judged by the Credentials Committee, in the case of Non-North American applicants).

(2) The applicant must be licensed to practice in the state or territory where his/her practice is conducted (if a license is issued there).

(3) The applicant must conform to the standards set forth in the Code of Ethics of his/her National Professional Organization.

(4) The applicant must meet the following requirements in the field of cognitive therapy, as specified by Part I of the application: a) at least 40 hours of training specific to cognitive therapy, b) treatment of at least ten (10) patients using the cognitive model, c) satisfaction of at least five (5) of the Cognitive Therapy Reading Requirements, d) utilization of the cognitive model in treatment for at least one (1) year prior to application, e) submission

of two (2) letters of Professional Recommendation from colleagues and f) submission of a current *curriculum vita* evidencing sufficient cumulative education and training in cognitive therapy.

3. Application Process

Candidate must submit the required application (Part I and Part II), fees and supporting documents within the established deadlines as determined by the Credentials Committee. No exceptions or waivers will be granted for any element of the application. The procedure for filing applications is set forth below:

(1) Applicants will submit Part I of the application;
(2) Only upon notification that Part I has been approved, the applicant will be asked to submit Part II of the application.
(3) Part II must be submitted no more than two (2) years after the notification date of a successful Part I submission. If more than two (2) years have passed since this notification date, the applicant will need to resubmit Part I and the associated fee and receive notice of approval prior to submitting Part II of the application.

4. Notification

The Credentials Committee will notify the applicant of the result of his/her Part I or Part II submission or Recertification Exam within 90 days.

6. Appeals Policy

The right of appeal is granted to anyone who is denied certification in ACT. In requesting an appeal, the appellant is provided with two options: (1) he/she may request that an additional, independent member of the Credentials Committee rate the submission or (2) he/she may request a formal appeal hearing. The fee for the additional rater is $75 and the decision of that rater is final. There is no fee for an appeal hearing, and the decision of the Appeals Committee is final. The Appeals Committee retains the right to deny any Appeal Petition that is brought forth on insufficient grounds.

7. Confidentiality Policy

It is ACT's policy to keep confidential all information relating to the personal information of ACT applicants, certificants and consumers; specific applicant submission and scoring information; contact information of certificants (unless expressly deemed public information by the certificant); applicant appeal petitions and all Appeals Committee recommendations of same.

8. Verification of Identification

ACT will require all applicants to submit a photocopy of a valid license to practice psychotherapy in their state as well as to sign a testament of authenticity of all materials submitted as part of the application process in order to verify identity of applicants and authorship of materials.

9. Disciplinary policy

ACT retains the right to deny or revoke eligibility or certification of any applicant or certificant of ACT according to the provisions put forth in ACT's disciplinary policy, which includes but is not limited to any application to ACT that includes falsified or fraudulent credentials or materials or is predicated upon deceptive means. The complete Disciplinary Policy is available upon request.

10. Procedures for ADA Compliance

Our assessment instruments do not require applicants to come to the ACT Administrative Office for testing. Applicants may complete their application in the privacy of their own homes or offices. Requests for test accommodations therefore do not apply. ACT is fully compliant with the Americans with Disabilities Act.

11. Nondiscrimination

It is the Corporation's fundamental policy that discrimination on the basis of race, color, religion, national origin, ancestry, sex, disability, sexual orientation, or age is strictly prohibited in the terms, conditions and privileges of employment and affiliation in the Corporation, and in the administration, and implementation and utilization of programs and services.

Appendix A: Application – Part I

Application for Certification as a Cognitive Therapist

Please submit ***an original and one copy*** of this application, a copy of your current professional license (if available in your locale), a copy of your current *curriculum vitae,* and your check payment for $250, to the Academy of Cognitive Therapy, 260 South Broad St., 18th Floor, Philadelphia, PA 19102, USA.
(For your safety, ACT will no longer accept faxed, mailed, or emailed credit card numbers. If you wish to pay with a credit card, please visit our website, www.academyofct.org or call (267) 350-7683)

PART ONE

Date: _____

DEMOGRAPHIC INFORMATION (Please type or print clearly):

Name: _____

Please circle: Male / Female

Business address(es):

1. _____
Street Suite City State Zip

_____
Phone Fax Email

2. _____
Street Suite City State Zip

_____
Phone Fax Email

3. _____
Street Suite City State Zip

_____
Phone Fax Email

Home address:

_____
Street Suite City State Zip

_____
Phone Fax Email

How did you hear about ACT? _____

PROFESSIONAL DEGREE

Please indicate that you hold an advanced professional degree. This is a professional degree in medicine, psychology, nursing, social work, occupational therapy, pastoral counseling, or another discipline in which you have received advanced education in health care.

Degree (Please Circle): M.D., Ph.D., Psy.D., Ed.D., M.A., M.S., M.S.W., L.C.S.W., M.S.N., O.T.R.

OTHER (please specify) : _____

Institution granting the degree: _____

Location of the institution:

_____

Street City State Zip

_____

Street City State Zip

Date of the degree: _____

LICENSE

If a license for your profession is obtainable in your state, please fill in the following section and submit a copy of the license.

If your state does not grant a license for your profession, please submit a statement to that effect, and submit transcripts from the institution granting your professional degree. If your state does grant a license for your profession but you do not hold it, you are not eligible to apply for ACT certification.

License Type: _____

State(s): _____ Year(s) Obtained: _____

Please remember to submit a copy of your license with this application

PROFESSIONAL LIABILITY CARRIER INFORMATION

Name of Carrier: _____

Address: _____

City: _____ State: _____ Zip:_____

Policy #: _____ Amount of Coverage:_____

Date of Inception: _____ Date of Expiration: _____

Name of Agency: _____

PROFESSIONAL LIABILITY QUESTIONNAIRE

Has your professional liability insurance ever been terminated by action of any insurance company?	☐ YES ☐ NO
Have you ever been denied professional liability insurance coverage or been rated at a higher than average risk class for your specialty?	☐ YES ☐ NO
Has your present professional liability insurance carrier excluded any specific procedures or events from your coverage?	☐ YES ☐ NO
Have any professional liability suits or claims ever been filed against you?	☐ YES ☐ NO
Have any professional liability suits or claims been filed against you which are presently pending?	☐ YES ☐ NO
Have any judgements or settlements been made against you in professional liability cases?	☐ YES ☐ NO

If the answer is yes to any of the above questions, please explain the case(s) and the outcome(s) on the following Professional Liability Detail Sheet. Provide a full explanation including the name of the carrier, the date, and specific information concerning any limitation.

PROFESSIONAL LIABILITY DETAIL SHEET

☐ CHECK HERE IF NOT APPLICABLE

Please copy this page if additional sheets are needed.

Please fill in the following details for each pending or settled malpractice suit or claim you have experienced.

Pending
Settled Date: _____/_____/_____

List the allegations:

_____
_____
_____

Date of occurrence:

_____

Name of institution involved (i.e., hospital):

_____

Name and address of insurance carriers involved:

_____
_____
_____

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Please supply the following details for each malpractice lawsuit in which you were a defendant, and which resulted in a jury award or court judgment against you:

Title of court case: _____
The court case number: _____
The venue of the case (place where court case took place, such as Jefferson County District Court):

_____
_____

Allegations listed in complaint:

_____
_____
_____

Date of incident(s) leading to complaint:

_____

Place of incident(s):

_____

Name and address of malpractice insurance carrier:

_____

Amount of jury award or amount awarded by the court or settlement amount:

_____

PRACTICE INFORMATION

Please answer each of the following questions in full. If the answer to any part of the question is "yes," please provide full explanation of the details on a separate sheet and attach.

1. Have any actions ever been initiated or are there any pending against you by any state licensing board? □ Pending □ Settled □ Resolved	□ YES □ NO
2. Has your license to practice in any state ever been denied, limited, suspended? □ NOT APPLICABLE Has your license to practice in any state ever been sanctioned, revoked, voluntarily or involuntarily relinquished, or not renewed? □ NOT APPLICABLE	□ YES □ NO □ YES □ NO
3. Have you ever been suspended, sanctioned, or otherwise restricted from practicing in private, federal or state health insurance program (for example, Medicare, Medicaid)?	□ YES □ NO
4. Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health Insurance program?	□ YES □ NO
5. If applicable, have your narcotics registration certificates ever been limited, suspended, or revoked, voluntarily or involuntarily surrendered, or not renewed? □ NOT APPLICABLE	□ YES □ NO
6. If applicable, is your federal and/or state narcotics registration certificate being challenged? □ NOT APPLICABLE	□ YES □ NO
7. Have you been named as a defendant or convicted of a felony or misdemeanor? If YES, Within the last ten (10) years?	□ YES □ NO □ YES □ NO
8. Have your employment, medical staff appointment or clinical privileges ever been voluntarily or involuntarily suspended, diminished, revoked, limited or not renewed at any health care facility?	□ YES □ NO
9. Have you ever withdrawn your application for appointment, reappointment, clinical privileges, or resigned from the medical staff of any health care facility before a decision was made by its governing board?	□ YES □ NO
10. Have you ever been the subject of disciplinary proceedings at any hospital or health care facility?	□ YES □ NO
11. Have you ever been denied membership or renewal thereof, or been subject to disciplinary or adverse action in any medical or professional organization?	□ YES □ NO

PERSONAL HEALTH STATUS

Please answer the following question in full. If the answer to any part of the question is "yes," please provide full explanation of the details on a separate sheet and attach.

Are you aware of any health problems you possess, emotional, mental and/or physical, which could affect your clinical judgement or motor skills?	☐ YES ☐ NO

LETTERS OF RECOMMENDATION

Using the two attached checklist-format letters, please submit two letters of recommendation from professionals who are familiar with your work in cognitive therapy.

TRAINING IN COGNITIVE THERAPY

"Cognitive therapy is a goal-oriented, problem-focused, time-sensitive psychotherapy. The therapist conceptualizes the patient in cognitive terms and, guided by the conceptualization, develops an empirically-based treatment plan which emphasizes cognitive and behavioral techniques to bring about cognitive, emotional, and behavioral change. The therapist's style is predominately active, directive, and collaborative. Patient and therapist monitor the outcome of treatment using objective or subjective measures."

Academic training in cognitive therapy. Please see the attached list of Required and Recommended readings in cognitive therapy. **Applicants must have read a minimum of 5 books from the lists, at least 3 of which must be from the Required list**. Please check off the books you have read.

Clinical training in cognitive therapy. Please list workshops, graduate courses, seminars, or supervision in cognitive therapy (see definition of cognitive therapy above). 40 hours of clinical training are required. At least 10 hours of clinical supervision that includes tape review of actual therapy sessions is strongly recommended.

For each training entry, please provide the date of the training, a description of the format, title of the course/workshop, location of the course, names of persons providing the training, and number of hours of training provided. Possible formats include: clinical workshop, clinically-oriented graduate school course, supervised practicum, case supervision, intramural or extramural training program, and/or post-doctoral fellowship.

Article I. REQUIRED READINGS IN COGNITIVE THERAPY:

Directions: Please check the books that you have read. A minimum of 3 books are required from this list.

__ Beck, A.T. (1976). Cognitive therapy and the emotional disorders. New York: International Universities Press.

__ Beck, A.T., Emery, G., & Greenberg, R. (1985). Anxiety disorders and phobias: A cognitive perspective. New York: Basic.

__ Beck, A.T., Freeman, A., and Associates. (1990). Cognitive therapy of personality disorders. New York: Guilford.

__ Beck, A.T., Rush, A.J., Shaw, B. F., & Emery, G. (1979). Cognitive therapy of depression. New York: Guilford.

__ Beck, A.T., Wright, F.D., Newman, C. F., & Liese, B. S. (1993). Cognitive therapy of substance abuse. New York: Guilford.

__ Beck, J.S. (1995). Cognitive therapy: Basics and beyond. New York: Guilford.

__ Dattilio, F.M., & Padesky, C.A. (1990). Cognitive therapy with couples. Sarasota: Professional Resources Exchange, Inc.

__ Freeman, A., Pretzer, J., Fleming, B., & Simon, K.M. (1990). Clinical applications of cognitive therapy. New York: Plenum Press.

__ Leahy, R. (1996). Cognitive therapy: Basic principles and applications. New Jersey: Jason Aronson Inc.

__ Padesky, C.A., & Greenberger, D. (1995). Clinician's guide to mind over mood. New York: Guilford.

_ Persons, J.B. (1989). Cognitive therapy in practice: A case formulation approach. New York: Norton.

RECOMMENDED READINGS IN COGNITIVE THERAPY

Directions: Please check off the books you have read from the list below.

Theory and Research

_____ Alford, B.A., & Beck, A.T. (1997). The integrative power of cognitive therapy. New York: Guilford.

_____ Alloy, L.B., & Riskind, J.H. (Ed.). (2005). Cognitive vulnerability to emotional disorders. Mahwah, NJ: Lawrence Erlbaum Associates.

_____ Beck, A.T. (1999). Prisoners of hate: The cognitive basis of anger, hostility, and violence. New York: Harper Collins Publishers.

_____ Beck, A.T. (1999). Cognitive aspects of personality disorders and their relation to syndromal disorders: A psychoevolutionary aspect. In Cloninger, C.R. (Ed.), Personality and psychopathology. Washington, DC: American Psychiatric Press.

_____ Bond, F., & Dryden, W. (Eds.). (2004). Handbook of brief cognitive behaviour therapy. New York: John Wiley & Sons.

_____ Butler, A. C., & Beck, J. S. (2000). Cognitive therapy outcomes: A review of meta-analyses. Journal of the Norwegian Psychological Association, 37, 1-9.

_____ Clark, D. (Ed.). (2004). Intrusive thoughts in clinical disorders. New York: Guilford Publications.

_____ Craighead, L., Craighead, W., Kazdin, A., & Mahoney, M. (1994). Cognitive and behavioral interventions: An empirical approach to mental health problems. Boston: Allyn & Bacon.

_____ Gelder, M. (1997). The scientific foundations of cognitive behavior therapy. In Clark, D.M., & Fairburn, C.G. (Eds.), Science and practice of cognitive behaviour therapy (pp. 27-46). New York: Oxford University Press, Inc.

_____ Gilbert, P. (Ed.). (2004). Evolutionary theory and cognitive therapy. New York: Spring Publishing Company.

_____ Hays, P. & Iwamasa, G. (Eds.). (2006). Culturally Responsive Cognitive-behavioral therapy: Assessment, practice, and supervision. Washington, DC: American Psychological Association Press.

_____ Hollon, S.D., & Beck, A.T. (1994). Cognitive and cognitive-behavioral therapies. In M. J. Lambert (Ed.), Bergin and Garfield's handbook of psychotherapy and behavior change (5th Ed., pp. 447-492). New York: John Wiley & Sons, Inc.

_____ Holmes, E. A., & Hackmann, A. (Eds.). (2004). Mental imagery and memory in psychopathology. London: Psychology Press, Taylor and Francis Group.

_____ Ingram, R.E., Miranda, J., & Segal, Z.V. (1999). Cognitive vulnerability to depression. New York: Guilford.

_____ Kendall, P., & Hollon, S. (Eds.). (1979). Cognitive-behavioral interventions: Theory, research, & procedures. New York: Academic Press.

_____ Leahy, R. (Ed). (2004). Contemporary cognitive therapy: Theory, research, and practice. New York: Guilford Press.

_____ Leahy, R. L. (2003). Psychology and the economic mind: Cognitive processes and conceptualization . New York: Springer Publishing Co.

_____ Papageorgiou, C., & Wells, A. (2003). Depressive rumination: Nature, theory and treatment. New York: John Wiley & Sons.

_____ Taylor, S. (Ed.). (1999). Anxiety sensitivity: Theory, research, and treatment of the fear of anxiety. Mahwah, NJ: Erlbaum.

_____ Wells, A. (2002). Emotional disorders and metacognition: Innovative cognitive therapy. New York: John Wiley & Sons.

Clinical Applications: General

_____ Antony, M., Ledley, R., & Heimberg, R. (Eds.). (2005). Improving outcomes and preventing relapse in cognitive-behavioral therapy. New York: Guilford.

_____ Bennett-Levy, J., et al. (Eds.). (2004). Oxford guide to behavioural experiments in cognitive therapy. Oxford: Oxford University Press.

_____ Blackburn, I.M., Twaddle, V., & Associates. (1996). Cognitive therapy in action. A practitioner's casebook. London: Souvenier Press Ltd.

_____ Caballo, V.E. (Ed.). (1998). International handbook of cognitive and behavioural treatments for psychological disorders. Oxford: Pergamon/Elsevier Science.

_____ Clark, D.M., & Fairburn, C.G. (Eds.). (1997). Science and practice of cognitive behavior therapy. New York: Oxford University Press.

_____ Dobson, K.S. (Ed.). (1999). Handbook of cognitive-behavioral therapies (2nd ed.). New York: Guilford.

_____ Freeman, A. (2005). Encyclopedia of cognitive behavior therapy. New York: Plenum Publishing.

_____ Freeman, A., & Dattilio, F.M. (1992). Comprehensive casebook of cognitive therapy. New York: Plenum Press.

_____ Freeman, A., Simon, K.M., Beutler, L., & Arkowitz, H. (Eds.). (1989). Comprehensive handbook of cognitive therapy. New York: Plenum Publishers.

_____ Frisch, M.B. (2006). Quality of life therapy: Applying a life satisfaction approach to positive psychology and cognitive therapy. Hoboken: New Jersey: John Wiley & Sons.

_____ Gabbard, G., Beck, J., & Holmes, J. (2005). Oxford textbook of psychotherapy. New York: Oxford University Press.

_____ Gilbert, P., & Leahy, R.L. (2007). The therapeutic relationship in the cognitive behavioral psychotherapies. New York: Routledge.

_____ Granvold, D. K. (Ed.). (1998). Cognitive and behavioral treatment: Methods and applications (2nd ed.). Wadsworth Publishing.

_____ Hawton, K., Salkovskis, P., Kirk, J., & Clark, D. (Eds.). (1989). Cognitive behavior therapy for psychiatric problems. New York: Oxford University Press.

_____ Kazantzis, N., Deane, F., Ronan, K., & L'Abate, L. (Eds.). (2005). Using homework assignments in cognitive-behavioral therapy. New York: Routledge.

_____ Kuehlwein, K.T., & Rosen, H. (Eds.). (1993). Cognitive therapies in action: Evolving innovative practice. San Francisco: Jossey-Bass.

_____ Lazarus, A. (1981). The practice of multimodal therapy. Baltimore: John Hopkins University.

_____ Lazarus, A. (1997). Brief but comprehensive psychotherapy: The multimodal way. New York: Springer Publications Co.

_____ Ledley, D. R., Marx, P., & Heimberg, R. G. (2005). Making cognitive-behavioral therapy work: Clinical process for new practitioners. New York: Guilford.

_____ Leahy, R. L. (Ed.). (1997). Practicing cognitive therapy: A guide to interventions. Northvale, NJ: Jason Aronson Inc.

_____ Leahy, R. L. (2003). Cognitive therapy techniques: A practitioner's guide. New York: Guilford Press.

_____ Leahy, R. L. (Ed.). (2004). Contemporary cognitive therapy. New York: Guilford press.

_____ Leahy, R. L. (Ed.). (2003). Roadblocks in cognitive-behavioral therapy: Transforming challenges into opportunities for change. New York: Guilford.

_____ Leahy, R. L., & Dowd, T. E. (Ed.). (2002). Clinical advances in cognitive psychotherapy: Theory and application. York: Springer Publishing Company.

_____ Lyddon, W.J., Jones, J.V. (Ed.). (2001). Empirically supported cognitive therapies: Current and future applications. York: Springer Publishing.

_____ McMullin, R.E. (1999). The new handbook of cognitive therapy techniques (2nd ed.). New York: W.W. Norton Co.

_____ Needleman, L.D. (1999). Cognitive case conceptualization: A guidebook for practitioners. Mahwah, NJ: Lawrence Erlbaum Associates.

_____ Neenan, M., & Dryden, W. (2004). Cognitive therapy: 100 key points and techniques. New York: Routledge.

_____ Neenan, M., Dryden, W., & Dryden, C. (2000). Essential cognitive therapy. London: Whurr Publications Limited.

_____ Nezu, A., Nezu, C.M., & Lombardo, E. (2004). Cognitive-behavioral case formulation and treatment design: A problem-solving approach. New York: Springer Publishing Co.

_____ O'Connell, K. (2005). Cognitive behavioral treatment of tic disorders. New York: John Wiley & Sons.

_____ O'Donohue, W., Fisher, J., Hayes, S. (2004). Cognitive behavior therapy: Applying empirically supported techniques in your practice. New York: John Wiley and Sons.

_____ Reinecke, M., & Clark, D. (Eds.). (2003). Cognitive therapy across the lifespan: Evidence and practice. Cambridge, UK: Cambridge University Press.

_____ Rosner, J. (2002). Cognitive therapy and dreams. New York: Springer Publishing Company.

_____ Salkovskis, P.M. (Ed.). (1996). Frontiers of cognitive therapy. New York: Guilford.

_____ Salkovskis, P.M. (Ed.). (1996). Trends in cognitive therapy and behavioural therapies. New York: John Wiley & Sons.

_____ Schuyler, D. (2003). Cognitive therapy: A practical guide. New York: W. W. Norton and Company.

_____ Scott, J., Williams, J., & Beck, A. T. (Eds.). (1989). Cognitive therapy in clinical practice: An illustrative casebook. New York: Routledge.

_____ Scott, M. (1989). A cognitive-behavioral approach to clients' problems. New York: Routledge.

_____ Simos, G. (Ed.). (2002). Cognitive behaviour therapy: A guide for the practicing clinician. New York: Brunner-Routledge.

_____ Vallis, T., Howes, J., & Miller, P. (1991). The challenge of cognitive therapy: Applications to nontraditional populations. New York: Plenum Press.

_____ Wright, J., Basco, M.R., & Thase, M. (2005). Learning cognitive-behavior therapy: An illustrated guide. Arlington, VA: American Psychiatric Publishing, Inc.

Clinical Applications: Books on Specific Disorders, Problems, or Populations

Anxiety Disorders

_____ Antony, M.M., & Swinson, R.P. (2000). Phobic disorders and panic in adults: A guide to assessment and treatment. Washington, DC: American Psychological Association.

_____ Asmundson, G. J. G., Taylor, S., & Cox, B. J. (Eds.). (2001). Health anxiety: Clinical and research perspectives on hypochondriasis and related disorders. Chichester, UK: Wiley.

_____ Clark, D. A. (2004). Cognitive-behavioral therapy for OCD. New York: Guilford.

_____ Clark, D. (Ed.). (2004). Intrusive thoughts in clinical disorders. New York: Guilford Publications.

_____ Dozois, D. J. A., & Dobson, K. S. (Eds.). (2003). The prevention of anxiety and depression: Theory, research, and practice. Washington D.C.: American Psychological Association.

_____ Foa, E.B., & Rothbaum, B.O. (2001). Treating the trauma of rape: Cognitive-behavioral therapy for PTSD. New York: Guilford.

_____ Follette, V.M., Ruzek, J.I., & Abueg, F.R. (1998). Cognitive-behavioral therapies for trauma. New York: Guilford.

_____ Foy, D. (Ed.). (1992). Treating PTSD: Cognitive-behavioral strategies. New York: Guilford Press.

_____ Frost, R.O., & Steketee, G. (Eds.). (2002). Cognitive approaches to obsessions and compulsions: Theory, assessment, and treatment. Elmont, NY: Pergamon Press.

_____ Furer, P., Walker, J., & Stein, M. (2006). Treating health anxiety and fear of death: A practitioner's guide. New York: Springer Publishing.

_____ Heimberg, R.G., & Becker, R.E. (2002). Cognitive-behavioral group therapy for social phobia. New York: Guilford.

_____ Heimberg, R., Liebowitz, M., Hope, D., & Schneier, F. (1995). Social phobia: Diagnosis, assessment, & treatment. New York: Guilford Press.

_____ Leahy, R.L., & Holland, S.J. (2000). Treatment plans and interventions for depression and anxiety disorders. New York: Guilford.

_____ Litz, B. (Ed.). (2003). Early intervention for trauma and traumatic loss. New York: Guilford Press.

_____ McGinn, L., & Sanderson, W. (1999). Treatment of obsessive-compulsive disorder. Northvale: Jason Aronson Inc.

_____ Najavits, L.M. (2001). Seeking safety: A treatment manual for PTSD and substance abuse. New York: Guilford.

_____ Rachman, S. (2003). The treatment of obsessions. Oxford: Oxford University Press.

_____ Rygh, J. R., & Sanderson, W. C. (2004). Treating generalized anxiety disorder: Evidence-based strategies, tools, and techniques. New York: Guilford Press.

_____ Smucker, M. R., & Dancu, C. V. (1999). Cognitive behavioral treatment of adult survivors of childhood trauma: Imagery rescripting and reprocessing. London: Jason Aronson Publishing.

_____ Steketee, G. (1999). Overcoming obsessive-compulsive disorder: A behavioral and cognitive protocol for the treatment of OCD. Oakland: New Harbinger Publications.

_____ Taylor, S. (2000). Understanding and treating panic disorder: Cognitive-behavioural approaches. New York: Wiley.

_____ Taylor, S., & Asmundson, G. J. G. (2004). Treating health anxiety: A cognitive-behavioral approach. New York: Guilford.

_____ Taylor, S. (2004). Advances in the treatment of posttraumatic stress disorder: Cognitive-behavioral perspectives. Springer Publishing.

_____ Taylor, S. (Ed.). (1999). Anxiety sensitivity: Theory, research, and treatment of the fear of anxiety. Mahwah, NJ: Erlbaum.

_____ Woods, D., & Miltenberger, R. (Eds.). (2001). Tic disorders, trichotillomania, and other repetitive behavioral disorders: Behavioral approaches to analysis and treatment. Norwell, MA: Kluwer Academic Press.

_____ Wright, J. (Ed.). (2004). Cognitive-behavior therapy: Review of psychiatry. Washington, D.C.: American Psychiatric Press.

Bipolar Disorder

_____ Basco, M.R., & Rush, A.J. (2005). Cognitive-behavioral therapy for bipolar disorder (2nd ed.). New York: Guilford.

_____ Johnson, S. L., & Leahy, R. L. (Eds.). (2003). Psychological treatment of bipolar disorder. New York: Guilford Press.

_____ Lam, D. H., Jones, S. H., Hayward, P., & Bright, J. A. (1999). Cognitive therapy for bipolar disorder: A therapist's guide to concepts, methods and practice. Chinchester, UK: John Wiley & Sons.

_____ Newman, C. F., Leahy, R. L., Beck, A. T., Reilly-Harrington, N.A., & Gyulai, L. (2002). Bipolar disorder: A cognitive therapy approach. Washington D.C.: American Psychological Association.

_____ Reiser, R., & Thompson, L. (2005). Bipolar disorder: Advances in psychotherapy-Evidence-based practice (Vol. 1). Cambridge, MA: Hogrefe.

Children and Adolescents

_____ Albano, A. M., & Kearney, C. A. (2000). When children refuse school: A cognitive behavioral therapy approach-Therapist guide. Psychological Corporation.

_____ Allen, J.S., & Christner, R.W. (2003, Fall). The process and structure of cognitive-behavior therapy (CBT) in the school setting. Insight, 24(1), 4-9.

_____ Barkley, R. (1997). Defiant children: A clinician's manual for assessment and parent training (2nd Ed.). New York: Guilford Press.

_____ Barkley, R. (1997). ADHD and the nature of self-control. New York: Guilford Press.

_____ Barkley, R. (2000). Taking charge of ADHD: The complete authoritative guide for parents (Rev. ed.). New York: Guilford Press.

_____ Barkley, R. (2005). Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment (3rd ed.). New York: Guilford Press.

_____ Barkley, R., & Murphy, K. (2005). Attention-deficit hyperactivity disorder: A clinical workbook (3rd ed.). New York: Guilford.

_____ Braswell, L., & Bloomquist, M.L. (1991). Cognitive-behavioral therapy with ADHD children: Child, family, and school interventions. New York: Guilford.

_____ Christner, R.W., & Allen, J.S. (2003). Introduction to cognitive-behavioral therapy (CBT) in the schools. Insight, 23(3), 12 - 14.

_____ Christner, R.W., Stewart, J.L., & Freeman, A. (2007). Handbook of cognitive-behavior group therapy with children and adolescents: Specific settings and presenting problems. New York: Routledge.

_____ Clarizio, H. (1980). Toward positive classroom discipline (3rd ed.). New York: John Wiley & Sons.

_____ Deblinger, E., & Heflin, A.H. (1996). Treating sexually abused children and their nonoffending parents: A cognitive behavioral approach. Thousand Oaks, CA: SAGE Publications.

_____ Dudley, C.D. (1997). Treating depressed children: A therapeutic manual of cognitive behavioral interventions. Oakland: New Harbinger Publications.

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CLINICAL TRAINING IN COGNITIVE THERAPY:

Date(s)	Format	Title	Location	Faculty	No. of Hours

CLINICAL EXPERIENCE IN COGNITIVE THERAPY:

Please indicate you have at least one year's experience in providing cognitive therapy by indicating the date you first provided cognitive therapy to a client.

Date: _____

Please complete the attached log documenting that you have provided cognitive therapy to at least 10 clients who have completed treatment. List, for each client, the client's initials, the setting in which treatment occurred (e.g., inpatient unit at X Hospital; outpatient clinic at Y University), the approximate dates treatment began and ended, Axis I and II diagnoses, and the total number of sessions provided.

	Client Initials	Setting	Treatment Began	Treatment Ended	Total No. Sessions	Specify Axis I and/or Axis II
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

By my signature below, I verify that the information contained in this, Part I of the application for certification in ACT, is true and correct to the best of my knowledge, information and belief.

_____ _____ _____

Signature Printed Name Date

ACT℠ PROFESSIONAL REFERENCE REQUEST

Date:_____

Dear _____:

I have submitted an application to be credentialed as a certified cognitive therapist by the Academy of Cognitive Therapy. As part of the credentialing process, professional references are required. Please complete the following checklist and return this form as soon as possible to:

260 South Broad Street
18th Floor
Philadelphia, PA 19102
Fax: 215.731.2182

Unless required by law, Academy of Cognitive Therapy will not release this assessment to me without your written authorization.

Thank you for your assistance in this matter.

Sincerely,

_____ _____
Signature of ACT Applicant Name of ACT Applicant [Please Print]

My assessment of the above clinician's professional capabilities is as follows:

	Outstanding	Excellent	Acceptable	Problematic*	Not Enough Information to Rate
Skills as a Cognitive Therapist					
Clinical Knowledge					
Clinical Judgment					
Professional Relations with Patients					
Professional Relations with Colleagues					
Ethical Conduct					

Additional Comments (if yes, please attach an additional sheet)

_____ _____
Signature of Rater Name of Rater [Please Print]

_____ _____ _____
Degree Title [if applicable] Date

Contact Information for Rater (please type or print clearly):

_____
Street Address

_____
Street Address

_____
Phone, Fax, Email

* If Problematic, please give details on an attached sheet.

ACT℠ PROFESSIONAL REFERENCE REQUEST

Date:_____

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Clinical Knowledge					
Clinical Judgment					
Professional Relations with Patients					
Professional Relations with Colleagues					
Ethical Conduct					

Additional Comments (if yes, please attach an additional sheet)

_____ _____
Signature of Rater Name of Rater [Please Print]

_____ _____ _____
Degree Title [if applicable] Date

Contact Information for Rater (please type or print clearly):

_____
Street Address

_____
Street Address

_____
Phone, Fax, Email

* If Problematic, please give details on an attached sheet.

Appendix B: Cognitive Therapy Scale

Cognitive Therapy Scale

Therapist:_____ Patient_____ Date of Session: _____

Tape ID#:_____ Rater:_____ Date of Rating:_____

Session#_____ ( ) Videotape ( ) Audiotape ( ) Live Observation

Directions: For each time, assess the therapist on a scale from 0 to 6, and record the rating on the line next to the item number. Descriptions are provided for even-numbered scale points. If you believe the therapist falls between two of the descriptors, select the intervening odd number (1, 3, 5). For example, if the therapist set a very good agenda but did not establish priorities, assign a rating of a 5 rather than a 4 or 6.

If the descriptions for a given item occasionally do not seem to apply to the session you are rating, feel free to disregard them and use the more general scale below:

0	1	2	3	4	5	6
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

Please do not leave any item blank. For all items, focus on the skill of the therapist, taking into account how difficult the patient seems to be.

Part I. GENERAL THERAPEUTIC SKILLS

___1. AGENDA

0 Therapist did not set agenda.

2 Therapist set agenda that was vague or incomplete.

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

5 Therapist worked with patient to set an appropriate agenda with target problems, suitable for the available time. Established priorities and then followed agenda.

___2. FEEDBACK

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

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

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

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

___3. UNDERSTANDING

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

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

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

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

___4. INTERPERSONAL EFFECTIVENESS

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

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

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

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

___5. COLLABORATION

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

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

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

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

___6. PACING AND EFFICIENT USE OF TIME

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

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

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

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

Part II. CONCEPTUALIZATION, STRATEGY, AND TECHNIQUE

___7. GUIDED DISCOVERY

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

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

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

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

___8. FOCUSING ON KEY COGNITIONS OR BEHAVIORS

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

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

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

6 Therapist very skillfully focused on key thoughts, assumptions, behaviors, etc. that were most relevant to the problem area and offered considerable promise for progress.

___9. STRATEGY FOR CHANGE (Note: For this item, focus on the quality of the therapist's strategy for change, not on how effectively the strategy was implemented or whether change actually occurred.)

0 Therapist did not select cognitive-behavioral techniques.

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

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

6 Therapist followed a consistent strategy for change that seemed very promising and incorporated the most appropriate cognitive-behavioral techniques.

___10. APPLICATION OF COGNITIVE-BEHAVIORAL TECHNIQUES (Note: For this item, focus on how skillfully the techniques were applied, not on how appropriate they were for the target problem or whether change actually occurred.)

0 Therapist did not apply any cognitive-behavioral techniques.

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

4 Therapist applied cognitive-behavioral techniques with moderate skill.

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

___11. HOMEWORK

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

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

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

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

Part III. ADDITIONAL CONSIDERATIONS

12. (a) Did any special problems arise during the session (e.g., non-adherence to homework, interpersonal issues between therapist and patient, hopelessness about continuing therapy, relapse?)

YES NO

___ (b) If yes:

0 Therapist could not deal adequately with special problems that arose.

2 Therapist dealt with special problems adequately, but used strategies or conceptualizations inconsistent with cognitive therapy.

4 Therapist attempted to deal with special problems using a cognitive framework and was moderately skillful in applying techniques.

6 Therapist was very skillful at handling special problems using cognitive therapy framework.

13. Were there any significant unusual factors in this session that you feel justified the therapist's departure from the standard approach measured by this scale?

YES (Please explain below) NO

Part IV. OVERALL RATINGS AND COMMENTS

14. How would you rate the clinician overall in this session, as a cognitive therapist?

0	1	2	3	4	5	6
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

15. If you were conducting an outcome study in cognitive therapy, do you think you would select this therapist to participate at this time (assuming this session is typical?)

0	1	2	3	4
Definitely Not	Probably Not	Uncertain – Borderline	Probably Yes	Definitely Yes

16. How difficult did you feel this patient was to work with?

0	1	2	3	4	5	6
Not difficult -Very receptive			Moderately difficult			Extremely difficult

17. COMMENTS AND SUGGESTIONS FOR THERAPIST'S IMPROVEMENT:

18. OVERALL RATING:

Rating Scale:

0	1	2	3	4	5
Inadequate	Mediocre	Satisfactory	Good	Very Good	Excellent

Using the scale above, please give an overall rating of this therapist's skills as demonstrated on this tape. Please circle the appropriate number.

For instructions on the use of this scale, see: Young J.E., & Beck, A.T. (August, 1980). Cognitive Therapy Scale Rating Manual.

Appendix C: Cognitive Therapy Scale Manual

COGNITIVE THERAPY SCALE
RATING MANUAL

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General Instructions to Raters

The most serious problem we have observed in raters is a "halo effect". When the rater thinks the therapist is good, he/she tends to rate the therapist high on all categories. The reverse is true when the rater believes the session is bad.

One of the most important functions of the Cognitive Therapy Scale is to identify the therapist's specific strengths and weaknesses. It is rare to find a therapist who is uniformly good or bad. It may be helpful, therefore, for raters to list positive and negative observations as they listen to a session, rather than concentrate on forming one global impression.

A second problem is the tendency of some raters to rely solely on their own notions of what a particular scale point means (e.g., 4 is average) and to disregard the descriptions provided on the form. The problem with this is that we each attach idiosyncratic meanings to particular numbers on the 6-point scale. The most critical raters assign a 1 whenever the therapist is "unsatisfactory", while the most generous raters assign a 5 when the therapist has merely "done a good job" or "tried hard".

The descriptions on the scale should help to insure more uniformity across raters. Therefore, we urge you to base your numerical ratings on the descriptions provided whenever possible. Do not be concerned if the resulting numerical score does not match your overall "gut feeling" about the therapist. (After all, you are free to express your "gut feeling" in the overall rating on the first page.)

The only exception should be in sessions where the descriptions do not seem to describe the specific therapist problems and behaviors you observed. When this is the case, disregard the specific descriptions and rely on the more general scale descriptions supplied in the directions. With these exceptions, it would be helpful if raters noted why the descriptions did not seem to apply, so the scale can be refined in the future.

1. AGENDA

Objective

Because cognitive therapy is a relatively short-term, problem-solving therapy, the limited time available for each interview must be used judiciously. At the beginning of each session, the therapist and patient together establish an agenda with specific target problems to focus on during each session. The agenda helps insure that the most pertinent issues are addressed in an efficient manner.

Background Material

a. Cognitive Therapy of Depression, pp. 77-78, 93-98, 167-208.

b. Cognitive Therapy and the Emotional Disorders, pp. 224-300.

Desirable Therapist Strategies

The agenda usually begins with a brief resume of the patient's experiences since last session. This resume includes relevant events of the past week, discussion and feedback regarding homework, and the patient's current emotional status (as indicated by the BDI score, Anxiety Checklist score, and patient's verbal report of progress).

Because cognitive therapy is relatively short-term, it relies heavily on the pinpointing of specific target problems. Without target problems, therapy is much less focused, much less efficient, and therefore much slower. If the target problem is not chosen properly, the therapist may find it very difficult to make headway, either because a more central problem is interfering with progress or because the patient is not sufficiently concerned about the problem to cooperate fully. In some cases, a target problem may be central, yet not be amenable to treatment at a given point in therapy.

At the beginning of a session, therefore, the patient and therapist together develop a list of problems that they would like to work on during the hour. These might include specific depressive symptoms, such as apathy and lack of motivation, crying, or difficulty concentrating; to external problems in the patient's life, such as marital problems, career issues, child-rearing concerns, or financial difficulties.

After the list of possible topics has been completed, the patient and therapist discuss and reach conclusions about which topics to include, the order to cover them, and, if necessary, how much time should be allotted to each topic. Some of the considerations in setting priorities are: the stage of therapy, the severity of the depression, the presence of suicidal wishes, the degree of distress associated with each problem area, the likelihood of making progress in solving, the problem, and the number of different life areas affected by a particular theme or topic.

Some of the most common mistakes we observe in novice cognitive therapists are: 1) failure to agree on specific problems to focus on; 2) selection of a peripheral problem to attack rather than an central concern; and 3) a tendency to skip from problem to problem across sessions rather than persistently seek a satisfactory solution to one or two problems at a time.

Generally, in the earlier phases of treatment and in working with more severely depressed patients, behavioral goals are likely to be more useful than strictly cognitive ones. As therapy

progresses, the emphasis often switches from relieving specific depressive symptoms (such as inactivity, excessive self-criticism, hopelessness, crying, and difficulty concentrating) to broader problems (such as anxiety about work, life goals, and interpersonal conflicts).

The process of selecting a target problem usually involves a certain degree of "trial and error." The therapist should attempt to follow the agenda throughout the session. However, the therapist and patient should be willing to switch to a different problem occasionally if it becomes apparent that the one they have selected is less important or not yet amenable to change. However, a switch in target problem should be a collaborative decision and should follow a discussion of the rationale for changing topics. If the therapist switches without explanation, it may be perceived by the patient as evidence that the problem cannot be solved and is hopeless.

The therapist must also be sensitive to patients' occasional desires to discuss or "ventilate" regarding issues that are important to the patient at the particular moment, even though such discussions may not seem to offer much relief in the long run or may
seem irrelevant to the therapist. Such flexibility epitomizes the collaborative relationship in cognitive therapy.

Agenda-setting should be done quickly and efficiently. The therapist should avoid discussing the content of specific agenda items with the patient prior to completing the agenda. Furthermore, the agenda should not be overly ambitious; it is usually impossible to cover more than one or two target problems in a given session. When done properly, the agenda can usually be set within five minutes.

2. FEEDBACK

Objective

The therapist should work to carefully elicit the patient's positive and negative reactions to all aspects of therapy. Feedback also includes checking to be sure that the patient understands the therapist's interventions, formulations and line of reasoning, and the therapist has accurately understood the patient's main points.

Background Material

a. Cognitive Therapy of Depression, pp. 81-84.

Desirable Therapist Strategies

The cognitive therapist strives throughout each session to be certain that the patient is responding positively to the therapeutic process. Beginning with the first session, the therapist carefully elicits the patient's thoughts and feelings about all aspects of therapy. He/she routinely asks for the patient's evaluation of each session, and encourages the patient to express any negative reactions to the therapist, to the way a particular problem is handled, to homework assignments, etc. The therapist must also be sensitive to negative covert reactions to the interviews expressed verbally or nonverbally by the patient, and should ask for the patient's thoughts when such clues are noticed. Whenever possible, the therapist should ask the patient for suggestions about how to proceed, or to choose among alternative courses of action.

A final feature of the feedback process is for the therapist to check continually to be certain that the patient understands the therapist's formulations. Depressed patients often indicate understanding simply out of compliance. Thus, the therapist should regularly provide capsule summaries of what has happened during the session and ask the patient to abstract the main points from the therapy session. In fact, it is often helpful to have the patient write down these conclusions to review during the week. Similarly, it is important for the therapist to summarize regularly what he/she believes the patient is saying and to ask the patient to modify, correct, or "fine tune" the therapist's summary.

3. UNDERSTANDING

Objective

The therapist accurately communicates an understanding of the patient's thoughts and feelings. "Understanding" refers to how well the therapist can step into the patient's world, see and experience life the way the patient does, and convey this understanding to the patient. Understanding incorporates what other authors have referred to as listening and empathic skills.

Background Material

a. Cognitive Therapy of Depression, pp. 47-49.

Rationale

The ineffective therapist often misinterprets or ignores the patient's view and incorrectly projects his/her own attitudes, conventional attitudes, or attitudes derived from a particular theoretical system onto the patient. When this happens, the interventions will probably fail since they will be directed at cognitions or behaviors that are not really central to the patient's view of reality.

Desirable Therapist Strategies

The therapist should be sensitive both to what the patient explicitly says and to what the patient conveys through tone of voice and non-verbal responses. Sometimes, for example, a patient may not recognize or verbalize a particular feeling (such as anger) and yet may communicate the emotion to the therapist through his/her tone of voice in describing a particular event or person.

Unless the therapist is able to grasp the patient's "internal reality", it is unlikely that he/she will be able to intervene effectively. Furthermore, it will be difficult for the therapist to establish rapport unless the patient believes that the therapist understands him/her. The therapist can convey this understanding by rephrasing or summarizing what the patient seems to be feeling. The therapist's tone of voice and non-verbal responses should convey a sympathetic understanding of the patient's point of view (although the therapist must maintain objectivity toward the patient's problems).

Ideally, the therapist's understanding of the patient's "internal reality" will lead to an accurate conceptualization of the patient's problems and then to an effective strategy for change.

Special Considerations in Rating

"Understanding" seems to be one of the most difficult categories in terms of achieving interrater agreement. It is important, therefore, that raters pay special attention to the descriptions for each scale point. The 0 level means that the therapist completely missed the point of what the patient was saying. To score "0" the therapist fails to repeat accurately even the most obvious elements of what the patient says. The 2 level applies to

therapists who are too literate or tangential -- they are able to reflect what the patient explicitly says, but either seem dense regarding more subtle connotations that suggest something else is going on or they accurately repeat peripheral aspects of what the patient says but they miss the main point.

The 4 and 6 levels both indicate that the therapist seems to grasp the patient's perspective. The 6 level, however, indicates both greater skill at communicating a sympathetic understanding to the

patient and a keener grasp of the patient's world that may be reflected in the therapist's ability to predict how and why the patient reacts as he/she does in particular situations.

4. INTERPERSONAL EFFECTIVENESS

Objective

The cognitive therapist should display optimal levels of warmth, concern, confidence genuineness, and professionalism.

Background Material

a. Cognitive Therapy of Depression. pp. 45-47, 49-50.

Rationale

A variety of research studies support the importance of these "non-specific" variables in favorable outcomes of psychotherapy. For cognitive therapists, these interpersonal skills are essential in establishing collaboration.

Desirable Therapist Strategies

The cognitive therapist should be able to communicate that he/she is genuine, sincere, and open. The therapist should not act in a manner that seems patronizing or condescending, not should he/she evade patients' questions. Thus, the experienced cognitive therapist does not seem to be playing the role of a therapist, but comes across as straightforward and direct.

Coupled with this openness, cognitive therapists should convey warmth and concern through the content of what they say and through such non-verbal behaviors as tone of voice and eye contact. Therapists must be careful that, in the course of questioning the patient's point of view they do not seem to be critical of, disapproving of, or ridiculing the patient's perspective. The therapist can often use and encourage humor in establishing a positive relationship.

It is also vital for therapists to display a professional manner. Without seeming distant or cold, the cognitive therapist must convey a relaxed confidence about his/her ability to help the depressed patient. This confidence can serve as a partial antidote to the patient's initial hopelessness about the fixture. A professional manner may also make it easier for the therapist to take a directive role, impose

structure, and be convincing in expressing alternative points of view. Although the patient and therapist share
responsibility for the therapy, the effective therapist must be able to use the leverage accorded him as the professional when necessary.

Special Considerations in Rating

Interpersonal effectiveness is another category in which interrater agreement has been less than ideal. The 0 level should be used for therapists who could reasonably be expected to have negative effects on the patient because of their poor interpersonal skills. Such therapists, because they are hostile, cold, or critical, may undermine the patient's self-esteem and make the development of trust impossible. The 2 level is intended for therapists who are not likely to be destructive to the patient, but who may hinder therapy progress by being impatient, insincere, aloof, or by not seeming competent. Such therapists will not be able to use the leverage available to therapists who are able to build a stronger relationship with their patients. 4 and 6 levels both represent interpersonal skills; the difference is simply one of degree.

5. COLLABORATION

Objective

One of the fundamental precepts of cognitive therapy is that there be a collaborative relationship between the patient and therapist. This collaboration takes the form of a therapeutic alliance in which the therapist and patient work together to fight a common enemy: the patient's distress.

Background Material

a. Cognitive Therapy and the Emotional Disorders, pp. 220-221.

b. Cognitive Therapy of Depression, pp. 50-54.

Rationale

There are at least three goals of this collaborative approach. First, collaboration helps insure that the patient and therapist have compatible goals at each point in the course of treatment. Thus, they will not be working at cross purposes. Second, the process minimizes patient resistance that often arises when the therapist is viewed as a competitor or an aggressor, or is seen as trying to control or dominate the patient. Third, the alliance helps prevent misunderstandings between the patient and therapist. Such misunderstandings can lead the therapist to go down blind alleys or can lead the patient to misinterpret what the therapist has been trying to convey.

Desirable Therapist Strategies

Rapport. Rapport refers to harmonious accord between people. In cognitive therapy, this rapport involves a sense that the patient and therapist are functioning together as a team, that they are comfortable working together. Neither is defensive or unduly inhibited. To develop rapport, the therapist will often need to exhibit the understanding and interpersonal qualities described in items 2, 3, and 4 on the Cognitive Therapy Scale. Rapport, however, involves more than showing warmth and empathy. It requires that the therapist adapt the structure and style of the therapy to the needs and desires of each particular patient.

Balancing structure against patient autonomy. To establish a collaborative relationship, the therapist needs to strike a balance between being directive and imposing structure on the one hand, and allowing the patient to make choices and take responsibility on the other. This balance involves deciding when to talk and when to listen; when to confront and when to back off; when to offer suggestions and when to wait for the patient to make his/her own suggestions.

Focusing on problems both patient and therapist consider important. One of the most important aspects of collaboration is the knowledge that the session is focused on a problem that both patient and therapist consider important. Unless the therapist is attentive to the patient's desires in each session, he/she may persist in focusing on a problem or technique that the patient does not consider relevant or important. The patient and therapist may begin to work at cross purposes and the collaboration can break down.

Explaining the rationale for interventions. Another element of the collaborative process is for the therapist to explain the rationale for most interventions he/she makes. This rationale demystifies the process of therapy and thus makes it easier for the patient to understand an particular approach. Furthermore, when the patient can see the relationship between a particular homework assignment or

technique and the solution to his/her problem, it is more likely that the patient will participate conscientiously.

6. PACING AND EFFICIENT USE OF TIME

Objective

The therapist should accomplish as much as possible during each session, taking into account the present capacity of the patient to absorb new information. To optimize the available time, the therapist must maintain sufficient control, limit discussion of peripheral issues, interrupt unproductive discussions, and pace the session appropriately.

Background Material

a. Cognitive Therapy of Depression, pp. 65-66.

Desirable Therapist Strategies

We have often observed sessions in which the therapist paced the session much too slowly or too rapidly for a particular patient. On the other hand, the therapist may belabor a point after the patient has already grasped the message or may gather much more data than is necessary before formulating a strategy for change. In these cases, the sessions seem painfully slow and inefficient. On the other hand, the therapist may switch from topic to topic too rapidly, before the patient has had an opportunity to integrate a new perspective. Or the therapist may intervene before he/she has gathered enough data to conceptualize the problem.

The agenda provides a structural plan that should help the therapist use time efficiently. The therapist should monitor the flow of discussion and maintain sufficient control over the process of each session to insure that both patient and therapist adhere to their original plan. In so doing, the most important agenda items will be covered. Unfinished business should be rescheduled.

During agenda-setting, the therapist's input can limit discussion of peripheral issues. However, during the session, the patient and therapist may inadvertently drift from the critical agenda topic to a related, yet less important item. In such cases, the therapist should politely interrupt these peripheral discussions and return to the agenda item.

Even when focused on a central issue, the therapy discussion may reach a point when progress is no longer being made. In such cases, the therapist should gently interrupt the unproductive discussion and try to approach the issue from another perspective.

7. GUIDED DISCOVERY

Objective

Guided discovery is one of the most basic strategies of the effective cognitive therapist. The cognitive therapist often uses exploration and questioning to help patients see new perspectives where other therapists use debating or lecturing. The cognitive therapist attempts to avoid "cross-examining" the patient or putting the patient on the defensive.

Background Material

a. Cognitive Therapy of Depression, pp. 66-71.

Rationale

We have observed that patients often adopt new perspectives more readily when they come to their own conclusions than when the therapist tries to debate with the patient. In this respect, the cognitive therapist is more like a skilled teacher than a lawyer. He/she guides the "student" to see logical problems in the student's present position; to examine evidence that contradicts the students beliefs; to gather information when more is necessary to test a hypothesis; to look at new alternatives that the student may never have considered, and to reach valid conclusions after this exploration. The techniques for changing cognitions and behaviors in this therapy can for the most part be subsumed within this more basic strategy, which educators label "guided discovery". Thus, hypothesis testing, empiricism, setting up experiments, inductive questioning, weighing advantages and disadvantages, etc. are all tools at the therapist's disposal to aid in the process of "guided discovery."

Desirable Therapist Strategies

Questioning deserves special attention since it is so critical to the process of guided discovery. Skillfully-phrased questions presented in a logical sequence are often extremely effective. A single question can simultaneously make the patient aware of a particular problem area, help the therapist evaluate the patient's reaction to this new area of inquiry, obtain specific data about the problem,

generate possible solutions to problems that the patient had viewed as insoluble, and cast serious doubt in the patient's mind regarding previously distorted conclusions.

Some of the functions that questioning may serve in this process are outlined below:

1. To encourage the patient to begin the decision-making process by developing alternative approaches.
2. To assist the patient in resolving a decision by weighing the pros and cons of alternatives that have already been generated, thus narrowing the range of desirable possibilities.
3. To prompt the patient to consider the consequences of continuing to engage in dysfunctional behaviors.
4. To examine the potential advantages to behaving in more adaptive ways.
5. To determine the meaning the patient attaches to a particular event or set of circumstances.
6. To help the patient define criteria for applying certain maladaptive self-appraisals (see the discussion of the technique of operationalizing a negative construct in Section 9).
7. To demonstrate to the patient how he/she is selectively focusing on only negative information in drawing conclusions. In the excerpt that follows, a depressed patient was disgusted with herself for eating candy when she was on a diet:

Patient: I don't have any self-control at all.
Therapist: On what basis do you say that?
Patient: Somebody offered me candy and I couldn't refuse it.
Therapist: Were you eating candy every day?
Patient: No, I ate it just this once.
Therapist: Did you do anything constructive during the past week to adhere to your diet?
Patient: Well, I didn't give in to the temptation to buy candy every time I saw it at the store.... Also, I did not eat any candy except the one time it was offered to me and I felt I couldn't refuse it.
Therapist: If you counted up the number of times you controlled yourself versus the number of times you gave in, what ratio would you get?
Patient: About 100 to 1.

Therapist: So if you controlled yourself 100 times and did not control yourself just once, would that be a sign that you are weak through and through?

Patient: I guess not -- not <u>through</u> and <u>through</u> (smiles).

8. To illustrate to the patient the way in which he/she disqualifies positive evidence. In the example below, the patient recognizes that he has ignored clear-cut evidence of improvement.

Patient: I really haven't made any progress in therapy.

Therapist: Didn't you have to improve in order to leave the hospital and go back to college?

Patient: What's the big deal about going to college every day?

Therapist: Why do you say that?

Patient: It's easy to attend these classes because all the people are healthy.

Therapist: How about when you were in group therapy in the hospital? What did you feel then?

Patient: I guess I thought then that it was easy to be with the other people because they were all as crazy as I was.

Therapist: Is it possible that whatever you accomplish you tend to discredit?

9. To open for discussion certain problem areas that the patient had prematurely reached closure on, and which continue to influence his/her maladaptive patterns.

This is not to say that the effective cognitive therapist relies solely, or even primarily, on questioning in all sessions. In some instances, it is appropriate for the therapist to provide information, confront, explain, self-disclose, etc. rather than question. The balance between questioning and other modes of intervention on the particular problem being dealt with, the particular patient, and the point in therapy. The appropriateness of an intervention can be assessed by observing: its effect on the collaborative relationship; the degree of dependency it promotes on the patient; and, of course, its success in helping the patient adopt a new perspective.

There is often a fine line between guiding a patient and trying to persuade a patient. In some instances the cognitive therapist may need to reiterate forcefully a point that the therapist and patient have already established. The main distinction, then, in deciding whether a therapist is acting in a desirable manner is not whether the therapist is forceful or tenacious but whether the therapist overall seems to be collaborating with the patient rather than arguing with the patient. In the excerpt that follows, the therapist uses questioning to demonstrate to the patient the maladaptive consequences of holding the assumption that one should always work up to one's potential.

Patient: I guess I believe that I should always work up to my potential.

Therapist: Why is that?

Patient: Otherwise I'd be wasting time.

Therapist: But what is the long-range goal in working up to your potential?

Patient: (Long pause.) I've never really thought about that. I've just always assumed that I should.

Therapist: Are there any positive things you give up by always having to work up to your potential?

Patient: I suppose it make it hard to relax or take a vacation.

Therapist: What about "living up to your potential" to enjoy yourself and relax? Is that important at all?

Patient: I've never really thought of it that way.

Therapist: Maybe we can work on giving yourself permission not to work up to your potential at all times.

Example of an Undesirable Application The desirable applications above can be contrasted with one of the most common stylistic errors we observe in trainees. The therapist's behavior sometimes inappropriately resembles that of a high pressure salesman, persuading patients that they should adopt the therapist's point of view. For contrast, here is a brief example of the "high pressure" approach:

Patient: I just can't do anything right in school anymore.

Therapist: That's easy to understand. You're depressed. And when people are depressed, they have a hard time studying.

Patient: I think I'm just stupid.

Therapist: But you did very well up until a year ago, when your father died and you got depressed.

Patient: That's because the work was easier then.

Therapist: Surely there must be something you are doing right in school. You're probably exaggerating.

8. FOCUSING ON KEY COGNITIONS AND BEHAVIORS

Objective and Rationale

Once the therapist and patient have agreed on a central target problem, the next step is for the therapist to conceptualize why the patient is having difficulty in this particular area. In order to conceptualize this problem, the therapist must elicit and identify the key automatic thoughts, underlying assumptions, behaviors, etc. that comprise the problem. These specific cognitions and behaviors then serve as targets for intervention.

Background Material

a. Cognitive Therapy and the Emotional Disorders pp. 6-131, 246-257.

b. Cognitive Therapy of Depression pp. 142-152, 163-166, 244-252.

Conceptualizing the Problem

The effective cognitive therapist is continually engaged in the process of conceptualizing the patient's problem while he/she is helping the patient identify key automatic thoughts, assumptions, behaviors, etc. Through this conceptualization, the therapist integrates specific cognitions, emotions, and behaviors into a broader framework that explains why the patient is having difficulty in a particular problem area. Without this broader framework (which may undergo continued revision) the therapist is like a detective who has a lot of clues but still has not solved the mystery. (Once the clues are pieced together, though, the nature of the "crime" becomes clear.) The therapist can then distinguish between thoughts and behaviors that are central to the probing and those that are peripheral. The conceptualization therefore guides the therapist in deciding which automatic thoughts,

assumptions, or behaviors to focus on first, and which to postpone until a later date. Without such conceptualization, the therapist may select cognitions or behaviors in a "hit-or-miss" fashion and therefore make limited or erratic progress.

Although the quality of a therapist's conceptualizing is difficult to assess from observing a single session, we believe that in the long run it proves to be one of the most crucial determinants of the effectiveness of a cognitive therapist. We try to make inferences about the quality of the conceptualization by observing whether the specific conditions or behaviors focused on in a given session seem to be central to the patient's problem rather than peripheral. If the therapist's conceptualization is poor (we hypothesize) ,then the rationale for focusing on a particular thought or behavior will not be clear to the experienced rater. Furthermore, target problems, interventions, homework, etc. will appear to "hang together" in a unified framework if the conceptualization is good.

Desirable Therapist Strategies for Eliciting Automatic Thoughts

Inductive Questioning

The therapist can ask the patient a series of questions designed to explore some of the possible reasons for the patient's emotional reactions. Skillful questioning can provide patients with a strategy for introspective exploration that they can later employ by themselves when the therapist is not nearby. (See the example in the section on guided discovery).

Imagery

When patients can identify events or situations that seem to trigger the emotional response, the therapist can suggest that the patients picture the distressing situation in detail. If the image is realistic and clear to the patients they are often able to identify the automatic thoughts they were having at the time. The excerpt below illustrates this technique:

Patient:	I can't go bowling. Every time I go in there, I want to run away.
Therapist:	Do you remember any of the thoughts you had when you went there?
Patient:	Not really. Maybe it just brings memories, I don't know.
Therapist:	Let's try an experiment to see if we can discover what you were thinking. OK?

Patient: I guess so.

Therapist: I'd like you to relax and close your eyes. Now imagine you are entering the bowling alley. Describe for me what's happening.

Patient: (Describes entering the alley, getting a score sheet, etc.) I feel like I want to get out, just get away.

Therapist: What are you thinking now?

Patient: I'm thinking "Everyone I play with is going to laugh at me when they see how bad I play."

Therapist: Do you think that thought might have led to your wish to run away?

Patient: I know it did.

Role Playing.

When the trigger event is interpersonal in nature, role-playing is often more effective than imagery. With this strategy, the therapist plays the role of the other person involved in the upsetting situation, while patients "play" themselves. If patients can involve themselves in the role-play, the automatic thoughts can often be elicited with the assistance of the therapist.

Mood Shift During the Session.

The therapist can take advantage of any changes in mood that take place during the session by pointing them out to the patient as soon as possible. The therapist then asks the patient what he/she was thinking just prior to the increase in dysphoria, tears, anger, etc.

Daily Record of Dysfunctional Thoughts.

This is the simplest method of pinpointing automatic thoughts once the patient is familiar with the technique. The patient lists automatic thoughts at home in the appropriate column on the form. The therapist and patient review these thoughts during the session.

It is important to distinguish this process of eliciting automatic thoughts from the "interpretations" made in other psychotherapies. The cognitive therapist does not volunteer an automatic thought that the patient has not already mentioned. This "clairvoyance" undermines the patient's role as collaborator and makes it difficult for the patient to identify these thoughts at home when the therapist is not nearby. Even more important, if the therapist's "intuition" is

wrong, he/she will be pursuing a blind alley. On occasion, it will be necessary for the therapist to suggest several plausible automatic thoughts (a multiple choice technique) when other strategies have failed.

The example of "clairvoyance" that follows provides a contrast to the imagery technique illustrated previously:

Patient: I can't go bowling. Every time I go in there, I want to run away.
Therapist: Why?
Patient: I don't know. I just want to leave.
Therapist: Do you tell yourself, "I wish I didn't have to bowl by myself'?
Patient: Maybe. I'm not sure.
Therapist: Well, maybe you keep thinking that bowling isn't going to solve the problems in your life. You're right, but it's a beginning.

Ascertaining the Meaning of an Event.

Sometimes, skillful attempts by the therapist to elicit automatic thoughts are not successful. Then, the therapist should attempt to discern, through questioning, the specific meaning for the patient of the event that preceded the emotional response. For example, one patient began to cry whenever he had an argument with his girlfriend. It was not possible to identify a specific automatic thought. However, after the therapist asked a series of questions to probe the meaning of the event, it became obvious that the patient had always associated any type of argument or fight with the end of a relationship. It was this meaning, embedded in his view of the event that preceded his crying.

Desirable Therapist Strategies for Identifying Underlying Assumptions.

We often observe general patterns that seem to underlie patients' automatic thoughts. These patterns, or regularities, act as a set of rules that guide the way a patient reacts to many different situations. We refer to these rules as assumptions. These assumptions may determine for example, what patients consider "right" or "wrong" in judging themselves and other people.

Although patients can often readily identify their automatic thoughts, their underlying assumptions are far less accessible. Most people are unaware of their "rulebooks." Typical unarticulated assumptions include:

1. In order to be happy, I have to be successful in whatever I undertake.
2. I can't live without love.

When these rules are framed in absolute terms, are nonrealistic, or are used inappropriately or excessively, they often lead to disturbances like depression, anxiety, and paranoia. We label rules that lead to such problems as "maladaptive." One of the major goals of cognitive therapy, especially in the later stages of treatment, is to help patients identify and challenge the maladaptive assumptions that affect their ability to avoid future depressions.

In order to identify these maladaptive assumptions, the therapist can listen closely for themes that seem to cut across several different situations or problem areas. The therapist can then list several related automatic thoughts that the patient has already expressed on different occasions, and ask the patient to abstract the general "rule" that connects the automatic thoughts. If the patient cannot do this, the therapist can suggest a plausible assumption, list the thoughts that seem to follow from it, and then ask the patient:
if the assumption "rings true." The therapist should be open to the possibility that the assumption does not fit that patient and then work with the patient to pinpoint a more accurate statement of the underlying "rule".

Special Considerations in Rating

There are essentially two separate processes incorporated into this category. The first process involves using appropriate techniques to elicit automatic thoughts, underlying assumptions, behaviors, etc. from the patient. If the therapist completely fails to elicit them, then the rater should assign a 0. If the therapist uses appropriate techniques to elicit thoughts and behaviors, he/she should be given a rating of at least 2.

The second step in this process is for the therapist to integrate these cognitions and behaviors into a conceptualization of the patient's problem. The conceptualization explains how the particular constellation of cognitions/behaviors are peripheral to the problem -- and therefore should be

postponed -- and which are central and should serve as the focus of intervention. If the therapist fails to focus on a particular thought or behavior, the therapist should be rated 2. Or, if the therapist's conceptualization is so far off that the focus seems totally inappropriate, the therapist should be rated 2.

If the therapist selects a relevant cognition/behavior to focus on, but the rater's conceptualization strongly suggests that some other focus would have been more fruitful, the rater should assign a 4. If the therapist's conceptualization and focus seem very promising and "on target", the rater should assign a 6.

Note that for this item the therapist need not intervene at all to receive a high score. The only requirement is that the therapist successfully elicit relevant thoughts/behaviors, conceptualize the problem, and identify important foci.

9. STRATEGY FOR CHANGE

Objective

After conceptualizing the problem and pinpointing key cognitions and/or behaviors, the therapist should plan a strategy for change. The strategy for change should follow logically from the conceptualization of the problem and should incorporate the most promising cognitive-behavioral interventions chosen for the particular patient and point in treatment.

Background Material

a. Cognitive Therapy and The Emotional Disorders, pp. 233-300 (esp. 257-262)

b. Cognitive Therapy of Depression, pp. 104-271.

Rationale

There are so many different therapeutic tactics available to the cognitive therapist that, unless he/she develops an overall strategy for a given case, the therapy may follow an erratic course based on trial-and-error. The therapist may be employing several procedures simultaneously; when this is the case, all of the procedure should fit together as part of a master plan. The strategy for change should follow logically from the conceptualization of the problem discussed in Section 9 ("Focusing in Specific Cognition or Behaviors").

The overall strategy for change generally incorporates techniques drawn from one or more of

three intervention categories: testing automatic thoughts, modifying assumptions, and changing behaviors.

Desirable Techniques for Testing Automatic Thoughts

Once the therapist and patient have identified a key automatic thought, the therapist asks the patient to suspend temporarily his/her conviction that the thought is undeniably true and instead to view the thought as a hypothesis to be tested. The therapist and patient collaborate in gathering data, evaluating evidence, and drawing conclusions.

This experimental method is basic to the application of cognitive therapy. The therapist help patients learn a process of thinking that resembles scientific investigation. The therapist demonstrates to the patient that the perception of reality is not the same as reality itself. Patients learn to design experiments that will test the validity of their own automatic thoughts. Patients thus learn how to modify the maladaptive thinking so that they can maintain their gains after treatment ends.

There are several techniques for testing the validity of automatic thoughts:

Examining available evidence. The therapist asks the patient to draw on his/her previous experiences to list the evidence supporting and contradicting the hypothesis. After weighing all available evidence, patients frequently reject their automatic thoughts as false, inaccurate, or exaggerated.

Setting up an experiment. The therapist asks the patient to design an experiment to test the hypothesis. Once the experiment has been planned, the patient predicts what the outcome will be, then gathers data. Frequently the data contradicts the patient's prediction, and the patient can reject the automatic thoughts.

Inductive Questioning. When the previous two approaches are not appropriate or applicable, the therapist may produce evidence from his/her own experience that contradicts the patient's hypothesis. This evidence is presented in the form of a question that poses a logical dilemma for the patient (e.g., "90% of my patients say they won't get better, yet most of them do improve. Why do you think you are different from them?"). Alternatively, the therapist,

through questioning, may point out logical flaws within the patients' own belief system. (e.g., “You say that you have always been a weak person. Yet you also tell me that before you were depressed you got along fine. Do you see any inconsistency in this thinking?”).

Operationalizing a negative construct and defining terms. Sometimes, as a step in testing an automatic thought, the therapist and patient have to define in more concrete terms what the patient means by using a particular word or expression. For example, one patient at our clinic kept telling himself, "I'm a coward." To test the thought, the therapist and patient first had to define and give referents of the construct. In this instance, they operationalized "cowardice" as not defending oneself when being attacked. After this criterion had been agreed upon, the therapist and patient examined past evidence to assess whether the label of "coward" was a valid one. This procedure can help the patient recognize the arbitrary nature of his self-appraisals and bring them more in line with common-sense definitions of these negative terms.

Reattribution. One of the most powerful techniques for testing automatic thoughts is "reattribution." When patients unrealistically blame themselves for unpleasant events, the therapist and patient can review the situation to find other factors that may explain what happened other than, or in addition to, the patient's behavior. This technique may also be used to show patients that some of the problems they are having are symptoms of depression (e.g., loss of concentration) and not indications of permanent physiological deterioration.

Generating Alternatives. When patients view particular problems as insoluble, the therapist can work with the patient to generate solutions to the problem that had not been considered. Sometimes the patient has already considered a viable solution, but has prematurely rejected it as unworkable or unlikely to be effective.

Desirable Techniques for Modifying Underlying Assumptions.

The cognitive therapist emphasizes questioning in the modification of underlying assumptions. We find that the most effective approach is one in which the patient develops evidence against the assumption either alone or in collaboration with the therapist. After an assumption has been identified,

the therapist asks the patient a series of questions to demonstrate the contradictions or problems inherent in the assumption.

Another strategy for testing assumptions is for the therapist and patient to generate lists of the advantages and disadvantages of changing an assumption. Once the lists have been completed, the therapist and patient can discuss and weigh the competing considerations. A related approach is for the patient to weigh the long-term and short-term utility of the assumptions.

Many assumptions take the form of "shoulds" -- rules about what patients should ideally do in given situations. A behavioral strategy, "response prevention" has been adapted as a technique for overcoming these "shoulds." Once the "should" has been identified, the therapist and patient devise an experiment to test what would happen if the patient did not obey the rule. The patient makes a prediction about what the result would be, the experiment is carried out, and the results are discussed. Generally, it is desirable to generate a series of graded tasks that violate the "should," so that the patient attempts less threatening changes first. For example, the patient who believes he "should" work all of the time could experiment with gradually increasing the amount of time devoted to leisure pursuits.

Desirable Techniques for Changing Behaviors

The cognitive therapist also uses a variety of behavioral techniques to help the patient cope better with situations or inter-personal problems. These behavioral techniques are "action-oriented" in the sense that patients practice specific procedures for dealing with concrete situations or for using time more adaptively. In contrast to strictly cognitive techniques, therefore, behavioral techniques focus more on how to act or cope than on how to view or interpret events.

One of the principle goals of behavioral techniques is to modify dysfunctional cognitions. For example, the patient who believes "I can't enjoy anything anymore" often modifies this automatic thought after completing a series of behavioral assignments designed to increase the number and variety of pleasurable activities he/she engages in. Thus behavioral change is often used as evidence to bring about cognitive change.

Behavioral techniques are incorporated throughout the course of treatment, but are usually concentrated during the early stages of therapy. This is especially true with more severely depressed patients who are immobilized, passive, anhedonic, socially withdrawn and have trouble concentrating.

Brief descriptions of behavioral techniques follow below:

Scheduling activities. The therapist uses an activity schedule to help the patient plan activities hour-by-hour during the day. The patient then keeps a record of the activities that were actually engaged in hour-by-hour. Scheduling activities is usually one of the first techniques used with the depressed patient. It often seems to counteract loss of motivation, hopelessness, and excessive rumination.

Mastery and Pleasure. One of the goals of activity scheduling is for patients to derive more pleasure and a greater sense of accomplishment on a day-to-day basis. To do this, the patient rates each completed activity for both mastery and pleasure on a scale from 1 to 10. These ratings generally serve to directly contradict patients' beliefs that they cannot enjoy anything and cannot obtain a sense of accomplishment anymore.

Graded task assignment. In order to help some patients initiate activities for mastery and pleasure, the therapist will have to break down an activity into subtasks, ranging from the simplest part of the task to the most complex and taxing. This step-by-step approach permits depressed patients to eventually tackle tasks that originally seemed impossible or overwhelming to them. These graded tasks provide the immediate and unambiguous feedback to patients that they can succeed.

Cognitive rehearsal. Some patients have difficulty carrying out tasks requiring successive steps for completion. Frequently this is because of problems in concentration. "Cognitive rehearsal" refers to the technique of asking the patient to imagine each step leading to the completion of the task. This rehearsal imagery helps patient focus their attention on the task, and also permits the therapist to identify potential obstacles that may make the assignment more difficult for a particular patient.

Self-reliance training. The therapist may have to teach some patients to take increasing responsibility for their day-to-day activities, rather than relying on other people to take care of all their needs. For example, patients may begin by showering, then making their own beds,

cleaning the house, cooking their own meals, shopping, etc. This responsibility also includes gaining control over their emotional reactions. Graded task assignments, assertiveness training, and running experiments may all be used as part of self-reliance training.

Role-playing. In the context of cognitive therapy, role-playing may be used to elicit automatic thoughts in specific interpersonal situations; to practice new cognitive responses in social encounters that had previously been problematic for the patient; and to rehearse new behaviors in order to function more effectively with other people. A variation, role-reversal, is often effective in guiding patients to "reality test" how other people would probably view their behavior, and thus allow patients to view themselves more sympathetically. Role-playing can also be used as part of assertiveness training. Role-playing frequently is accompanied by modeling and coaching procedures.

Diversion Techniques. Patients can use various forms of diversion of attention to reduce temporarily most forms of painful affect, including dysphoria, anxiety, and anger. Diversion may be accomplished through physical activity, social contact, work, play, or visual imagery.

Special Note to Raters

In assessing the strategy for change, the rater should be primarily concerned with how appropriate the particular techniques are for the problems presented by the patient in the session being rated. In deciding the appropriateness of the techniques, the rater should
try to determine whether the techniques seem to be a part of a coherent strategy for change that follows logically from the therapist's conceptualization of the problem. If the rationale for employing the techniques is not clear, or if the rationale seems faulty, the rater should assign a low score to the therapist. If the rationale seems clear and appropriate, the rater should assign a high score.

The rater should not confuse the quality of the strategy for change (which is the main concern of this item) with how effectively the techniques are implemented (which is assessed in item 10) or whether change actually occurred (which is not necessary to receive a high score on any item).

10. APPLICATION OF COGNITIVE-BEHAVIORAL TECHNIQUES

Objective and Rationale

Once the therapist has planned a strategy for change that incorporates the most appropriate cognitive-behavioral techniques, he/she must apply the techniques skillfully. Even the most promising strategy will fail if executed poorly.

Background Material

a. Cognitive Therapy and The Emotional Disorders, pp. 221-225, 229-232, 250-254, 282-299.
b. Cognitive Therapy of Depression, pp. 27-32, 67-72, 104-271, 296-298.

Desirable Application of Techniques

It is extremely difficult to specify how to know whether a technique is being applied skillfully or not. Clearly, rating this item requires a great deal of clinical judgment and experience. Some general criteria can be outlined. The therapist should be fluent in applying the techniques, rather than fumble around and appear unfamiliar with them. The techniques should be presented articulately, in language the patient can easily understand. The techniques should be applied systematically, so that there is usually a beginning (introduction, statement of problem, rationale), middle (discussion of possible solutions or change), and end (summary of conclusions, relevant homework assignment). The therapist should be sensitive to whether the patient is actually involved in the change process, or merely "going through the motions" out of compliance. The therapist should be resourceful in presenting ideas to the patient in such a way that the patient can begin to superimpose the therapist's conflicting views. The therapist needs to anticipate problems the patient may have in changing perspectives or behaviors outside the session. Finally, the therapist should collaborate with the patient rather than debate, cross-examine, or high-pressure him/her.

Example of a Desirable Application

In the abbreviated example below, the therapist sets up an experiment to test the automatic thought, "I can't concentrate on anything anymore."

Patient: I can't concentrate on anything anymore.

Therapist: How could you test that out?

Patient: I guess I could try reading something.

Therapist: Here's a newspaper. What sections do you usually read?

Patient: I used to enjoy the sports section.

Therapist: Here's a Section on the Penn basketball game last night. How long do you think you'll be able to concentrate on it?

Patient: I doubt I could get through the first paragraph.

Therapist: Let's write down your prediction. (Patient writes "one paragraph.") Now let's test it out. Keep reading until you can't concentrate anymore. This will give us valuable information.

Patient: (Reads the entire Section.) I'm finished.

Therapist: How far did you get?

Patient: I finished it.

Therapist: Let's write down the results of the experiment. (Patient writes "eight paragraphs.") You said before that you couldn't concentrate on anything. Do you still believe that?

Patient: Well, my concentration's not as good as it used to be.

Therapist: That's probably true. However, you have retained some ability. Now let's see if we can improve your concentration.

It is important that the therapist remained neutral regarding the patient's initial prediction and did not assume automatically that the patient's belief was inaccurate or distorted. In some instances, the patient will be correct.

Special Note to Raters

In assessing how skillfully the therapist applied cognitive-behavioral techniques, the rater must try to ignore whether the techniques are appropriate for the patient's problem (since this is assessed in item 9) and also whether the techniques seem to be working. Sometimes a therapist will apply techniques very skillfully, yet a particular patient may be extremely rigid or unyielding and does not respond. In such cases, the therapist's flexibility, ingenuity, and patience may justify a high score on this item, even though the patient does not change.

It should also be pointed out that this item refers to the application of techniques designed to modify thoughts, assumptions, and behaviors (as outlined in item 9), not to techniques designed primarily to elicit cognitions (since the "eliciting" techniques are assessed in item 8).

11. HOMEWORK

Objective

The therapist assigns homework "custom-tailored" to help the patient test hypotheses, incorporate new perspectives, or experiment with new behavior outside the therapy session. The therapist should also review homework from the previous session, explain the rationale for new assignments, and elicit the patient's reaction to the homework.

Background Material

a. Cognitive Therapy of Depression, pp. 272-294.

Rationale

The systematic completion of homework is of crucial importance in cognitive therapy. Unless patients can apply the concepts learned in the therapy sessions to their lives outside, there will be no progress. Homework, therefore promotes transfer of learning. It also provides a structure for helping patients gather data and test hypotheses, thereby modifying maladaptive cognitions so they are more consistent with reality. Homework thus encourages patients to concretize the abstract concepts and insights that have traditionally been the province of psychotherapy, making psychotherapy a more active, involving process. Finally, homework encourages self-control rather than reliance on the therapist, and therefore is important in assuring that the improvement is maintained after termination of treatment.

Desirable Therapist Strategies

Providing Rationale. The therapist must stress the importance of homework in treatment. This can be accomplished by explaining the benefits to be derived from each assignment in detail,

and periodically reminding patients of how vital these benefits will be in helping the patient improve.

Assigning Homework. The therapist tailors the assignment to the individual patient. Ideally, it should follow logically from the problems discussed during the session. The assignment should be clear and very specific, and should be written in duplicate (one copy for the patient and one copy for the therapist), usually near the end of the session. Some typical homework assignments include asking patients to:

a. Keep a Daily Record of Dysfunctional Thoughts, with rational responses;
b. Schedule activities;
c. Rate mastery and pleasure;
d. Review a list of the main points made during the session;
e. Read a book or Section relevant to the patient's problem;
f. Count automatic thoughts using a wrist counter;
g. Listen to or view a tape of the therapy session;
h. Write an autobiographical sketch;
i. Fill out questionnaires like the Dysfunctional Attitude Scale or the Depression Inventory;
j. Graph or chart hour-by-hour mood changes like anxiety, sadness, or anger;
k. Practice coping techniques like distraction or relaxation; and
l. Try out new behaviors that the patient may have difficulty with (e.g., assertiveness, meeting strangers).

Eliciting Reactions and Possible Difficulties. It is usually desirable for the therapist to ask patients for their reactions to assignments ("Does it sound useful?" "Does it seem manageable?" "Is the assignment clear?"). It is often helpful for the therapist to suggest that the patient visualize carrying out the assignment to identify any obstacles that might arise. Finally, as therapy progresses, the patient should play an increasing role in suggesting and designing homework assignments.

Reviewing Previous Homework. Unless the therapist routinely reviews homework assigned from the previous week, the patient may come to believe that there is no need to complete the assignments carefully. Near the beginning of each session, the therapist and patient should discuss each assignment, and the therapist should summarize conclusions derived or progress made.

Appendix D: Case Write-Up Directions

I. Case History (Suggested # of words: 750)

General Instructions: The case history should briefly summarize the most important background information that you collected in evaluating this patient for treatment. Be succinct in describing the case history.

A Identifying Information
Provide a fictitious name to protect the confidentiality of patient. Use this fictitious name throughout the Case History and Formulation. Describe patient's age, gender, ethnicity, marital status, living situation, and occupation.

B Chief Complaint
Note chief complaint in patient's own words.

C History of Present Illness
Describe present illness, including emotional, cognitive, behavioral, and physiological symptoms. Note environmental stresses. Briefly review treatments (if any) that have been tried for the present illness.

D Past Psychiatric History
Briefly summarize past psychiatric history including substance abuse.

E Personal and Social History
Briefly summarize most salient features of personal and social history. Include observations on formative experiences, traumas (if any), support structure, interests, and use of substances.

F Medical History
Note any medical problems (eg., endocrine disturbances, heart disease, cancer, chronic medical illnesses, chronic pain) that may influence psychological functioning or the treatment process.

G Mental Status Observations
List 3-5 of the most salient features of the mental status exam at the time treatment began. Include observations on general appearance and mood. Do not describe the entire mental status examination.

H DSM IV Diagnoses
Provide five Axis DSM IV diagnoses.

II. Case Formulation (Suggested # of words: 500)

General Instructions: Describe the primary features of your case formulation using the following outline.

A. Precipitants:
Precipitants are large-scale events that may play a significant role in precipitating an episode of illness. A typical example is a depressive episode precipitated by multiple events, including failure to be promoted at work, death of a close friend, and marital strain. In some cases (eg., bipolar disorder, recurrent depression with strong biological features) there may be no clear

psychosocial precipitant. If no psychosocial precipitants can be identified, note any other features of the patient's history that may help explain the onset of illness.

The term *activating situations,* used in the next part of the Case Formulation, refers to smaller scale events and situations that stimulate negative moods or maladaptive bursts of cognitions and behaviors. For example, the patient who is depressed following the precipitating events described above may experience worsening of her depressed mood when she's at work, or when she's with her husband, or when she attends a class she used to attend with her friend who died.

Which *precipitants* do you hypothesize played a significant role in the development of the patient's symptoms and problems.

B. Cross-sectional view of current cognitions and behaviors:

The *cross-sectional* view of the case formulation includes observations of the predominant cognitions, emotions, behaviors (and physiological reactions if relevant) that the patient demonstrates in the "here and now" (or demonstrated prior to making substantive gains in therapy). Typically the cross-sectional view focuses more on the surface cognitions (ie., automatic thoughts) that are identified earlier in therapy than underlying schemas, core beliefs, or assumptions that are the centerpiece of the *longitudinal* view described below.

The *cross-sectional* view should give your conceptualization of how the cognitive model applied to this patient early in treatment. List up to three current activating situations or memories of activating situations. Describe the patient's typical automatic thoughts, emotions, and behaviors (and physiological reactions if relevant) in these situations.

C. Longitudinal view of cognitions and behaviors:

This portion of the case conceptualization focuses on a *longitudinal* perspective of the patient's cognitive and behavioral functioning. The *longitudinal view* is developed fully as therapy proceeds and the therapist uncovers underlying schemas (core beliefs, rules, assumptions) and enduring patterns of behavior (compensatory strategies).

What are the patient's key schemas (core beliefs, rules, or assumptions) and compensatory behavioral strategies? For patients whose pre-morbid history was not significant (eg., a bipolar patient with no history of developmental issues that played a role in generation of maladaptive assumptions or schemas) indicate the major belief(s) and dysfunctional behavioral patterns present only during the current episode. Report developmental antecedents relevant to the origin or maintenance of the patient's schemas and behavioral strategies, or offer support for your hypothesis that the patient's developmental history is not relevant to the current disorder.

D. Strengths and assets

Describe in a few words the patient's strengths and assets (eg., physical health, intelligence, social skills, support network, work history, etc.).

E. Working hypothesis (summary of conceptualization)

Briefly summarize the principal features of the working hypothesis that directed your treatment interventions. Link your working hypothesis with the cognitive model for the patient's disorder(s).

III. Treatment Plan (Suggested # of words: 250)

General Instructions: Describe the primary features of your treatment plan using the following outline.

A. Problem list

List any significant problems that you and the patient have identified. Usually problems are identified in several domains (eg., psychological/psychiatric symptoms, interpersonal, occupational, medical, financial, housing, legal, and leisure). Problem Lists generally have 2 to 6 items, sometimes as many as 8 or 9 items. Briefly describe problems in a few words, or, if previously described in detail in the HPI, just name the problem here.

B. Treatment goals

Indicate the goals for treatment that have been developed collaboratively with the patient.

C. Plan for treatment

Weaving together these goals, the case history, and your working hypothesis, briefly state your treatment plan for this patient.

IV. Course of Treatment (Suggested # of words: 500)

General Instructions: Describe the primary features of the course of treatment using the following outline.

A. Therapeutic Relationship

Detail the nature and quality of the therapeutic relationship, any problems you encountered, how you conceptualized these problems, and how you resolved them.

B. Interventions/Procedures

Describe three major cognitive therapy interventions you used, providing a rationale that links these interventions with the patient's treatment goals and your working hypothesis.

C. Obstacles

Present one example of how you resolved an obstacle to therapy. Describe your conceptualization of why the obstacle arose and note what you did about it. If you did not encounter any significant obstacles in this therapy, describe one example of how you were able to capitalize on the patient's strengths in the treatment process.

D. Outcome

Briefly report on the outcome of therapy. If the treatment has not been completed, describe progress to date.

Appendix E: Case Write-Up Sample

I. CASE HISTORY [actual word count: 774] (suggested # of words: 750)

A. Identifying Information: Ann is a 44-year-old, twice-divorced, Caucasian woman who has no children, lives alone, and has been working full-time as a Spanish teacher for the past 22 years.

B. Chief Complaint: Ann sought treatment due to an escalation in her depression which started in October, 1996. She reported that she was also binge eating and overusing and abusing laxatives at least once a week, though she was much more concerned by the depression than the eating/laxative problem.

C. History of Present Illness: In October, 1996, Ann divorced her second husband and began to develop depressive symptoms (sadness, crying, social withdrawal, severe self-criticism). The depression worsened until it reached the severe level in March, 1997. At intake (May, 1997), her symptoms included the following:

emotional symptoms: sadness, anxiety, lack of interest in almost all activities
cognitive symptoms: difficulty concentrating, believing she was worthless and unloveable
behavioral symptoms: crying, social isolation
physiological symptoms: difficulty falling asleep, tiredness

She developed subclinical symptoms of bulimia nervosa in April, 1997. At intake, she reported that she binged, felt out of control of this behavior, and overused laxatives about once a week; she was (and is) intermittently preoccupied with a misperception that she is fat and is highly self-critical.

The major stressors in Ann's life are social ones. Since her divorce she has withdrawn from friends, family, and co-workers. She has dated several times since her divorce but each date has been a "one-night stand," which leaves her feeling rejected and defective. She used to derive significant satisfaction from relationships but has isolated herself and now feels sad, lonely, and rejected by others. While she finds it more difficult to do her job, work does not appear to be a significant stressor.

Ann restarted Prozac about 2 weeks ago (prescribed by her family physician) but thus far sees no change in her depressive symptoms.

D. **Psychiatric History:** Ann's first episode of major depression occurred in 1977 when her first husband divorced her. She was hospitalized for three weeks and was given Elavil. She discontinued the medication (against medical advice) at discharge but initiated psychological treatment (cognitive therapy) for the first time. Her depression remitted after four months of this outpatient psychotherapy, though she remained in therapy on a biweekly basis for another year, working on Axis II issues.

In 1989, Ann and her second husband received about six sessions of (predominantly psychodynamic) marital counseling which she found "mildly helpful."
In October, 1996, Ann's family physician prescribed Prozac which initially helped reduce her depressive symptoms. The depression worsened in December, 1997, and she discontinued the medication on her own.

E. **Personal and Social History:** Ann grew up the middle child of three. Her parents were Italian immigrants and her mother did not speak English. Ann considered herself the "ugly duckling" of the family. Her older sister was considered thin and pretty while Ann was called "chubette" and "big nose." She felt as if she were an extra burden to her family since they strongly wanted a boy when she was born. Her younger brother was born 18 months later and received nearly all the family's attention. She describes her father as having been strict, controlling, demanding, and very concerned about what others thought of him. She describes her mother as quiet, unhappy, not affectionate, and old-fashioned. Ann felt unloved and unable to measure up to her siblings.

Ann attended Catholic school where she reports being trained to be "the perfect soldier." She married for the first time at age 18. She reports that she was abused and controlled by her first husband who was violent at times. She believed she deserved the abuse and submitted to his wrath. When she finally got the courage to leave the marriage, she did not have her family's approval and to this day resents their lack of support.

Ann remarried in 1989. Her second husband reportedly spent a lot of time with young men and Ann suspects he was bisexual. He ceased having any sexual relations with her about three years after their marriage. Though they tried marriage counseling briefly, her husband was

unwilling to work on modifying the situation and they divorced in October of 1996.

F. **Medical History:** Ann did not have any medical problems which influenced her psychological functioning or the treatment process.

G. **Mental Status Check:** Patient is fully oriented, with depressed mood.

H. **DSM IV Diagnoses:**

Axis I: Major Depressive Episode, Recurrent, Severe
Rule out Bulimia Nervosa
Axis II: Avoidant Personality Disorder
Axis III: None
Axis IV: Divorce, Multiple Relationship Failures
Axis V: GAF Current—68. Best in Past Year—80.

II. CASE FORMULATION: [actual word count: 403] (suggested # of words: 500)

A. **Precipitants:** Ann's second divorce probably precipitated a recurrence of depression. Although it was she who initiated the divorce, she nevertheless felt rejected, believing that if she were more loveable, her husband would have fought to save the relationship. Feeling not only unloved by and unloveable to her husband but also unloveable in general, she began to isolate herself. She was no longer getting much positive input from her friends, family, and co-workers because of her lack of contact with them—but, like the divorce, she perceived this self-initiated reduction of contact as their rejecting her, instead of her withdrawing from them. She became increasingly sad and lonely and other depressive symptoms began to develop.

B. **Cross-Sectional View of Current Cognitions and Behaviors:**

A typical current problematic situation is that Ann has just had sex on the first date with a man. Lying in bed with him she has the automatic thoughts, "I'm so ugly, what does he see in me, he'll never call, I might as well get up and leave now." Emotionally she feels sad and her behavior is to leave abruptly (probably appearing unfriendly, at best, to her date). A second typical situation is that she's reflecting on how a man has not called her back after a date. Her automatic thoughts are, "I'm too fat. No one wants me." She then feels sad, binges, and takes laxatives. A third situation is attending a family dinner where she perceives her father as being critical about her and her mother as lacking affection. She thinks, "No one cares about me; there's something wrong with me, I'm unimportant." She feels sad and becomes monosyllabic,

speaking only when spoken to.

C. Longitudinal View of Cognitions and Behaviors:

Ann grew up with non-English speaking Italian immigrant parents: a father who was demanding and critical and a mother who was emotionally distant. Early on she developed the belief that she was defective and unloveable, beliefs that were strengthened by the attention heaped upon her younger brother, by increasing academic expectations of her father, by the criticisms of her teachers, and by her self-comparisons to her more attractive older sister. She developed the following key assumption: "If I'm perfect, don't cause trouble, and try always to please others, they'll like me. If I don't, they'll find me unloveable." Her compensatory behavioral strategies included being overly compliant, submissive, "perfectly" behaved, and avoidant of conflict.

D. Strengths and Assets

Ann has had many years of success in her professional life. In her role as teacher, she is extremely well-liked by her students, and given high praise from her peers.

E. Working Hypothesis (summary of Conceptualization)

It is understandable that Ann came to view herself as unlovable and defective as a result of the circumstances of her childhood. Being the daughter of highly demanding, critical European parents, her strict parochial education, and her abusive marriages, laid the foundation and then reinforced her negative view of herself. This negative self view is typically activated in interpersonal situations where she perceives rejection.

In order to function in her world, she has established rigid assumptions for herself: i.e., "I must be perfect or people will reject me," "I must please others, or they will dislike me." to operationalize her assumptions, she has developed the following behavioral compensatory strategies: submission, avoidance, and acquiescence.

III. TREATMENT PLAN: [actual word count: 195] (suggested # of words: 250)

A. Problem List:

1. "Ann bashing"--hating self (ugly and unlovable)
2. Depression; especially loneliness, sadness, crying

3. Avoidance and isolation: wanting to be loved but fearing rejection
4. Anxiety: fearing serious consequence of unrelenting depression
5. Binge eating and abuse of laxatives
6. Resentment towards parents for lack of affection and love

B. Treatment Goals:

1. Reduce dysfunctional behaviors: Verbally berating herself
   Binging and purging
   Isolation
2. Reduce negative distorted thinking.
3. Increase self worth, self-value and self-image. (Modify unloveability and not-good-enough (defective) schemas).
4. Find healthier ways to have fun.
5. Gain confidence to go out alone and take risks in pursuing intimacy again.
6. Build assertiveness skills and reduce subjugation.

C. Plan for Treatment:

The treatment plan was to reduce Ann's depression through helping her respond to her automatic thoughts (especially those connected with unloveability) and activity scheduling (especially to increase socializing). We also worked on alternative behaviors to bingeing when she was upset. Next, we tested her assumptions about being rejected if she displeased people and then worked on assertiveness skills. We are currently working at the belief level, modifying her view of herself as unloveable and defective.

IV. COURSE OF TREATMENT [actual word count: 300] (suggested # of words: 500)

A. Therapeutic Relationship: Treatment was facilitated by Ann's eagerness to please ("If I please others, they'll like me") but the counterpoint to this assumption ("If I disagree with people, they won't [like me]") did interfere slightly. Ann was too eager to please in therapy; she quickly agreed with me, sometimes without really stopping to reflect on the hypotheses or alternative perspectives I presented to her. I was able to elicit from her another belief ("If I tell someone I disagree, they'll take it as criticism"), helped her test these beliefs with me, correct her thinking, and then she became more willing to tell me when she didn't fully understand or agree with what I had said.

B. Interventions/Procedures:

1. Taught patient standard cognitive tools of examining and responding to her automatic thoughts (which allowed the patient to see her dysfunctional distorted logic and thus significantly reduced depressive and anxious symptoms.)
2. Had Ann conduct behavioral experiments to test her assumptions (e.g., If I say no to a man about having sex on a first date, he'll get mad and never call me again.). This resulted in reduced avoidance and increased assertiveness.
3. Had Ann keep an ongoing log of evidence that she was a loveable person, which helped her modify a key core belief.

C. **Obstacles:** When Ann had a bad week, she became hopeless about therapy. We reframed her setback as a reactivation of her schema due to an unfortunate incident with a date and as an opportunity to practice responding to negative automatic thoughts and solidifying a new, healthier belief.

D. **Outcome:** Ann's depression gradually reduced over a four-month period after we started therapy, until she was in full remission. She remains in therapy to work on lingering problems with male relationships and her self-image.

Appendix F: Case Write-Up Scale

Case Write-Up Scale

Applicant: _____ Case Identification: _____
Rater: _____ Date of Rating:_____

Instructions: Please review the case information provided, and then rate it using the following dimensions. For each item, provide a rating of:

(0) - Not present
(1) - Present but inadequate
(2) - Present and adequate

Case History

(0) (1) (2) 1. Identifying Information and Problem List (chief complaint, diagnoses, etc.)
(0) (1) (2) 2. History (personal and social, problems, diagnoses, medical)

Case Formulation

(0) (1) (2) 1. Precipitants of current disorder or problems
(0) (1) (2) 2. Current cognitions and behaviors contributing to disorder or problems
(0) (1) (2) 3. Historical view of cognitions and behaviors (developmental considerations)
(0) (1) (2) 4. Review of current strengths and assets
(0) (1) (2) 5. Working hypothesis (summary of cognitive case conceptualization)

Treatment Plan and Course

(0) (1) (2) 1. Treatment goals and plan for treatment
(0) (1) (2) 2. Interventions/ procedures planned and used
(0) (1) (2) 3. Therapeutic relationship
(0) (1) (2) 4. Obstacles to treatment plan
(0) (1) (2) 5. Outcomes

Comments:

For administrative use:

_____ Total Score [ ] Pass [ ] Fail (Pass score = 20/24)