BRIDGING THE GAP BETWEEN SCIENCE AND PRACTICE:
A STUDY OF A PROTOCOL FOR CBT DISSEMINATION
AND IMPLEMENTATION IN A COMMUNITY MENTAL HEALTH CENTER

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Abstract

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This study tested a dissemination and implementation protocol for delivering Cognitive Behavioral Therapy (CBT) for depression to therapists within a community mental health center (CMHC). Twelve therapists and 116 patients participated, and patients received either Treatment as Usual (TAU, \( n = 74 \)) or CBT (\( n = 42 \)). Therapist CBT competence was measured using the Cognitive Therapy Rating Scale (CTRS), and patients’ symptomatology was measured using the Beck Depression Inventory-2 (BDI-II) and Beck Anxiety Inventory (BAI). Over the course of the study, therapist CTRS scores increased significantly while patients’ BDI-II and BAI scores showed a larger decrease when treated with CBT. This data suggests that the significant increase in therapist CBT competence may explain the significant decreases in patients’ reported depression and anxiety symptoms when receiving CBT compared to TAU. This study demonstrated that CBT could be successfully disseminated and effectively implemented to improve patient outcomes within a CMHC.
To my parents, Lynda and Tony,

To Darlene, Krissy, and Bryan, Alex and Taylor, and Peter

For their unconditional love and support.
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CHAPTER 1

INTRODUCTION

In 1998, Beutler identified over 400 different psychotherapies, of varying popularity, that were currently available to any given therapist, for any given disorder, and to be used at any given time for any given patient. In order to encourage the use of empirically supported treatments (ESTs), and “to reserve a place [for psychotherapy] in the future of medicine,” Division 12 of the American Psychological Association appointed the Empirically Supported Treatment Task Force on Promotion and Dissemination of Psychological Procedures (1995). As suggested by its name, this Task Force was created to promote and disseminate psychotherapies that are empirically supported. Viewed along with Beutler’s findings, the efforts of Division 12 to narrow down over 400 psychotherapies of unknown efficacy to provide a small number of empirically supported, efficacious treatments for psychologists to consider when choosing a treatment plan for their patients seems quite reasonable.

Two years after the EST Task Force had begun, a much more manageable list of 18 different psychotherapies had been identified as empirically supported. According to Chambless and Hollon (1998), these ESTs are “clearly specified psychological treatments shown to be efficacious in controlled research with a delineated population” (p. 7). According to Task Force criteria, for a treatment to be declared empirically supported and “well established,” it must be (a) manualized, (b) intended for a specific population (i.e.,
diagnostic condition), and (c) shown either to outperform a placebo or alternative
treatment condition or to be equivalent to an already established treatment in randomized
clinical trials by at least two different investigators. While the Task Force presented this
comprehensible and workable operational definition for the development and empirical
testing of ESTs, the dissemination and implementation processes of ESTs have not
proven to be quite as straightforward of a process.

For the purposes of this paper, dissemination and implementation will describe
two distinct, but related processes. Dissemination will refer to the processes/protocol that
characterize(s) the method by which a specified, manualized treatment is transported
from research to practicing therapists in a “real world” community. Implementation will
refer to the actual delivery/practice by these newly trained psychologists in their planning
and conducting of therapy sessions using the specific techniques and manual that have
been previously disseminated to them. To differentiate the necessary separation between
dissemination and implementation as two distinct processes, and because these two
concepts are at the heart of the current study, an example (albeit imperfect) might prove
to be most helpful.

Prior to a legal directive, car seatbelts were not required to be worn while driving
nor were they even required to be present in a manufactured vehicle. As a result, drivers
and passengers were severely injured in the course of accidents, and most of these
injuries were a direct result of a problem of poor (seatbelt) dissemination. Following the
injunction, seatbelts were then required to be present in every manufactured vehicle.
This development created an essentially perfect solution to the dissemination problem.
Unfortunately, drivers and passengers continued to suffer severe injuries from accidents
even though the cars now had seatbelts. Injuries were no longer a (seatbelt) dissemination problem, instead, injuries were now largely a seatbelt implementation problem. People were not wearing them! Even though the seat belts were perfectly disseminated (i.e., in all cars), the seatbelts were being poorly implemented (i.e., not worn). This is the case for the dissemination and implementation of a psychotherapy treatment as well. In order for a given treatment to perform at levels of empirical efficacy, the dissemination and implementation must both be successful. Simply handing a treatment to therapists is not helpful if that treatment is not then used in the way in which it is intended.

*Barriers to Treatment, Dissemination, and Implementation*

Even once specific ESTs have been identified, barriers currently exist throughout the progression from EST identification to EST dissemination into the community and then to implementation of the EST by mental health practitioners. In order for clinicians to implement any EST, the EST must first be disseminated to clinicians via a method that is clinically practical, economical, realistic, and delivered in light of the time constraints under which clinicians already reportedly struggle (Schmidt & Taylor, 2002).

Notable among the barriers to widespread dissemination of ESTs are the lack of effectiveness studies, inappropriate or unfriendly manuals, inadequate reliance upon a model of “appropriability of technology transfer,” and agency-specific complications, such as those typical of Community Mental Health Centers (CMHCs).

*Efficacy vs. Effectiveness.* For any given therapy or intervention, there are essentially three research questions that can be asked. First, does the therapy work under experimental conditions? Second, does the therapy work in practice? And third, does the
therapy work for a particular patient? The answers to the first two questions are at the heart of efficacy (experimental) and effectiveness (quasi-experimental) research, respectively, and are generally treatment focused. The third is answered ideographically and is patient focused (Howard, Moras, Brill, Martinovich, & Lutz, 1996).

Seligman (1995) deduces that clinicians’ refusal to adopt and implement ESTs has made it clear that, in the clinician’s view, efficacy studies are the wrong way to empirically validate psychotherapeutic interventions as they are actually implemented in practice. Several authors have also raised the concern that efficacy studies, notably randomized-control studies, are inadequate measures of a psychotherapy’s clinical effectiveness because of their extreme methodologically rigorous control for too many variables (Westen & Morrison, 2001; Goldfried & Wolfe, 1998; Persons & Silberschatz, 1998). These critics contend that by controlling specific variables, such as randomized assignment, the absence of comorbidity in subjects, a pre-determined number of therapeutic sessions for subjects, and strict inclusion/exclusion criteria in an efficacy study, any data collected or analyzed from these studies cannot accurately reflect real-world clinical practice. Researchers and clinicians that express those apprehensions towards the translational ability of ESTs seemingly believe that personalized therapies that cater specifically to their patient’s unique needs should outperform any standardized treatments supported empirically via an efficacy study.

One determining factor of dissemination and adoption of ESTs appears to be the clinician’s views of also adopting treatment manuals. In fact, Addis and Krasnow (2000) propose that “manuals reflect and contribute to epistemological differences between and within practitioners, researchers, clinical administrators, and other parties concerned with
psychotherapy outcomes. What is the role of controlled science versus clinical experience in constituting the knowledge base of our field?” To be sure, many effectiveness studies have been conducted, and some of these will be reviewed later in this paper, but appreciation of these findings is enhanced by awareness of the role of manuals in these studies, an issue to which we turn in the next section.

_Treatment Manuals._ Psychotherapy research and practice underwent a paradigm shift in the early 1980’s when several innovations were introduced and then modeled by the National Institute of Mental Health (NIMH) Treatments for Depression Collaborative Research Program (TDCRP, Elkin, Parloff, Hadley, & Autry, 1985). From this Collaborative, one of the foremost and influential products was the introduction of manualized treatments – manuals for therapists describing the implementation of specific forms of psychotherapy for specific disorders (Moras, 2002). Since the formal induction of manualized treatments in the 1980’s, the successful dissemination of these treatments to clinicians has proven to be difficult. This difficulty highlights the “well chronicled, chronic, ironic gap between science and practice in clinical psychology” (Moras, 2002).

Clinicians sometimes claim that the gap between science and practice is due to a reliance upon manualized treatments that oversimplify the treatment process, the patient’s presenting problems, and undermines and overly restricts the clinician’s own judgment during the course of therapy (Addis, Wade, & Hatgis, 1999; Garfield, 1996; Lambert, 1998; Parloff, 1998). Clinicians endorsing this view sometimes characterize the clinician as an improvisational artist who cannot be bound by a manualized treatment. In the extreme, this binding then reduces therapy to a painting by numbers scheme (Bohart, O’Hara, Leitner, 1998; Silverman, 1996) because manualized treatments ignore the
unique role and characteristics of the individual therapist involved (Garfield, 1996), as well as the complex intricacies of any given client’s presenting problems. However, contrary to clinicians’ beliefs about the lack of effectiveness of manualized treatments, Chambless and Ollendick (2002) could find no studies that pointed to individualized treatment(s) outperforming standardized, manualized treatment(s) in clinical practice. This suggests that manualized treatments do not detract from the overall outcome of psychotherapy. This would also suggest that efficacy findings could be translated into effective clinical practice.

Another issue that has hampered dissemination of ESTs is the abundance of manuals that are reportedly not “clinician-friendly” (Moras, 2002). Four themes appear to encompass the primary criticisms of treatment manuals: (a) limited applicability to the complex populations and presenting problems encountered in clinical practice (Abrahamson, 1999; Norcross, 1999), (b) excessive emphasis on technique with inadequate focus on working alliance and other important common elements of treatment (Addis, Wade, & Hatgis, 1999; Elliot, 1998), (c) restriction of clinical innovation and the clinical expertise of the therapist (Addis, Wade, & Hatgis, 1999; Castonguay, Schut, Constantino & Halperin, 1999; Norcross, 1999), and (d) feasibility when the manual is implemented by clinicians of great diversity regarding experience, discipline, and clinical expertise (Addis, Wade, & Hatgis, 1999).

Carroll and Nuro (2002) propose that the source of these criticisms is not the manuals describing ineffective treatments, but rather the manuals have not yet undergone adequate studies that focus on the transportability of the treatment from efficacy studies to clinical utility (i.e., issues such as the efficacy of the treatment in diverse populations,
systematic evaluation of different means of training therapists, estimation of cost-effectiveness). According to Carroll and Nuro’s (2002) stage model of treatment manual development, a treatment can only be successfully disseminated once several clinical trials have been completed and the outcome data from these studies are applied to a variety of patient populations. In other words, ESTs can be effectively disseminated and implemented only once the manualized treatments have been translated from “ideal” conditions to “realistic” clinical conditions (Wolfe, 1999). According to this model, the manualized treatment would be ready for dissemination and implementation only when similar outcomes as those found under “ideal” conditions are replicated in studies under “realistic” clinical conditions. This would include guidelines for clinicians on the flexibility of the treatments and how treatments can be tailored to meet a given patient’s needs.

The stage model development of manuals (see Carroll and Nuro, 2002) would prove to be a valuable tool in assisting the dissemination of manualized treatments. However, successful dissemination cannot be accomplished without significant attention also being given to the development of training programs to address clinicians’ concerns about empirically supported treatments and the use of treatment manuals. Unfortunately, there is currently a dearth of research involving training programs. In order to meet the goals of the Division 12 Task Force on the Promotion and Dissemination of ESTs, the integral step from manualized therapy to successful implementation of that therapy is dependent upon the development of a successful training program to facilitate in delivering the EST effectively (Northey & Hodgson, 2008; Calhoun, Moras, Pilkonis, & Rehm, 1998).
Appropriability vs. Knowledge Utilization. In a review of dissemination theory, Stirman, Crits-Christoph, and DeRubeis (2004) provide another account for the slow rate of transfer of ESTs from research clinics to community settings. Initially, researchers assumed that providers would adopt ESTs once empirical support for psychotherapies became available (Martin, Herie, Turner, & Cunningham, 1998). This approach is referred to as the “appropriability” approach to technology transfer (Rogers, 1995). However, it appears that this approach is proving to be insufficient for the successful dissemination of ESTs into the psychotherapy community, given the hesitancy of clinicians to adopt ESTs even after supportive data have become available. The specific reasons for this approach’s insufficiency are difficult to pin down, but the likely reasons include issues that are confronted at an organizational level as well as at an individual therapist and client level when the packaged ESTs are attempted in practice (Stirman, Crits-Christoph, & DeRubeis, 2004). Among the many appropriability approach issues are those associated with sustained adoption of the ESTs after their initial implementation, extra time needed to study and/or attend additional workshops to maintain a specified level of proficiency, access to materials to help assist in solving clinical problems within a specific ESTs framework, and lack of adequate supervision.

In response to these potential problems, Stirman et al. (2004) propose an alternative to the appropriability approach that they refer to as the “knowledge utilization” approach. This approach focuses on a more active engagement between researchers and clinicians in the promotion and dissemination of ESTs (Rogers, 1995; Tenkasi & Mohrman, 1995). By adopting a knowledge utilization approach to dissemination of ESTs, effectiveness researchers can begin to develop models and
systems of dissemination that not only lend support for the implementation of ESTs but also for the successful dissemination and maintenance of the ESTs. The call for an application of dissemination theory for ESTs is gaining traction; however, there are few effective dissemination methods that can consistently promote widespread dissemination of ESTs.

ESTs and Community Mental Health Centers. In contrast to University and other educational research settings, Community Mental Health Centers (CMHCs) are among the most disadvantaged clinical settings when considering the adoption of effective models for the dissemination of ESTs (Silverman, Kurtines, & Hoagwood, 2004). Within CMHCs, clinicians themselves are often either unaware or unfamiliar with the concept of ESTs or they are skeptical that such treatments will work in their setting. Further hindering implementation in CMHCs, the communication between researchers and practitioners is typically scarce, and when it does occur, it is often uni-directional, occurring only in the context of a research study and ending after the data are gathered (Garland, Hurlburt, & Hawley, 2006). Consequently, ESTs remain largely unavailable to clinicians, and subsequently clients, in CMHCs.

Further, even those mental health providers employed in community settings who are interested in learning newer ESTs often cannot find the necessary training and/or supervision for the transition to providing these modes of treatment (Lau, Dubord, Parikh, 2004). As a result, mental health treatment studies show that the majority of severe mental illnesses are not treated with ESTs (U.S. Surgeon General, 2000). Generally speaking, treatments showing extensive evidence for their efficacy in psychotherapy are not practiced widely in community mental health settings (Goisman,
Warshaw, & Keller, 1999; Stirman, Crits-Christoph, & DeRubeis, 2004). For a variety of reasons, despite the advances that psychotherapy research has made over the more recent years, clinicians are still choosing to use unsubstantiated treatment as usual (TAU) instead of ESTs in their clinical work (Barlow, Levitt, & Bufka, 1999; Hayes, 1996; Sanderson, 2002).

For purposes of the present investigation, CMHCs seem to be an especially appropriate setting in which to observe and address many of the barriers to dissemination. And, because CBT is one of the most referenced therapeutic modalities in the EST treatment literature, CBT appears to be an especially appropriate EST to investigate.

**CBT as an EST**

Over the past 20 years, the literature has seen numerous studies establishing CBT's efficacy in the treatment of both Axis I and Axis II disorders. The majority of these studies have focused on the treatment of anxiety and depression (Antony & Swinson, 1996; Dobson, 1999). In a recent meta-analytic and large-scale clinical trials review, Butler, Chapman, Forman, and Beck (2006) present compelling evidence that CBT performed at least as well or better than any other treatment, including psychopharmacology, for adult depression. To augment these outcome findings, Butler, et al. (2006) also found that at long-term follow up for up to a year following the termination of treatment, patients treated with CBT were significantly less likely to suffer a relapse. These findings provide strong evidence for the superior longevity of CBT relative to other efficacious and effective treatments (Hollon, Stewart, Strunk, 2006). Recognizing the strength of these CBT outcome data, clinical training programs have begun to emphasize the use of ESTs, and in particular CBT, as the most efficient way to
reduce symptoms of a variety of mental health disorders (Cukrowicz, White, Reitzel, Burns, Driscoll, Kemper, Joiner, 2005).

Unfortunately, the study of effective dissemination of CBT into CMHCs is essentially non-existent. However, the literature has recently begun to show researchers’ interest in providing recommendations for the transportability of CBT from its place in research to its dissemination into the community (see Wells & Miranda, 2006). Although still in its relative infancy, researchers, including and supported by the National Institute of Mental Health (NIMH), have begun to study the dissemination and implementation of ESTs such as CBT.

A search of the current literature provides evidence that research efforts over the past decade have increasingly focused on testing and fostering the use of ESTs outside of controlled clinical trials. These studies have assisted in bolstering the empirical support needed for practitioners to adopt ESTs as well as providing foundational knowledge needed by clinical practitioners in order to successfully implement ESTs. Studies have begun to show that a general dissemination and implementation of ESTs in mental health settings can reproduce patient outcome results that are similar to those found in controlled clinical trials (Merrill, Tolbert, Wade, 2003). However, successful means for specific protocols and methodologies of EST dissemination have yet to be established, although a significant number of initial investigations have been reported.

Investigations of CBT Dissemination and Implementation

Sholomskas, Syracuse-Siewart, Rounsaville, Ball, Nuro, and Carroll (2005) assigned 78 community-based clinicians to one of three training conditions: The review of a CBT manual only; the review of the manual plus access to a CBT training Web site;
or the review of the manual plus a didactic seminar followed by supervised casework. The primary outcome measure was the clinicians’ ability to demonstrate key CBT interventions, as assessed by independent ratings of structured role-plays. Statistically significant differences favoring the seminar plus supervision over the manual-only condition were found for adherence to the therapeutic protocol and for skill ratings for two of the three role-plays, with intermediate scores for the Web access condition. These preliminary findings suggest a model of a training that has proven to be effective in disseminating a manualized treatment. As a result, the specific components of this dissemination program can be used to investigate clinicians’ abilities to demonstrate key CBT interventions/components/techniques. Implementing this type of model may give rise to the following research questions: Are therapists who demonstrate these CBT skills more competent in providing CBT? If so, is there a relationship between a given therapist’s CBT competence and the resulting client outcomes?

Shaw et al. (1999) conducted a study on the relationship of therapist competence to the outcome of CBT in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. Therapists implementing cognitive-behavioral interventions at three separate U.S. sites, using a format of 20 sessions in 16 weeks, treated outpatients suffering from major depressive disorder. Findings provide some support for the relationship of therapist competence, as measured by the Cognitive Therapy Scale (CTRS; Young & Beck, 1980), to the reduction of patients’ depressive symptomatology. The overall results, however, were not as strong or consistent as expected. A possible reason for the weak results might have been the therapists’ inability to maintain a stable level of CBT competence throughout the study while receiving only a
minimal amount of continued intensive supervision. In addition, one outlier showing extremely poor CBT competence and extremely poor patient outcome was excluded from the final analysis. When this outlier was included in the analysis, a statistically significant relationship between CTRS scores and reduction of patient depressive symptomatology was obtained. The component of competence that was most highly related to outcome was a factor that reflected the therapist's ability to structure the treatment. That is, a relationship was found between the Structure subscale of the CTRS and the patients’ reaching a clinically significant improvement on various depression inventories.

In their recent review of the literature, Barber, Sharpless, Klostermann, and McCarthy (2007) provided further insight into the relationship between therapist competence and patient outcome. In their review, Barber et al., found a consistent positive association between therapist competence level and patient outcome; however, the associations tended to be weak. In addition, there were a few studies that showed no association and two studies that showed a negative association. The authors explored the reasons for the varied findings and determined that, among other possibilities, a restricted range of therapist competence in many studies may have lead to a small variability in therapist competence or patient outcome when using randomized-control trials. In addition, adherence and competence are not always disjoined concepts across measures of competence; therefore, the complex relationship between adherence and outcome could fail to separate itself from the relationship between competence and outcome. Regardless of these post hoc explanations for the varied findings of association between competence and outcome, the consistent trends of positive associations between therapist
competence and patient outcome continue to suggest that the level of therapist competence measured can provide some level of predictive value in patient outcome.

Cukrowicz et al. (2005) demonstrated EST’s (particularly CBT) effectiveness in a demographically diverse patient population with a broad range of psychopathology, with the two largest percentages of patients either having no diagnosis or a mood disorder diagnosis. Though published only a few years ago, this study was the first to propose and test a model of manualized CBT dissemination and implementation within a clinical training setting. This study included training graduate students in implementing treatment within a structured CBT framework. In this study, patient symptomatology decreased significantly, as reported by the Clinical Global Impression (CGI) Scale, and in significantly fewer sessions when delivering CBT as opposed to non-specific treatment as usual.

Cukrowicz et al. (2005) results suggest that ESTs can prove effective in a real-world clinical setting and that the benefit of implementing ESTs is not restricted to studies of efficacy. This study also speaks to translatability of manualized CBT psychotherapies. As presented earlier, many clinicians believe that manualized therapies are too restrictive and inflexible for individualized treatments. Here, Cukrowicz et al. (2005) have shown that, contrary to some clinicians’ beliefs, in disseminating a manualized treatment model, a degree of therapist flexibility is still present when implementing individual treatment plans. The clinician and patient can work together, within the manualized EST framework, in a way that still accounts for the patient’s unique needs (i.e., specific interpersonal situations, relevant problem areas, etc.). Perhaps most importantly, this study provides evidence that in order to effectively deliver a
manualized EST, the clinician need not have extensive experience with delivering the treatment. These findings suggest that the skills learned during the dissemination of the EST can be put to use effectively relatively quickly, even as the therapist is first beginning to implement them in practice.

_Lau et al. Study._ Lau et al. (2004) reported the first empirical study of disseminating a manualized model of CBT to a group of mental health practitioners, treating patients who were mostly presenting with mood and/or anxiety disorders. Lau et al. (2004) developed a unique training model based on a standardized treatment manual, _Cognitive Therapy Basics and Beyond_ (Beck, 1995). Ten chapters from this manual were chosen as the basis for which a 10-session longitudinal supervision course was developed. After attending a two-day didactic CBT workshop, the course continued with a 10-session supervision component. Each of the ten sessions included 30 minutes of didactics and demonstrations followed by 90 minutes of group case supervision.

The study was designed to assess therapists’ CBT skill acquisition both at the beginning of training and then again at the end of the 10-session supervision course using the Cognitive Therapy Scale (CTRS, Young & Beck, 1980; 1988). Only a limited subset of patients and therapists in this study could be analyzed and reported due to the incomplete nature of the clinical data successfully collected. The incomplete data could have occurred for any number of reasons: (a) subjects were physically unable to complete the outcome measures because of the severity of their mental illness, (b) subjects refused to continue to complete the measures each week if they deemed weekly measures to be excessive, (c) subjects could not complete their final outcome measure because the client dropped out of therapy prematurely, (d) therapists forgot to administer the measures at
each visit, (e) individual therapists deemed it excessive to administer the measures to subjects at each visit, (f) individual therapists deemed the data collected as unhelpful for their practice of CBT and voluntarily chose to cease administration of the measure, (g) administrative circumstances were such that subject data was misfiled, misplaced, or lost after the completion of the measure, and/or (h) therapists’ misunderstanding of the research protocol of collecting each measure during each weekly visit. However, regardless of these potential pitfalls, the results that were collected and analyzed suggest that the dissemination method used in this study was effective.

The results of Lau et al. (2004) suggest that therapist adherence to CBT improved from the introduction to the completion of the supervision course. Also, patient outcomes resulted in significantly lower depression and anxiety symptomatology as well as a significant change in a global assessment of reported illness severity at the completion of therapy when compared to initial assessment scores. This study advances the literature by providing an effective method of systematically disseminating a specific manualized EST to mental health care providers. Results suggest that when disseminated in a structured fashion, along with continual supervision provided to the therapists to monitor their implementation of CBT, it is feasible to provide therapists in the community with the knowledge and support needed to effectively deliver CBT.

While promising, this study fails to fully evaluate CBT effectiveness inasmuch as there were no comparisons with an untested control group, wait-list control group, or an alternative type of treatment. As a result, the findings in this study must be interpreted cautiously, bearing in mind that there is no way to determine how the patients would have fared had they been given treatment as usual from these same therapists. A second factor
that deserves attention when interpreting the results from this study is the therapists’ level of CBT competence at the beginning of the study, prior to the study’s formal CBT training portion. The group of therapists participating in the study began with baseline CBT competence scores that were already well above the threshold, or “red line,” that marks the acceptable level of therapist CBT competence as established by the NIMH TDCRP (Elkin et al., 1985; Shaw et al., 1999). Therefore, it is difficult to discern whether these same therapist competence gains and patient symptom reductions over the course of the study could be replicated when providing CBT training to a group of therapists who are much less seasoned in CBT competence from the outset of the study.

To summarize, the studies presented thus far suggest that it is feasible to disseminate CBT to mental health providers. In addition, preliminary evidence suggests that through these methods of dissemination, CBT can be effectively implemented in a way that provides both increased adherence to a CBT protocol by the therapist and significantly improved symptomotology in the patients. These findings are further evidence that CBT can be delivered effectively and implemented with results similar to those reported in efficacy studies.

*Depression*

In the current study, a training model including a two-day workshop, and follow-up supervision focused on a manualized version of CBT for depression, will be tested in a sample of CMHC clinicians. Major Depressive Disorder (MDD) has been chosen for evaluation as a dependent measure in this study because CBT has a lengthy history of being identified as an efficacious treatment for MDD, and MDD continues to be the mental health issue that has the highest lifetime prevalence rate. MDD is a significant
public health concern, and addressing treatment dissemination issues could assist in providing more effective treatment options for therapists to choose from when providing therapy for their patients suffering from MDD.

MDD is a serious mental illness that has wide-ranging intrapersonal and interpersonal effects. Throughout the duration of a depressive episode, people experience a significant decrease in positive affect and an increase in negative affect. This overall affective change results in a lowered quality of life. This can include – but is not limited to - health problems, job loss or academic failure, family issues, and unsatisfactory or unfulfilling social and intimate relationships. According to results from the National Comorbidity Survey Replication (Kessler et al. 2003), the lifetime prevalence rate for MDD is 16.2%. A recent review of the literature suggests that the prevalence rate of individuals in need of treatment for depression is more accurately estimated to be between 20% and 30% due to the MDD diagnosis in isolation being a poor proxy for treatment need in a community population (Patten, 2008).

Because MDD cuts pervasively across all demographics, developing efficient, effective treatments for MDD has become an essential issue for every community. With the current DSM-IV-TR (American Psychiatric Association, 2000) - generally considered to be the gold standard for most active therapists diagnosing depression - clinicians in a wide range of mental health settings have the opportunity for uniformity in MDD diagnoses; however, uniformity in implementing a specific treatment for MDD is not currently practiced (Bagby et al., 2008; Hollon, Thase, & Markowitz, 2002). Despite strong evidence showing that CBT tends to provide better longevity effects for MDD through a decreased relapse rate when compared to other efficacious and effective
treatments (Butler et al., 2006; Hollon et al., 2006), CBT training opportunities and/or programs are not sufficiently available or accessible to clinicians in the community (Weissman, et al., 2006). For those motivated clinicians in the community who are exposed to the typical CBT community offerings or Continuing Education courses, there is no evidence, and much doubt, that this brief exposure alone is sufficient to produce well trained, qualified CBT therapists. As a result of the current deficient state of EST mobilization, it becomes a fundamental and essential progression for researchers to establish feasible and effective models for widely disseminating ESTs into community mental health so they can be effectively implemented to provide enhanced patient outcomes.

The present study will test a specific dissemination and implementation training model/protocol of CBT for depression to therapists within a large community mental health center. Both the therapists and patients will be active participants in the study as therapist competence and patient symptomotology will be evaluated throughout the course of treatment. Patient outcomes before the therapists’ CBT training will be compared to patient outcomes after the therapists’ CBT training. Therapists will serve as their own quasi-control group by providing treatment both at baseline (i.e., pre-CBT training) as well as in the quasi-experimental setting (i.e., post-CBT training). It was hypothesized that the patients treated post-CBT training would show superior outcomes in both depression and anxiety symptomotology when compared to patients treated pre-CBT training. In order to assess the effect of the CBT training on the therapists’ CBT competence, therapists were monitored via videotaped sessions at three time points throughout the yearlong study. Using a standardized coding system, the therapists’ CBT
competency was assessed by expert raters trained together. It was hypothesized that the therapists’ overall CBT competency level(s) would improve significantly following their training and that these improvements would be sustained throughout the duration of the on-going CBT supervision.
CHAPTER 2

METHOD

Participants

Participants in this study included two groups: Patients and therapists. Twelve therapist participants (TP) were involved in this study and were employed by the Madison Center in the Depression Clinic and Madison Outpatient Unit. Madison Center is a large CMHC serving the mental health needs of the greater South Bend, IN area.

Therapists. The mean age of the TP was 55.4 years and 75% of them were female. Therapists averaged a total of 20.7 years in clinical practice and were employed by the Madison Center for an average of 16.2 years. Thirty-four percent of TP had completed a Doctorate in clinical psychology while the remaining 64% were Master’s-level therapists (see Table 1). Prior to the beginning of the study, all therapists identified their theoretical orientation as eclectic. All therapists signed a consent form prior to the start of the study. Along with receiving the intensive CBT exposure and training, TP also received a $100.00 bookstore gift certificate along with a suggested CBT reading list.

Patients. There were a total of 116 patient participants (PP) involved in the study with an age range of 22-69 years with a mean age of 41. Sixty-three percent of the PP were female, and of the PP who began treatment, 9% of the participants identified themselves as African American, 88% identified as Caucasian, and 3% identified as “Other” or chose not to identify their race. Eighty-nine percent had a primary diagnosis
of either MDD, Dysthymic Disorder, or Depression NOS, while 72% had a comorbid
Axis I or Axis II diagnosis (see Table 2).

TABLE 1

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (years)</td>
<td>55.4</td>
</tr>
<tr>
<td>% Female</td>
<td>75.0</td>
</tr>
<tr>
<td>% Master’s degree</td>
<td>66.0</td>
</tr>
<tr>
<td>% Doctorate degree</td>
<td>34.0</td>
</tr>
<tr>
<td>Clinical experience (years)</td>
<td>20.7</td>
</tr>
<tr>
<td>Madison Center experience (years)</td>
<td>16.2</td>
</tr>
</tbody>
</table>
TABLE 2
CLIENT CHARACTERISTICS AND CLINICAL DIAGNOSES (N = 116)

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>Age</th>
<th>Female</th>
<th>Depression Dx&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Primary Axis I Dx</th>
<th>Axis II Dx</th>
<th>Mean BDI-II(SD)</th>
<th>Mean BAI(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAU</td>
<td>74</td>
<td>41</td>
<td>62</td>
<td>82</td>
<td>40</td>
<td>65</td>
<td>25.1(10.5)</td>
<td>17.2(10.4)</td>
</tr>
<tr>
<td>CBT</td>
<td>42</td>
<td>40</td>
<td>66</td>
<td>95</td>
<td>65</td>
<td>69</td>
<td>25.5(13)</td>
<td>12.6(8.1)</td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td>41</td>
<td>63</td>
<td>88</td>
<td>51</td>
<td>66</td>
<td>25.2(11.5)</td>
<td>15.5(9.9)</td>
</tr>
</tbody>
</table>

* TAU = Treatment as Usual; CBT = Cognitive Behavioral Therapy; Dx = Diagnosis.
*<sup>a</sup> Depression Diagnosis includes Major Depressive Disorder, Dysthymic Disorder, and Depression NOS.

PP were chosen as a convenience sample by the therapists participating in the study. Therapists were instructed to choose three to four of their patients that were entering treatment with a diagnosis of depression and who also agreed to participate in the study as a PP. Upon explaining the study to the patients, PP signed consent forms to be involved as a participant whom was to receive a CBT model of psychotherapy. Patient participants were not compensated in any way other than receiving CBT treatment.

*Treatments.* The PP were split into two groups based upon the date they began receiving treatment at the Madison Center. Those entering treatment in February of 2007 were placed in the Treatment as Usual (TAU) group (n = 74), and 82% of the TAU PP had a primary diagnosis of depression (see Table 2). This group was used for baseline patient outcomes when entering into either the Depression Clinic or Madison Outpatient
Services Unit and received treatment prior to any formal therapist CBT training disseminated during the course of this study. The TAU provided by each therapist was not directly influenced by any factors involving the study or the research protocol or methodology. In order to capture the therapists true TAU processes, no guidelines were given to the therapists during the TAU phase of the study.

Those PP entering treatment in late April and after \( (n = 42) \), once the CBT model for depression was disseminated and therapist supervision had begun, were allocated to the Post-CBT training group, and 95% of the CBT PP had a primary diagnosis of depression. All Post-CBT PP received the CBT model of treatment that had been disseminated and tested in this study. TP were encouraged to use what they had learned in training, as well as during the on-going supervision sessions conducted for the duration of the study, and incorporate these elements as the individual TP deemed clinically appropriate.

*Study Design and CBT Training*

*Study Design.* The present study was conducted as a one-year longitudinal, quasi-experimental design in which PP were nested within the individual TP. Three waves of PP were involved in this study: (a) PP recruited pre-CBT training \( (n = 74) \), (b) PP recruited post-CBT training \( (n = 25) \), and (c) PP recruited post-CBT training approximately nine months after the second wave had been chosen and begun treatment \( (n = 17) \). The second and third wave of PP were collapsed into one “Post-CBT” group.

Patients were scheduled for weekly appointments and administered self-report measures to assess depression and anxiety symptomatology during each visit. During the sessions with the first wave PP, TP delivered TAU. As mentioned earlier, TAU was
defined as any form of treatment or combination of treatments that the TP would typically choose to implement with their clients presenting with a depressive disorder. The first wave of PP was seen continuously from February until April of 2007 unless sessions were terminated for any reason by either PP or TP prior to this date. At the completion of the TAU wave, TP were asked to record one of their therapy sessions with a PP of their choice, and this videotape was later coded for therapist baseline CBT competence.

Following the first wave of PP, all of the TP attended a CBT workshop and subsequent on-going tri-weekly CBT supervision for the duration of the yearlong study. After attending the CBT workshop, TP were instructed to choose three to four new incoming patients meeting diagnosis for a depressive disorder and consenting to be a PP receiving CBT in this study. The TP then implemented CBT during the second wave of the study rather than TAU provided in the first wave of the study. During the second wave, patients were again scheduled for weekly appointments and administered self-report measures (BDI-II and BAI) to assess depression and anxiety symptomatology during each visit. Data was collected for the second wave of PP until October (six months from the time of the CBT training, unless treatment was terminated for any reason by either party prior to that time). At the completion of the second wave of PP, TP were again asked to record a session with a PP of their choice, and this videotape was later coded for therapist CBT competence at the mid-way point of the study.

For the final wave of PP, TP choose a third set of patients for the study, and these patients were treated with CBT just like the second wave. PP were scheduled to be seen weekly and self-reported depression and anxiety symptoms were measured during each
session. Data was collected for PP for six months until April (or until treatment was terminated at any point prior to this date for any reason). At this time, the TP were asked to choose one of their third wave PP to engage in a videotaped CBT therapy session to be coded later for therapist CBT competence.

At the completion of the one-year study, self-reported depression and anxiety symptomatology had been collected from each PP involved in the study across all three waves of participants. In addition, three videos were collected and coded for therapist CBT competence for each TP across each of the three waves [Figure 1].

**CBT Training.** In April, after the first wave of PP received TAU and completed their portion of the study, all TP attended a two-day CBT workshop held on the campus of the University of Notre Dame and conducted by Dr. Christine Padesky. The workshop was based upon the manualized CBT treatment proposed by Padesky in her text, *Mind Over Mood* (Greenberger & Padesky, 1995) and *Collaborative Case Conceptualization* (Kuyken, Padesky & Dudley, 2009). The didactic workshop was an interactive, multimedia presentation that focused on core CBT concepts and components for treating depression such as case conceptualization, automatic thoughts, underlying assumptions, core beliefs, testing client beliefs, behavioral activation and how to employ core CBT-related tools such as thought records, behavioral logs, behavioral experiments, and other homework-related assignments for PP to engage in outside of the therapy sessions.

Following the completion of the two-day workshop, all TP participated in a series of 1-hour supervisory group conference calls with Dr. Padesky. These supervision telephone consultations were scheduled once every three weeks, and they continued regularly throughout the duration of the yearlong study (16 conference calls in total).
During these calls, TP were asked to bring any general themes or questions that tended to be commonly occurring during their process of implementing CBT in practice. The telephone supervision was structured as both an informational session as well as an opportunity to answer those questions brought by the TP to each conference call [Figure 1].

FIGURE 1. OVERVIEW TIMELINE OF THE STUDY DESIGN

**Measures**

*Beck Depression Inventory-2 (BDI-II).* The BDI-II (see Appendix A) is a 21-item, multiple-choice, self-report inventory designed to assess the severity of depressive symptomatology (Beck, Steer, & Brown, 1996). For each of the 21 items, the patient
reports on a scale of 0-3 expressing the severity to which they feel they have been experiencing each of the depressive symptoms within the past two weeks. The subject’s score is summed across all 21 items, giving a total score from 0 to 63. Higher total scores indicate more severe depressive symptoms. While the BDI-II is not designed to be a diagnostic tool for depression, it is commonly used to measure depression severity among an MDD-diagnosed population or as a screening tool for the general population. The reliability and validity of the measure have been well documented elsewhere (see Storch, Roberti, & Roth, 2004; Whisman, Perez, & Ramel, 2000; Beck, Steer, & Brown, 1996). The total BDI-II score at pre- and post-treatment serve as one of the two dependent PP outcome measures.

*Beck Anxiety Inventory (BAI).* The BAI (see Appendix B) is a 21-item, multiple-choice, self-report inventory designed to assess the severity of anxiety experienced (Beck, & Steer, 1990) by the patient within the previous week. Like the BDI-II, the participant reports the degree to which they have experienced the anxious symptom described by each of the 21 items on the BAI, and then the total score is summed across all 21 items, giving a total possible score range from 0 to 63. Higher total scores indicate more severe anxiety symptoms. While the BAI is not designed to be a diagnostic tool for anxiety disorders, it is one of the most commonly used research measures of anxiety (Piotrowski, 1999). The reliability and validity of the BAI have been well documented elsewhere (see Steer, Ranieri, Beck, & Clark, 1993; Beck, & Steer, 1990; Beck, Epstein, Brown, & Steer, 1988). The total BAI score at pre- and post-treatment serve as one of the two dependent PP outcome measures.
Cognitive Therapy Rating Scale (CTRS). The CTRS (see Appendix C) is an 11-item scale that was used to measure therapist CBT competence level in this study. Items are scored on a 6-point scale and are comprised by three specific subscales: (a) general therapy skills (feedback, understanding, interpersonal effectiveness, and collaboration), (b) CBT skills (guided discovery, focusing on key cognitions and behavior, strategy for change, application of CBT techniques), and (c) structure (agenda, pacing and efficient use of time, and use of homework assignments). As mentioned briefly in the design section, each of the therapists’ three videotapes were coded by a subset of six expert raters, compromised predominately of graduate students enrolled in the University of Oregon’s doctoral clinical psychology program, who were trained by Dr. Anne Simons, a Founding Fellow of the Academy of Cognitive Therapy. The doctoral students involved in the coding had at least two years of previous CBT training as well as experience treating clients with CBT under the supervision of Dr. Simons.

Each tape was viewed in its entirety and rated independently on all CTRS items. Following the independent ratings, ratings were then shared with the group on an item-by-item basis and discussed until a single, final consensus rating for each item was determined. The final consensus ratings were used in the data analyses, and these analyses were conducted on the overall CTRS scores as well as the scores on the individual subscales. Higher scores on all subscales indicate greater competence in these areas. The scale has shown modest to very strong inter-rater reliability ($r = 0.54$ to $0.96$) and has been shown to be sensitive to variability in the quality with which a cognitive therapy protocol is administered (Vallis, Shaw, & Dobson, 1986; Dobson, Shaw, & Vallis, 1985; Hollon et al., 1981; Young, Shaw, Beck, & Budenz, 1981). The CTRS “is
commonly used as the fidelity measure for many psychotherapy research projects and training programs. It is an extremely valuable educational and evaluation tool as a structured method of rating therapy sessions and a means to provide feedback to trainees” (Sudak, 2009). In the current literature, the CTRS is the most widely used measure of CBT competence and adherence (Barber et al., 2007). The scores on the CTRS serve as the dependent measure for assessing therapist CBT competence.
CHAPTER 3

RESULTS

Effects of CBT Training on General Skills, CBT Knowledge, and CBT Competence

Overall CTRS Scores. In order to test the second hypothesis that the therapists’ overall CBT competency level(s), as measured by CTRS scores, would improve significantly following their CBT training and that these improvements would be sustained throughout the duration of the study, an ANOVA was performed comparing CTRS scores at baseline (TAU videotape), 6 months after CBT training and during on-going supervision (first CBT videotape), and 12 months after CBT training and at the completion of the on-going supervision (second CBT videotape). As hypothesized, the results indicated that the overall CTRS scores showed significant differences for the three time points assessed by videotape, $F(2, 28) = 7.74, p = .002$. Figure 2 illustrates the sharp increase in TP CTRS scores received pre-training (baseline) to the six-month TP videotaped evaluation. In addition, CTRS scores appear to level off, though they did not reach an absolute ceiling, from the six-month to 12-month TP videotaped evaluation.

Subscale CTRS Scores. As mentioned earlier in presenting the CTRS, in addition to an overall CTRS total score, the CTRS also derives three different subscale scores that focus on general therapy skills, CBT skills, and structure. To evaluate each of these
subscales independently, GLM analyses were performed – one for each subscale - to compare the differences between the three CTRS subscale scores at the three video time points. The first analysis for the general skills subscale showed no significant difference between the TAU, first CBT, and second CBT videotape, $F(2, 28) = 2.56, p = .09$. The next two analyses showed significant differences for both the CBT skills, $F(2, 28) = 7.29$, $p = .003$, and structure, $F(2, 28) = 10.14$, $p = .005$, between the three videotapes [Figure 4].

FIGURE 2. CHANGES IN THERAPIST CTRS SCORES AT 3 TIME POINTS
Effects of TAU vs. CBT on Depression and Anxiety Symptomatology

Client characteristics. Before testing the primary hypothesis that the patients treated post-CBT training would show superior outcomes in both depression and anxiety symptomatology when compared to patients treated pre-CBT training (TAU), between-group baseline differences were tested on basic client characteristics, routinely collected in the course of the study, that might otherwise provide immediate alternative interpretations of the data collected from the BDI-II and BAI. The analyses revealed no significant between-group differences on PP age, \( t(114) = 0.20, p = 0.85 \); gender, \( X^2(1, N = 116) = 0.24, p = 0.63 \); depression as primary diagnosis, \( X^2(1, N = 116) = 1.96, p = 0.16 \); percent with a comorbid Axis II diagnosis, \( X^2(1, N = 116) = 1.71, p = 0.192 \); or percent with an overall comorbid diagnosis, \( X^2(1, N = 116) = 0.96, p = 0.33 \).

TAU vs. CBT: BDI-II and BAI Outcome ANCOVAs. In order to test the primary hypothesis of whether PP receiving CBT showed superior treatment outcomes when compared to PP receiving TAU, as measured by self-reported BDI-II and BAI scores, analyses of covariance (ANCOVA) were run for both the BDI-II and BAI. In order to control for baseline differences reported on the BDI-II and BAI, the initial baseline values for these measures were entered as the covariates for each of the ANCOVAs performed. As hypothesized, PP treated with CBT showed a greater change on the BDI-II from baseline to treatment termination when compared to PP receiving TAU, \( F(2, 113) = 53.40, p < .001 \). Also as hypothesized, PP receiving CBT showed a greater change on the BAI from baseline to treatment termination when compared to PP receiving TAU, \( F(2, 113) = 85.71, p < .001 \) [Figure 3; Figure 4]. Cohen’s effect sizes were moderate.
with regard to BDI and BAI scores \( (d = .59 \text{ and } .60, \text{ respectively}) \) in favor of the CBT group.

FIGURE 3. CHANGES IN CLIENT BDI-II AND BAI SCORES OVER THE COURSE OF THEIR TREATMENT

FIGURE 4. SUMMARY OF THERAPIST AND PATIENT OUTCOMES
CHAPTER 4

DISCUSSION

This study set out to test a specific dissemination and implementation training model/protocol of CBT for depression to therapists within a large community mental health center. The general training model chosen for this study - CBT workshop, plus a manual, plus a year of on-going CBT supervision - was empirically derived. Previous studies had shown that when combined, these three components (workshop, manual, supervision) provided the best opportunity for both a successful dissemination and implementation of CBT. As key contributors in their own way(s) to the successful dissemination and implementation of CBT, both therapists (CBT competence) and patients (symptomatology) were participants in this study. The result of creating a specified, successful dissemination and implementation protocol to deliver CBT to therapists in CMHCs will not only equip therapists with an efficaciously proven treatment for treating depressed clients, but there have also been studies suggesting fewer relapses occurring as a result of providing a superior treatment (CBT for depression) as opposed to TAU that is usually supplied within clinical settings and CMHCs. The CBT dissemination protocol employed in this study showed significant changes in therapist CBT competence over the course of the study, and these therapist gains were maintained throughout the duration of the study. The therapist gains in CBT competence also appear to reflect a greater reduction in patient symptom outcomes [Figure 3].
When a patient seeks treatment for depression, the ultimate goal of therapy is to reduce the patient’s levels of distress and impairment and increase the patient’s ability to function at a capacity that is consistent with their abilities and levels of functionality prior to their depressive episode. Obviously, the greater the decrease of patients’ symptoms and the greater the increase in patients’ functionality, the more successful the therapy has been, and the goal of these changes is at the heart of what psychotherapy intends to accomplish. The findings in this study add confirmation to previous findings showing CBT as a more effective treatment for depression than TAU. Both of the study’s initial hypotheses were confirmed, as the dissemination of the CBT protocol was successful in increasing therapist CBT competence, and patients being treated under the CBT condition saw superior outcomes on self-reported depression and anxiety symptomotology when compared to the patients being treated with TAU.

Specific Factors vs. Non-specific Factors Treatment Outcomes

The second level of importance to this study’s findings, that specific factors of a structured protocol of CBT appear to contribute to greater treatment outcomes when compared to non-specific factors provided with TAU [Figure 3], deserves much more attention. Critics of the promotion and dissemination of ESTs often cite the “non-specific factors” theory. This theory states that rather than adopting the “specific factors” theory – that individual (specific) treatment components (factors) that are unique to a given treatment modality are the cause for patient symptomatic improvement - patient symptomatic improvement is due to the non-specific factors of psychotherapy that are common across all bona fide treatments (Ahn & Wampold, 2001).
Originally presented by Rosenzweig (1936) and later supported by Luborsky, Singer, and Luborsky (1975) in their seminal review of psychotherapy outcome literature, the Dodo bird verdict has come to signify the idea that regardless of the specific psychotherapeutic approach taken, the psychotherapeutic outcomes remain generally equivalent. This supported Rosenzweig’s (1936) intimation that the positive outcomes seen in psychotherapy were not due to any specific factors in the treatment type, but rather due to the common, or non-specific factors that are present throughout any treatment that has shown empirical efficacy. This theory would suggest that regardless of the particular disorder, and regardless of the specific treatment chosen, the patient would nonetheless respond with a generally similar symptomatic outcome.

A hallmark meta-analysis performed by Wampold et al. (1997) cited that effect sizes seen for patient outcomes across all bona fide psychotherapies did not differ significantly when a specific therapy was implemented. As a result, Wampold (1997) contends that because the effect sizes for patient outcomes were not significantly different based upon the specific therapy that was implemented, the treatment outcomes could not be attributed to the “specific factors” that differentiate one bona fide treatment from another. However, it is important to note that this meta-analysis did not analyze these studies to determine if there were any Type of Therapy X Type of Disorder effects (DeRubeis, Brotman, Gibbons, 2005). Therefore, the non-specific factor argument should be interpreted with caution and liberal skepticism. Its apparent prima facie confirmation should be interpreted in light of Wampold’s own admission that Therapy X Disorder was not tested in these meta-analyses. DeRubeis, et al. (2005) also brings attention to repeated findings in the literature showing continued therapy outcome non-
equivalence when comparing by specific disorder. The non-equivalence of outcomes suggests that there are indeed additional specific factors, above and beyond non-specific factors, being implemented in treatment that are influencing patient outcome. In concordance with this assertion, the findings in the current study suggest that that specific-factors do appear to play a role in differentiating patient outcomes when a specific structured, manualized, EST treatment is implemented to treat a specific disorder. In the present study, CBT for depression showed significant decreases in depressive symptomotology than did TAU. Further, superior patient outcomes were seen on the BDI-II and BAI after the addition of specific CBT skills to the therapists already effective general therapy skills. This suggests that the specific factors of the CBT skills that were added to the therapists’ therapeutic database might account for the superior outcomes seen in patients treated under the CBT condition.

_Efficacy vs. Effectiveness and Patient Comorbidity_

It is also important to note the effect that CBT treatment for depression appeared to have on patient outcomes on anxiety symptoms as well. While anxiety symptomotology was decreased during both CBT and TAU, significant decreases in these symptoms were only seen in the CBT treatment condition. These findings are important because they show that not only did CBT treatment for depression have superior patient outcome effects for depressive symptomotology, but CBT treatment for depression also showed secondary benefits for anxiety symptoms as well. While identifying the specific mechanisms for change were beyond the scope of the current study, these findings do suggest that whatever these mechanisms may be, they were found in a CBT protocol whereas they appear to have been lacking in the TAU protocol(s). These findings are
especially significant in light of the argument that is typically waged against the effective implementation of ESTs within “real-world” clinical settings due to the patients’ generally more severe, comorbid diagnoses that tend to present in CMHCs (Stirman, DeRubeis, Bordy, & Crots-Christoph, 2003). As presented earlier, some clinicians contend that the outcomes in treatment efficacy studies will not and cannot translate into effective clinical practice outcomes. The current study extends upon the literature that ESTs, particularly CBT, can translate into community settings with “real-world” patients, and superior outcomes, similar to those in efficacy studies, can be found in the populations of CMHCs.

**Therapist CBT Competence and Knowledge**

The therapists participating in this study were a seasoned cohort of clinicians. Prior to this study, the therapists averaged 20.7 years in clinical practice, and an average of 16.2 of these years have been spent working at the Madison Center. As can be seen in Figure 2, the therapists involved entered the study with a very high level of general therapeutic skills. Many of the previous attempts to study the dissemination of an EST or CBT protocol have been conducted with therapists in training, typically clinical graduate students or new clinicians. The current study extends upon the existing literature by showing that therapists who already have a broad knowledge base of general therapy skills can still learn and develop CBT competence that is similar to levels previously seen in clinicians who have been trained only, or at least primarily, in CBT.

*The “red line.”* In order to better conceptualize and interpret the findings of therapist CBT competence, it is important to understand the concept of what has been deemed the “red line” when referring to the CTRS scores. The “red line” can be
understood as a threshold that marks an acceptable level of CBT competence, as established mainly through the influence by the NMIH Treatment for Depression Research Collaborative Project (Elkin et al., 1985; Shaw et al., 1999). The CTRS total score “red line” has been set at 39, and scores that fall below this number are considered unacceptable, and the therapists with these scores would not meet the requirements for being considered for certification in CBT. Any CTRS total scores above 39 are considered an acceptable level of CBT competence, and these therapists show a sufficient proficiency in CBT competence to be considered for official CBT certification. It is important to note that the “red line” is not a line that marks expertise or full mastery of CBT, but rather marks a general level of competence.

As can be seen in Figure 2, prior to the CBT training component of the current study, the therapists showed a mean CTRS total score that fell well below the “red line,” and the two lowest subscale scores for the therapists were related to specific CBT concepts that are emphasized in CBT training. However, only six months after the CBT workshop and on-going CBT supervision, the therapists’ mean CTRS total scores increased to a level that met the “red line,” and these CTRS scores stayed at the “red line” through the completion of the study. Unfortunately, whether these therapist gains in CBT competence remained following the completion of the study is unknown.

This is an important question for further research into the sustainability of therapist gains. However, the current study does show that with on-going supervision - even only for one hour, every three weeks - it is possible to maintain levels of CBT competence above the “red line.” Therefore, while these data do not answer whether on-going CBT supervision is a necessary component to maintaining CBT competence levels
above the “red line,” these findings do suggest that supervision can be viewed as a sufficient component for maintaining CBT competence levels above the “red line.” This is notable for future studies and mental health agencies intending to provide an effective dissemination protocol for delivering CBT to clinicians.

**Therapist Gains.** Naturally, the largest gains seen for the therapists in their CBT knowledge and competence were between the first and second videos. Unfortunately, since only three videotapes were collected and coded throughout the course of the year for each therapist, this study was not designed to examine the more specific progression of the gains seen between videotapes. Therefore, it is unclear whether the significant gains seen during the first CBT video (six months after training and during on-going supervision) were immediate gains or were progressive gains. Furthermore, it is also unclear as to whether these gains were even linear. As seen in Figure 2, the gains are presented in a linear fashion; however, the true progression of the therapists’ CBT competence between tapes cannot be determined.

In addition, it is difficult to determine from these data exactly how much training can be considered efficient training for therapists to be able to provide CBT effectively to their clients. As noted, this study was designed to test a specific CBT dissemination (workshop, manual, and supervision) and implementation (as scene through videotaped sessions) protocol over the course of a one-year study. It is possible that these same gains could have been seen in a much shorter period of time (i.e., weeks) rather than over the course of months. Likewise, it is also possible that the gains seen after 12 months could have continued to rise given a longer period of time for the therapists to develop
their skills and continue with supervision. However, this latter possibility is tempered by the plateau effect seen between the six- and 12-month CTRS scores.

As noted earlier, the therapists involved in this study all had considerable clinical experience prior to their CBT training. An interesting, and possibly overlooked due to its non significant result, finding from this study was the lack of change in therapist general skills following CBT training. Because the therapists’ general skills scores were quite high at the beginning of the study, it is not surprising that the scores on this subscale did not improve over the course of the study. However, it is worth noting that the therapist general skills did not decrease over time as CBT skills and structure skills increased.

Critics of EST dissemination and implementation tend to generally believe that the impersonal, cookbook-style method of providing manualized treatments to patients is an insufficient model for delivering therapy because it sacrifices general psychotherapy skills for the overly-structured and rigorous components of the given EST. However, the findings from this EST study suggest that when increasing CBT competence and adhering to CBT skills via a manualized treatment, general psychotherapy skills actually increased, albeit non significantly, rather than decreased.

Limitations

While the results from the current project are a promising step for the existing literature on EST dissemination and implementation, there are several limitations in the methodological approach taken in this study, and these limitations should be considered when interpreting the data. First, there was minimal monitoring of the actual content of the therapy sessions over the course of the yearlong study. The only direct evidence that exists to confirm the events that took place during the therapy sessions are the three
videotapes that were coded when collecting the CTRS data. It is possible that the sessions that were recorded and coded were not representative of the majority of sessions that took place over the course of the study. However, following the completion of the study, anonymous interviews were conducted with the therapists, and they were asked if they had any reason to believe that the sessions being taped were not representative of the actual work that was done with clients during the study. None of the therapists responded in a manner that would lead the investigators to believe that the videotaped sessions were not representative of the sessions with the patients that were not videotaped.

Second, as mentioned, the patients participating in this study were not randomly selected. Researchers did not provide therapists with any criteria – aside from the criteria that the patient be diagnosed with a depressive disorder - by which to select patients to participate in the study, rather, the therapists self-selected the patients for both the TAU and CBT conditions. Likewise, researchers did not provide the therapists with any selection criteria by which to select patients to be videotaped. Therefore, as long as the patients gave their consent, the therapists were free to select which patients would participate in the study and which patient would be videotaped for each of the three videotapes.

In addition, participants were not randomly assigned to treatment groups (TAU or CBT). While a lack of random assignment does not invalidate the results found in this study, it does potentially limit the precision of the statistical inferences that can be garnered from these results. For instance, it is possible that the significant differences found between the TAU and CBT groups in the current study may not actually be due to the type of treatment the patients received. Instead, the differences could have been
caused by another variable, or interaction of variables, that was not specifically identified or considered in this study. As a result, therapists could have selectively chose (purposefully or not) patients for the CBT groups that the therapists deemed to be “more easily treatable” or “more likely to respond to treatment.” Perhaps providing a newly adopted treatment (CBT) to depressed patients was a difficult enough task for the therapists to manage during the study that they chose patients for the CBT groups that were more likely to respond to any kind of treatment. In that case, the outcome differences found between the TAU and CBT groups could more aptly be attributed to patient characteristics than the type of treatment the patient received. However, even a search of the current literature provides little assistance for determining exactly what characteristics make for a “good candidate” for CBT. Therefore, it is unlikely that therapists would all be successful at self-selecting patients who would respond better to CBT than any other patient.

It is also possible that client and therapist outcome expectations were increased for the CBT conditions compared to the TAU conditions. It has been well documented, through the well-known placebo effect, that in nearly all clinical trials the patient expectations for treatment outcome can affect actual treatment outcome. Client expectations for better treatment outcome has been shown in previous studies to hold true for CBT for depression as well (Curry, et al., 2006). Given the design of this study, it is not possible to exclude the possibility that patient and therapist expectations may have played a role in the improved patient outcomes for the CBT conditions in this study.

Finally, given that the nature of this study was to capture “real-world” clinical patients with “real-world” clinical complications, there were a number of patient
variables that researchers chose to not control for in order to gather a representative sample of clients typically presenting in CMHCs. Therefore, variables such as number of sessions patients attended, medications or medication levels, or patients’ race were not matched between the TAU and either of the CBT groups.

**Future Directions**

This study provides a promising protocol for the effective dissemination and implementation of CBT for depression into CMHCs. Future examinations of the effects that a particular CBT dissemination and implementation protocol has on patient outcomes might include collecting a broader range of assessment measures for patient outcomes. While the current study focused exclusively on self-reported depression and anxiety symptomatology as outcome measures to define patient improvement, there are certainly other variables of interest that could be used to measure patient outcome such as specific measures of patient stress levels or medication reduction or number of therapy sessions needed. Investigating these additional variables would give a more comprehensive review of CBT outcomes for the specific dissemination and implementation protocol used in the current study.

Also, follow-up studies for patients treated with CBT through various protocols of dissemination and implementation would be beneficial in assessing patients’ recurrence of depression symptoms and relapse for depression. Previous studies have shown that one of the largest advantages for providing CBT for depression, as oppose to other therapies or medication alone, is that CBT appears to show greater longevity effects for patients that is evidenced by lower occurrences of depression relapse in the future.
Likewise, follow-up studies should be conducted with the therapists who are CBT-trained as well. The current study measured therapist CBT competence at three time points over the course of one year. While the therapists in this study showed a significant increase in CBT competence between time 1 (pre-CBT training) and time 2 (six months after CBT training) and a minimal increase between time 2 (six months after CBT training) and time 3 (12 months after CBT training), therapists’ retention and use of CBT-specific skills beyond the year that the therapists were involved in the study remains relatively unknown. Follow-up studies should explore whether therapists’ learned CBT skills remain for any period of time after the training and regular CBT supervision sessions end. These follow-up studies could assess related, but qualitatively different questions. First, once CBT training and supervision come to an end, does therapist CBT knowledge and competence decrease as a function of time? Second, if CBT knowledge and competence does not decrease over time, do therapists still provide CBT as they had been trained? Or in the alternative, does therapist behavior tend to revert back to whatever previously defined their unique TAU approach prior to their CBT training?

Finally, the literature is beginning to take note of the need for developing methods to mobilize CBT from clinical trials into CMHCs; however, a search of the current literature reveals a dearth of research focusing on an element that is crucial to the ultimate success of the dissemination and implementation process: The therapists’ personal experiences throughout the training and implementation process. So much effort has been focused on whether or how to disseminate ESTs that the therapists’ experience of this process has been largely overlooked.
A follow-up study to the current study presented here is planned to evaluate the therapists’ experience of participating in this study. Following the completion of this yearlong study, semi-structured “exit interviews” were conducted, taped, and transcribed with each of the participating therapists. The purpose of these exit interviews was to gather qualitative information regarding the therapists’ experiences throughout the process of the CBT training, supervision, and implementation. Conceptual content analysis will be applied to the therapist transcripts by using selective reduction to group significant statements into overall themes (i.e., supervision, training, implementation, etc.). The goal of this project will be to gather conceptual themes from the therapists’ transcript data that can be helpful in modifying future CBT dissemination and implementation protocols to make them as therapist friendly as possible. It is the hope that the current study, along with planned future studies, will provide the literature with critical stepping stones that will help advance the proliferation of CBT specifically, and ESTs generally, to CMHCs nationwide.
APPENDIX A

BECK DEPRESSION INVENTORY II (BDI-II)

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APPENDIX B

BECK ANXIETY INVENTORY (BAI)

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APPENDIX C

COGNITIVE THERAPY RATING SCALE (CTRS)

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 rating of 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. GERNERAL THERAPEUTIC SKILLS

___1. AGENDA

0  Therapist did not set agenda.

2  Therapist set agenda that was vague or incomplete.

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

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

__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 he 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.
APPENDIX C (CONTINUED)

___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.
APPENDIX C (CONTINUED)

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.

5 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
APPENDIX C (CONTINUED)

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 –                                         Moderately                                 Extremely
Very Receptive                                         Difficult                                  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.
REFERENCES


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