Clinicians' use of cognitive therapy in community settings after intensive consultation

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Participating clinicians

Consumers who agreed to participate as training cases

Beck Initiative Provider Agencies

Beck Initiative Mentors
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- Luke Schultz PhD
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Philadelphia's Beck Initiative Training Program

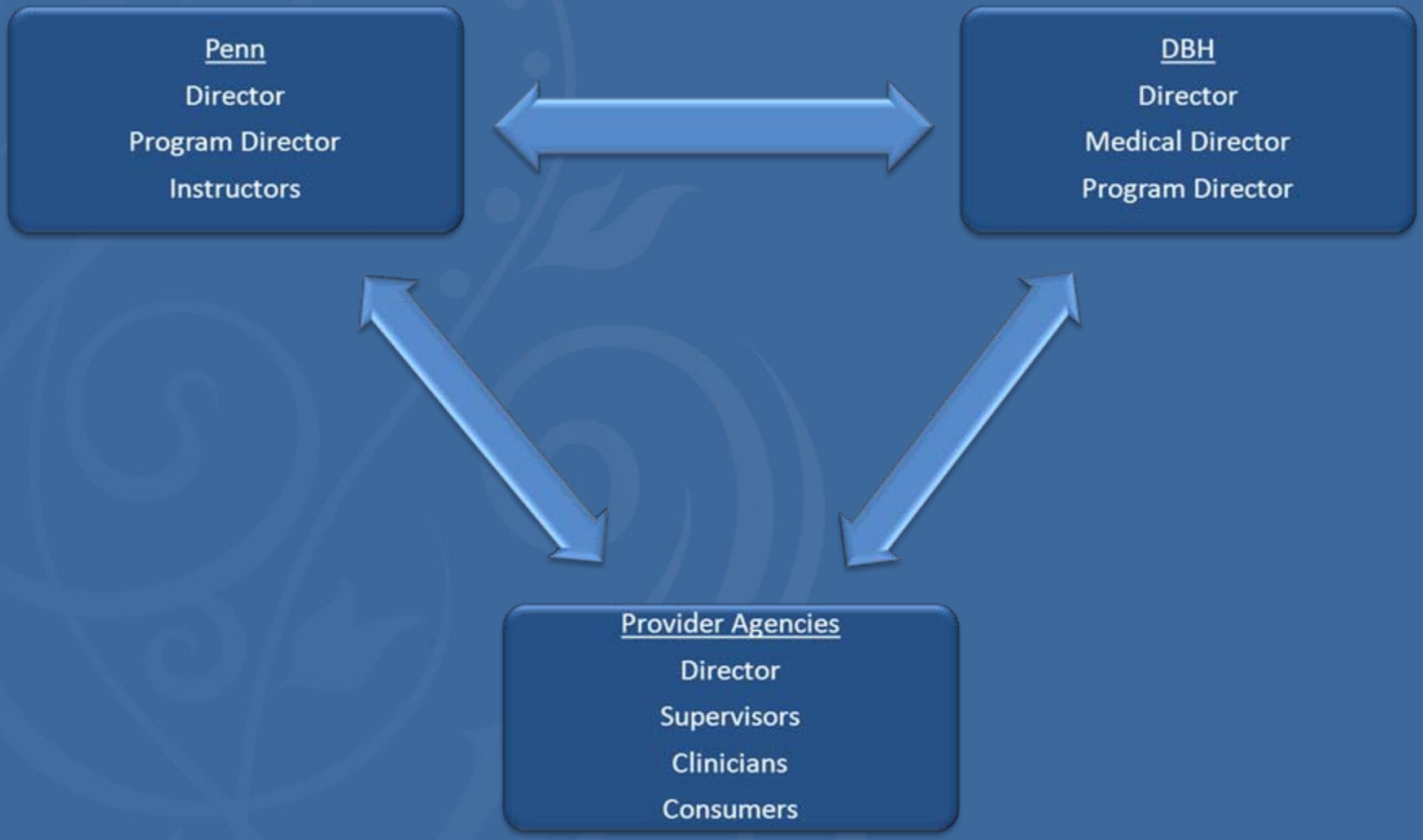
- Partnership between Penn and Philadelphia's Department of Behavioral Health
- Began in 2007
- Basic workshops for over 300 clinicians, 90 clinical care managers, and 27 support staff; 84 clinicians received intensive consultation in CT for adults (including specialized training); 36 to date for child programs; new specialized trainings underway

Stirman, Buchhofer, McLaulin, Evans, & Beck, *Psychiatric Services*, *2009*

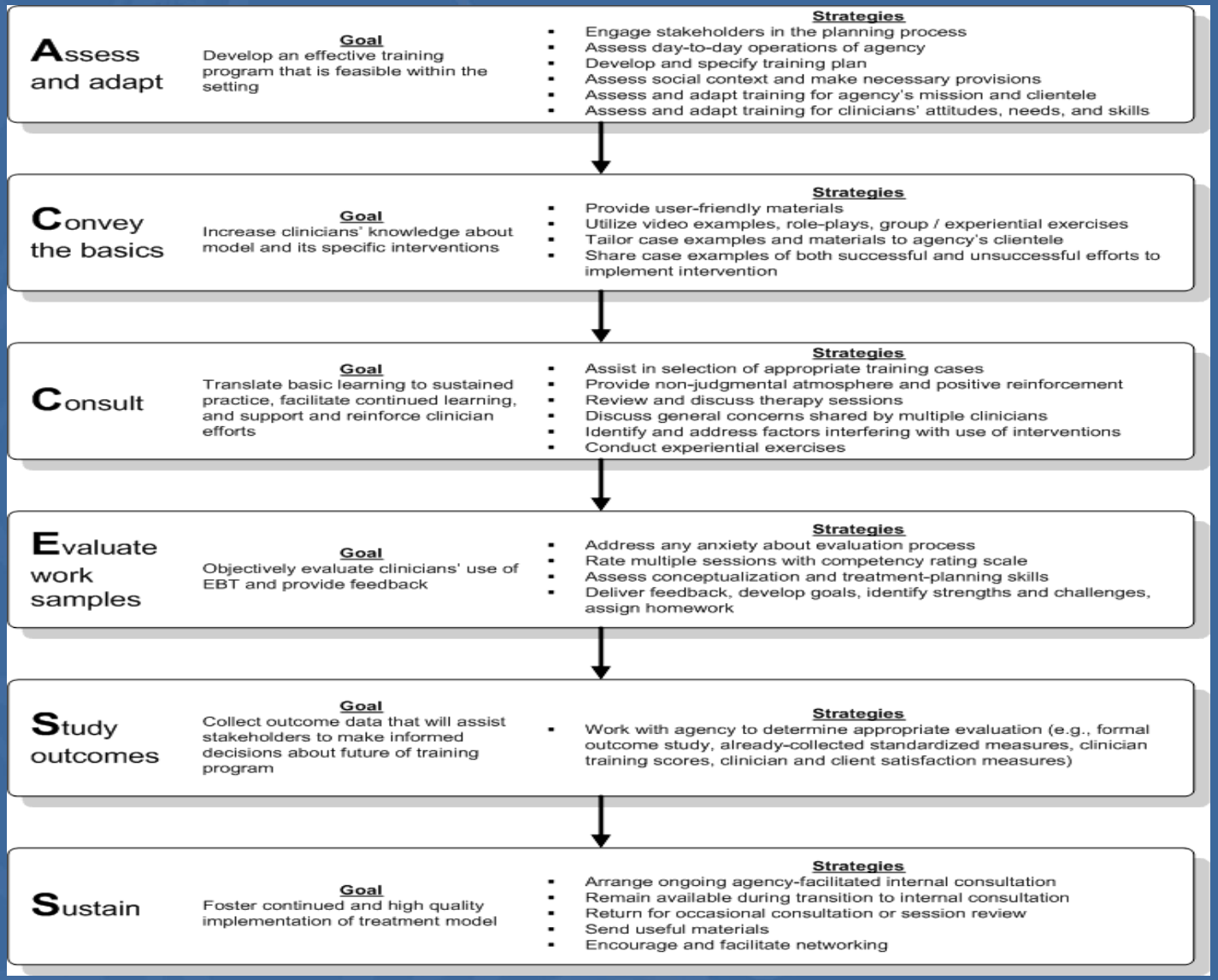
Setting/Context

- Agencies vary in size
- Diverse clientele, variety of presenting problems
- ~ 100% Publicly-funded mental health coverage

Structure of the Beck Initiative



ACCESS Model of Training and Consultation



Stirman et al., (2010) PPRP

Overview of Training Program

- Based on the ACCESS Model[1]
- Initial 16 hour workshop
  - Basic cognitive model –overview of theory
  - Cognitive interventions
  - Applications to specific disorders
- 6 months of consultation
  - Weekly recording of sessions
  - Feedback delivered in individual or group format
  - Regular consultation meetings
- Standards for completion (“passing”)
  - Meet attendance requirements
  - Turn in 15 sessions for review
  - Achieve a 40 on the Cognitive Therapy Scale
- “Recertification”(not formal certification in CT)
  - Attend 80% of internal consult groups over 2 years
  - 1 Continuing Education activity related to CT
  - Achieve a 40 on the Cognitive Therapy Scale for a submitted session recording

[1]Stirman et al., *2010*

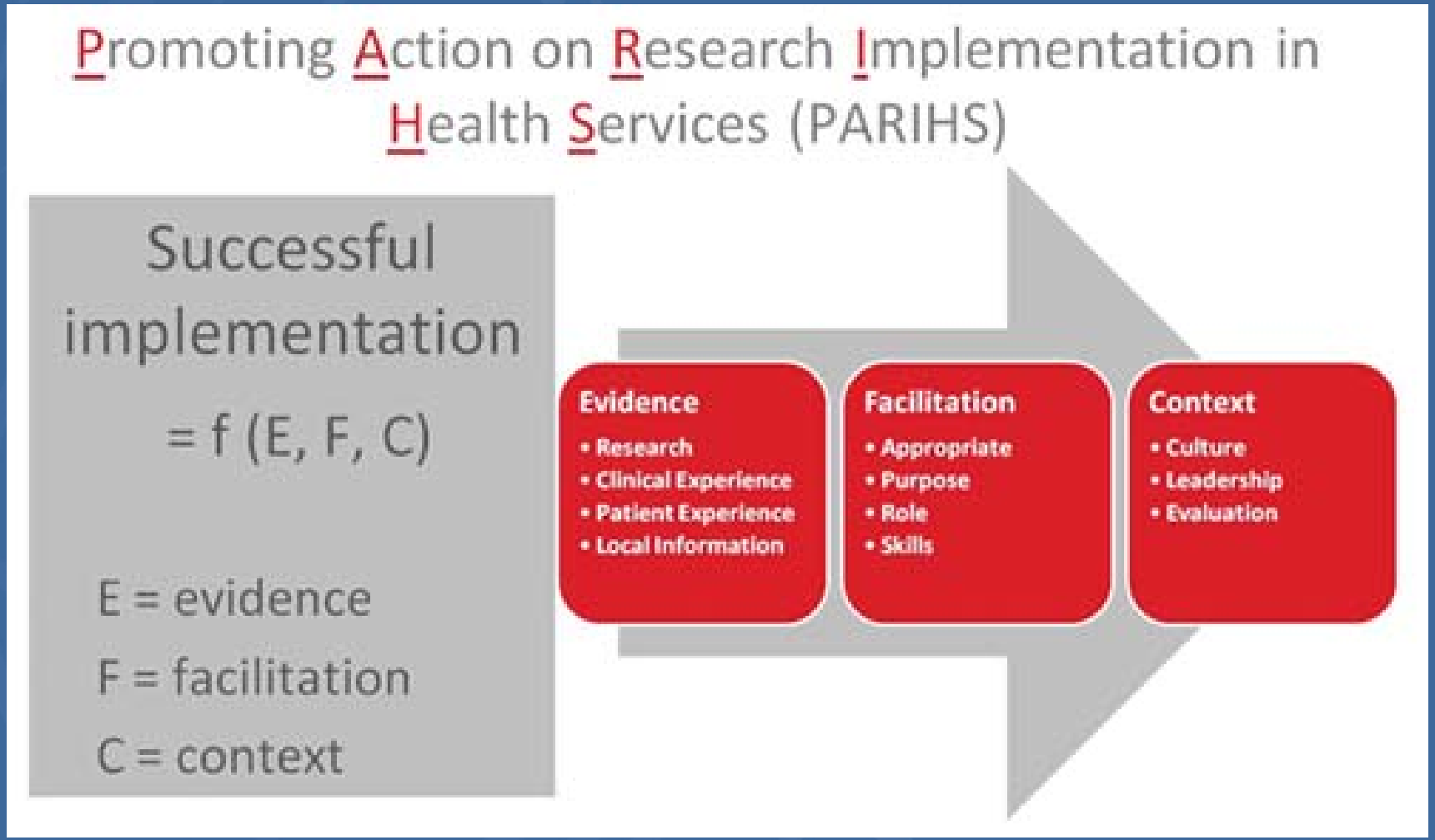
Available Data

- Surveys (pre- & post-training, follow-up)
  - Organizational Social Context (Glisson et al., 2008)
  - Evidence-based Practice Attitude Scale (Aarons et al., 2004)
  - Counselor Follow-up Survey (specific to CT)
- Interviews with 24 clinicians (coding partially completed)
- Minutes and meeting notes, session recordings, program evaluation

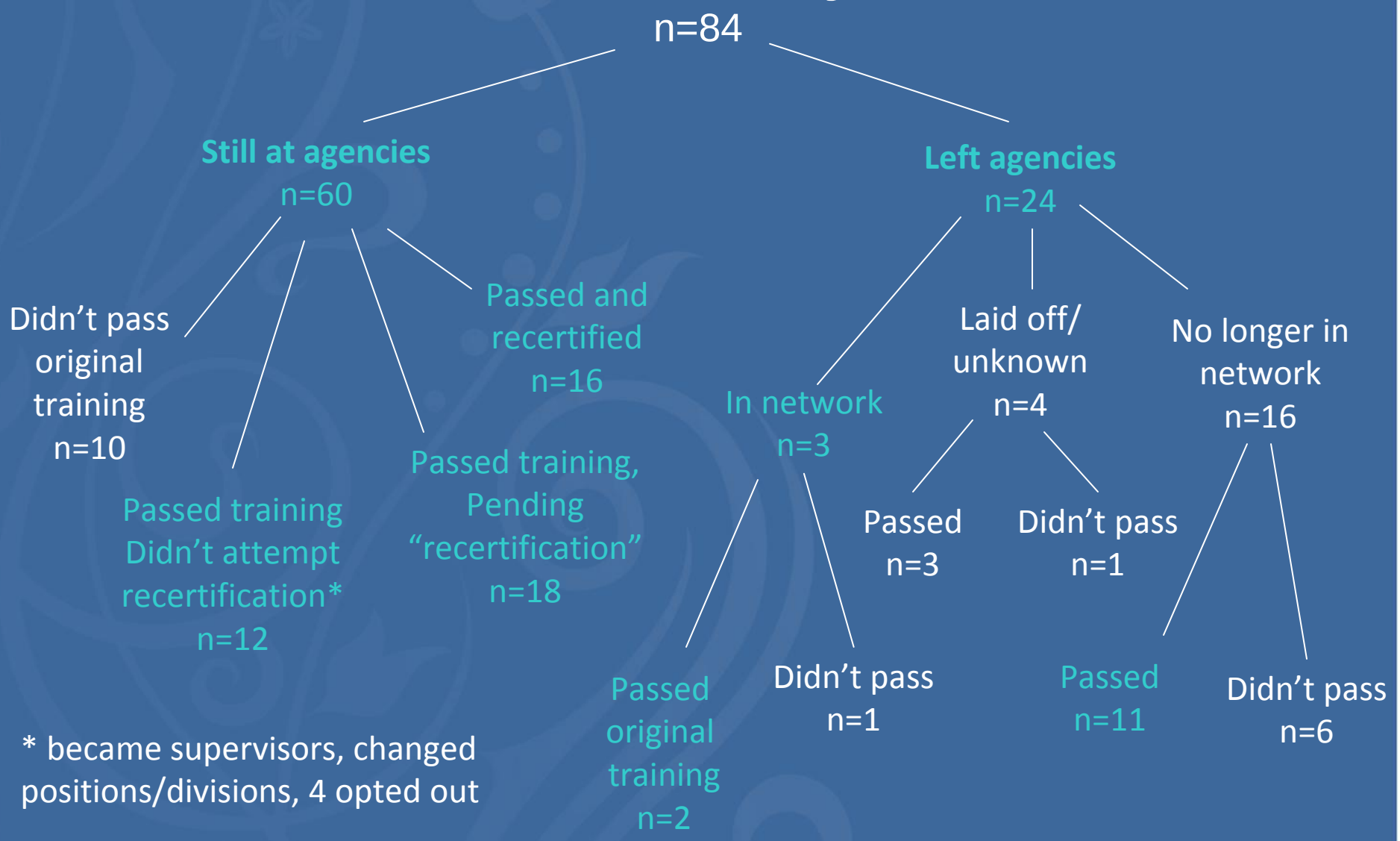
Clinician Participants (n=40)

- Participated in the Beck Initiative Training program
- Work with adults in outpatient settings (including IOPs)
- 67% Female
- Race/Ethnicity
  - 69% White
  - 25% African American
  - 5% Hispanic/Latino
- 81% Master's or social work degree
- Years of experience
  - 52% >10 years
  - 29% 5-10 years
  - 21% 0-5 years
- Modal number of supervised hours in CT = 0
- Mean number of clients on caseloads = 40 (sd = 28)

PARIHS Framework for Implementation



Where are they now?



* became supervisors, changed positions/divisions, 4 opted out

Program evaluation data

USE OF COGNITIVE THERAPY

	How Often	How Helpful
Element of CT	**M (SD)**	**M (SD)**
Entire CT session (e.g., following structure, using interventions)	1.43(.97)	2.17(.94)
Agenda Setting	2.07(.97)	2.42(.74)
Evaluation of automatic thoughts	2.29 (.66)	2.60 (.63)
Assignment of Homework	1.82 (.82)	2.00 (.77)

0=Not at all, 1=Not very, 2=Somewhat, 3=Very

I don't use cognitive behavioral therapy…I use a very different modality. I'm more psychodynamically trained and that speaks to me more than cognitive behavioral therapy.

Never

I haven't used the actual structure, full session, in a long time. But every time I see a client I use something that I learned in CT.

Bits and pieces

I can just, in any session can pop CT there because that's how I do sessions. I don't have a piece of paper that says, 'Now we're going to do this, now we're going to do that,' etc. That's not how I do my sessions and I never will do it that way…So the little components kind of get intertwined with their thinking. It gets integrated into the entire session

Weave it in

Regularly

Well certainly [I use CT] everyday. I'm not using it with every client… I may be using some CT techniques with every client. I would say that that would be a fair thing to say. The strict model I probably am using with 60 percent of my clients.

Always

PERCEPTIONS OF COGNITIVE THERAPY

	M (SD)
Therapist satisfaction with CT	2.25 (.59)
Client satisfaction with CT	2.17 (.69)
Effectiveness of CT	2.11 (.68)
Relative advantage	2.36 (.78)
Ease of use	1.68 (.90)

0=Not at all, 1=Not very, 2=Somewhat, 3=Very

[At first] I didn’t feel like it was my thing to do because I felt like it was too structured and too, I didn’t have a calling for this. [Now] I do believe that there are a lot of myths with what CT is and it’s like inhuman without validation of any feelings but that has nothing to do with reality.

…I believe in it. I believe that it works. I've experienced that it works. So I know that from an experiential knowledge and not a "head" knowledge…

So as you're kind of picking up from me, doing CT does take a lot more work. Takes a lot more energy for me to do all of the points

I think I was a little more enthusiastic about it at first and over time it’s harder to stay true to it without kind of sliding backwards and some of your old methods or old ways of doing things. Overall I still like it a lot, I think sometimes I struggle with it more than I did or after I first did the training.

MODIFICATIONS TO COGNITIVE THERAPY

Modifications

Language

Like [if] they've [only] completed 6th grade? It gets a little challenging…I just have to make sure I put it in the simplest form, to their level of understanding.

I think you can do CT but you have to use the language of the person to do it. …you sort of have to use the same ideas but describe them a little differently.

Pacing

You know, with somebody severely paranoid, it's just going to take a long time. And you know don't expect to go anywhere with them. You're not going to be talking about core beliefs any time soon. Just the basics.

Sometimes I don't set the agenda with him, you know, and whatever he's talking about right then and there, we'll just talk about it, just a regular conversation, initially, and then I'll start to incorporate some of the coping skills, some of the things that, "Well have you looked at it this way?" You know, I just do it that way.

Structure

"Modifiable Periphery"

Core Elements

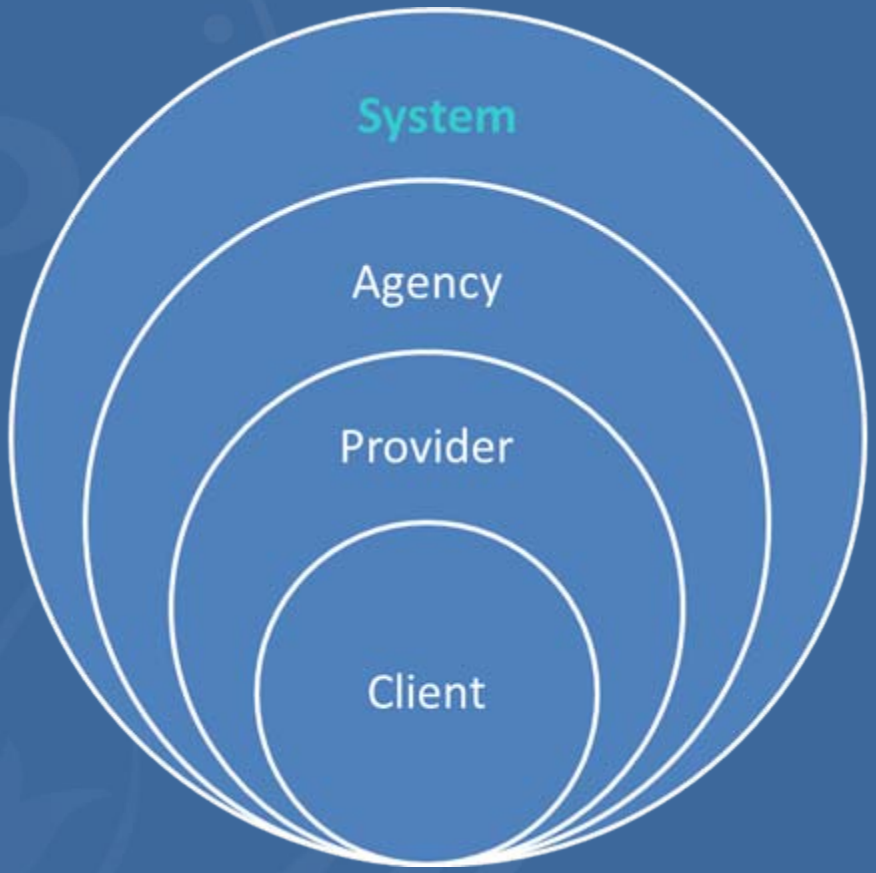
INFLUENCES ON USE OF COGNITIVE THERAPY

When they don't use CT, why not?

	M (SD)
Clients don't attend regularly enough to benefit	.75 (.70)
Too structured	.67 (.82)
My clients need a long-term approach	.64 (.83)
My client resisted when I tried to use CT	.61 (.69)
I'm too busy to prepare for a session	.46 (.69)
I think another approach will work better	.45 (.60)
Not enough time in the session to use CT	.43 (.74)
It hasn't worked for other/similar clients	.39 (.56)
CT is too superficial	.30 (.67)
CT is a "cookbook" approach	.30 (.67)
CT is not appropriate for this particular client	.29 (.53)
CT is too difficult to use	.29 (.46)
I didn't really want to learn CT in the first place	.21 (.57)
CT is not client-focused	.15 (.46)

0 = Not a factor, 1 = A minor factor, 2 = A major factor

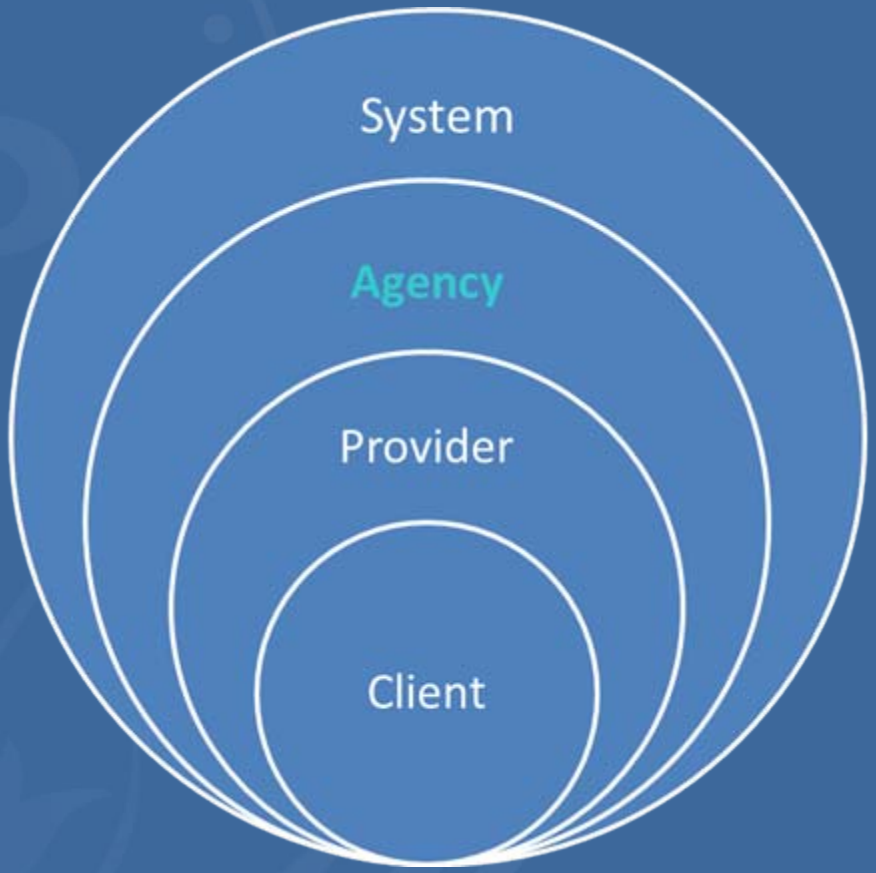
The fact that [the mental health system] , which is our main funding source, wants to see it implemented here is also a good push.



There's a specific format we have to follow for making treatment plans that doesn't really necessarily blend with how we would do that kind of thing within a CT framework

A lot of practical issues and pressures of having to do all the paperwork that was required [by the system]

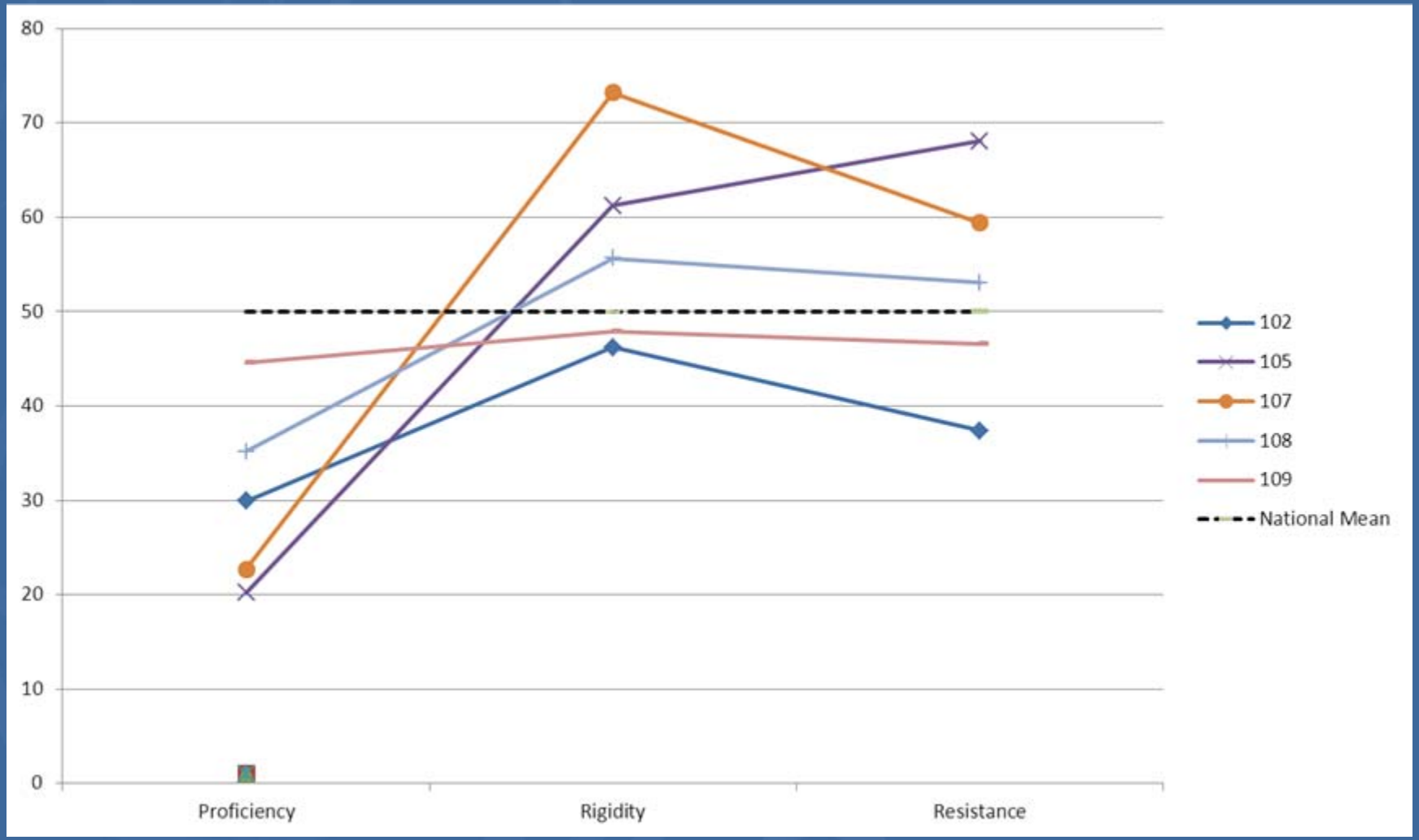
The high volume of clients we had to see…There's no preparation time here at all. There's no time to even think through your clinical notes, and everything is done super, super fast



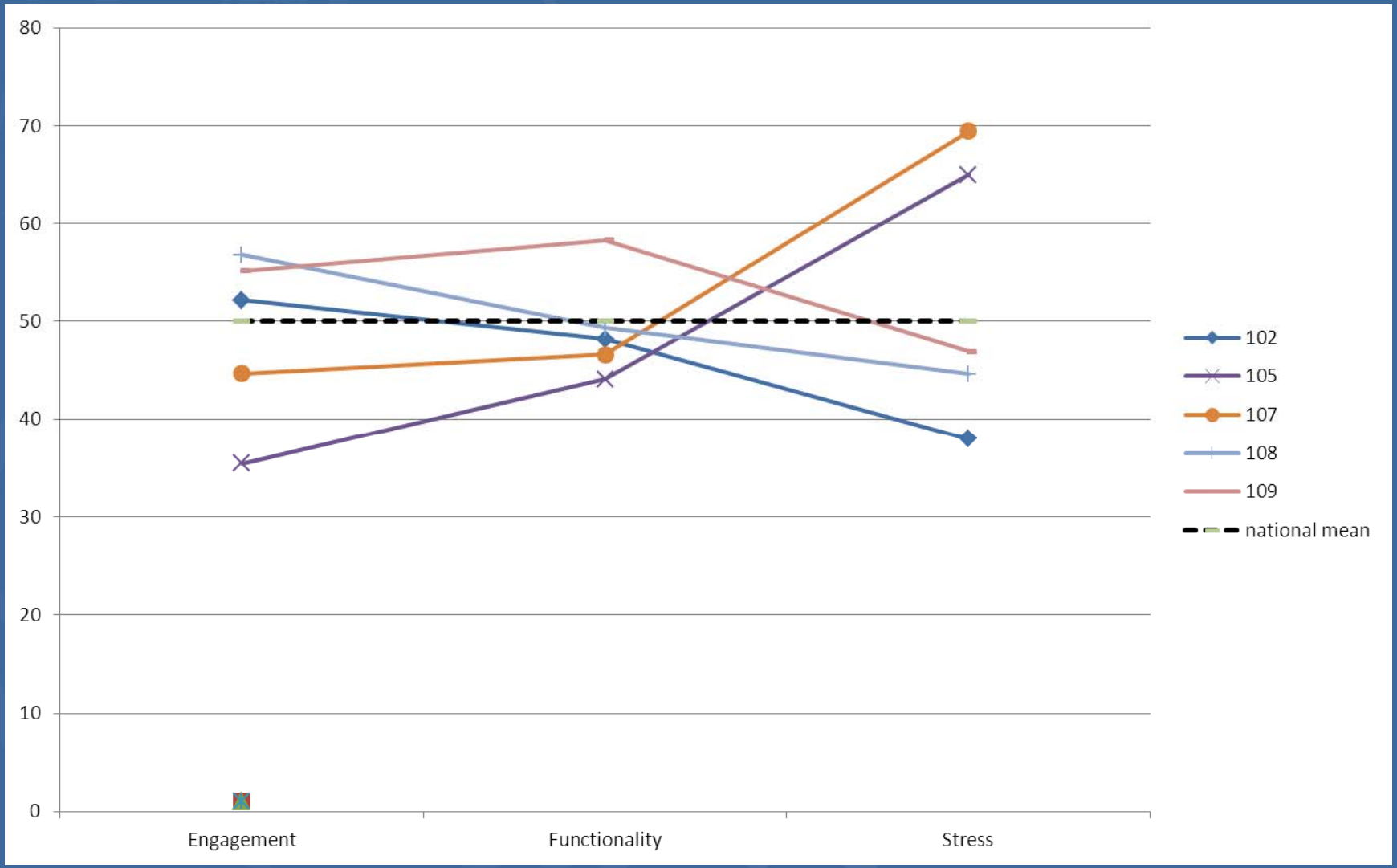
There's some support there for teaching clinicians and support staff here about CT. We have weekly ongoing training here where we practice CT. I think all those things definitely promote using CT here

It would be helpful if the administration here was really on board with it …and making sure that it was actually a priority that we have the time scheduled to maintain our skills in CT, and it wasn't just something that I had to fight for every week, because it seems secondary to making money...

Culture-OSC Scales at 5 clinics



Climate-OSC scales at 5 clinics



My own fatigue. …It's easy to fall back [on a psychodynamic approach] when you're tired. …It's harder for me to do CT at the end of the day. ..

Sometimes it just seems that it's more fun to wander than it is to be structured…But I try to remind myself that the goal of the hour is not to entertain the therapist

I mean, if this is really what you want to do, and you're interested in it, you're naturally going to be wanting the same thing. Going to want to be on the same level [as the training consultants]. To be able to deliver it well. And so it lifts me up. And I endeavor to kind of be like they are.

Sometimes I think that the techniques are not as effective with some clients or their goal is simply to be supported without making much change

The ones that are not in the 75-80% [with whom I use CT] are the ones that I've tried to use the whole protocol with. So, they either they dropped out of treatment or it just wasn't really working for them. They weren't really taking to it, so I just sort of backed away from it.

I found a lot of it relevant, but then there are those times, again, when I get those difficult cases and I'm almost just at a standstill, like, I don't know what to do.

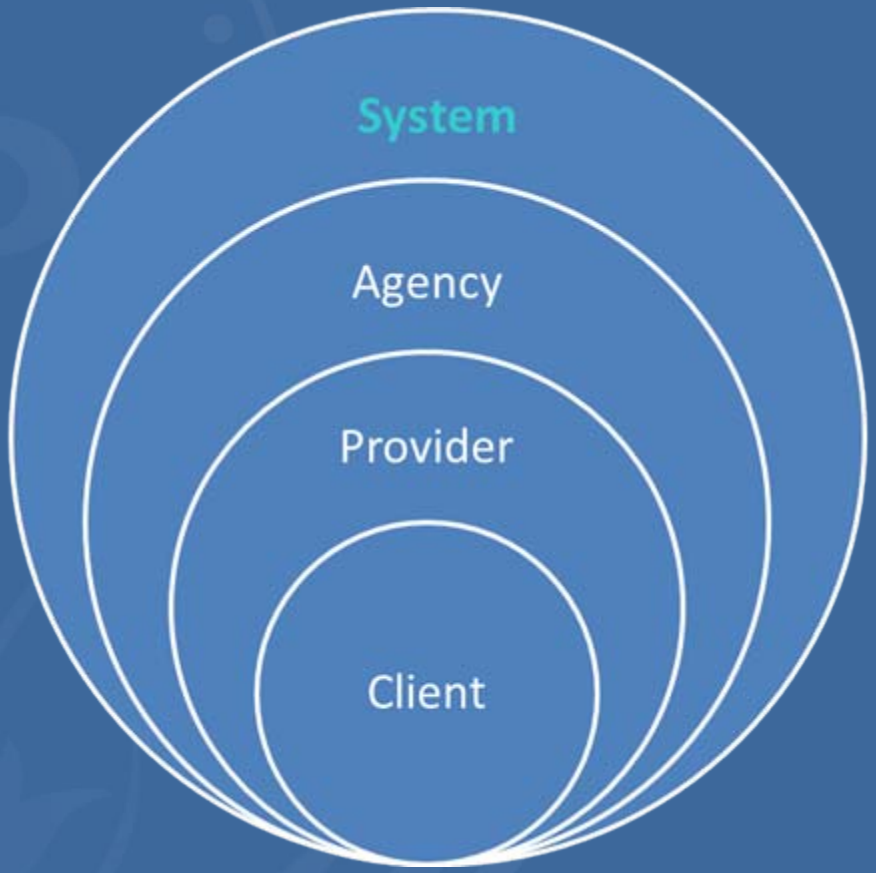
I'd like to use it more, but our clients are pretty, you know, they're all over the place.

FACILITATING SUSTAINABILITY

Quarterly meetings to trouble-shoot and support

Requires and monitors ongoing internal consultation

Requirements for recertification



Implementing higher reimburseme nt rates for EBPs

Alignment

Replenishing CT trained clinicians within the agency

Ongoing learning

	%
Sought additional training	25
Continue to consult with colleagues re: CT	97

Internal Consultation

I think that continues to motivate me to use cognitive therapy. **We have continued to tape, so that's good, so I get the feedback**. A lot of other co-workers, they're being trained in it now, so our trainings are going to be bigger. Our supervision is going to be larger, so that's good. **I like to hear what other people are doing with the same kinds of clients, and that works, so that's the one thing that I really, really appreciate – the ongoing supervision**.

Try to immerse yourself around other people who believe in it. Because then it becomes contagious. [The training consultants] helped me… **I think that when you see therapy being done the way you like it, and the way you think it really should be done. And it's done well. And you see the way the consumers or patients are reacting to the therapists.**

If the end goal is to have high level, high quality CT clinicians and community behavioral health, they really have to think about, I think, how are they're gonna keep people trained, AND trained not just with, like, a one hour kind of a didactic, but with a full on kind of training, because I think you need that.

Key themes thus far

- Most clinicians are still using CT, in at least some way, with some, or even many, of their clients
- Barriers include agency/system demands, caseloads and fatigue, and some client characteristics and preferences
- Modifications include language, pacing, structure, and some integration of other theories and strategies.
  - While they grew to appreciate the structure of a CT session, they are also willing to dispense with it
- Ongoing internal consultation appears to support ongoing use of CT

Future Directions

- Continuing to interview and code data
- Integrate climate/culture data further
- Examine predictors of training outcomes/sustainment

Thank you!

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Using Elements of CT

When I can I try and use the elements even if it's not a full structured CT session but I do when it's possible…Well I do believe I add my style and again with some clients you can use some structure but again it depends on the client and the situation. Sometimes they need more validation like processing feelings during a session, rather than just using CT structure, like offering support and being there for them.

Experiences with Consultation

It was great. The way they set up. The way the Penn folks set it up. The attitude of the administrators here. Everything was green light, go, we're behind you 100%. So, that was a blessing. That was really good…[Consultant], he was excellent. I was so glad I had him. I can't say how the other ones would be great, but that guy really knew what he was doing. And I just - I love the way, his tone, his gentleness with people. Even the people, the therapists who had their own strong opinions about the way things should be or shouldn't be done - the CT way. I just love the way that he disarmed people. Very, whatever that thing is that he did. And then he had all that stuff that they do down really well. So then I got some great supervision from him. And that was great.

- I really hated the training. I'm going to be honest, hated it. One, because I was told this was not what you all had wanted, here at this agency we didn't have a choice. We weren't told, "Hey do you want to do this thing? Do you want to learn about CBT?" We were told, "You are going to this." So, it was mandatory. So I really wasn't onboard with that because I didn't really have an interest in learning about it. I also didn't care for any - excerpt for my supervisor at the time - I didn't really care for any of the people who were running the study, or the training or whatever. And I didn't like the fact -- I didn't like the fact that our agency was partnered with [another agency] during it because those folks, a lot of them are not masters-level degree therapists, and their questions were so basic that it just seemed like you just wasted our time to me. .. And their clientele were so different from our population that it was hard to sort of talk about cases. Because we just had such kind of different case loads. And they were all so enthusiastic. Well, a few of us were disgruntled over there, so that didn't mesh at all…. I was just told, "Oh, we're going here. We're doing this." And then when I complained, somebody from your department [Penn] said, "Oh, we didn't want that." And they didn't. They had wanted volunteers, which is what I had understood the [other agency] did. They had volunteered. So I already sort of went into it, and this isn't your guys' fault, feeling what's the word…I had a bad taste in my mouth.

There were two women that were running our training and they were very different in many ways. Both had their strengths but you could tell very easily how one person could kind of interpret one way and the other could interpret the other way. It could give you vastly different feedback. ***I felt that it would have been helpful to have gotten more than one person's perspective for every tape***…. It would have been very helpful to see the different styles in technique but when in my feedback it was obviously just this one person's perspective and ***I don't like recordings and I certainly didn't want to share them with a group***. And I don't know that I ever had to but I was comfortable. I was eventually comfortable with having her review them but I would not have been comfortable had the group had to review them

- I thought it was a well-run, very supportive training…Yeah, no, it was really great. In fact, [I had], it saddens me that whatever the funding isn't there for others to get that same support in training. I mean, the web-based training is great- I don't know how great it is. The web-based training is efficient, but it doesn't measure up to the other training at all.

I don’t know if it was like that for every agency but it was very, I know ***it was stressful for me to have to go through this type of training with somebody who was my superior***. I don’t know how my therapist having to go through it with me but I imagine that there were some similar feelings, though I was much closer with them than I was with my superior. I know that they were also uncomfortable with her there so that was a big piece for a lot of people because we felt like, I felt like I had to say certain things and I was not as open in the training as you probably would have hoped that I would have been…

So, the training kind of hopped directly into the nuts and bolts and ***I would've liked more of an understanding of the framework*** within which I was, the theoretical framework within which I was working in. I think it would be useful for other people being trained as well because if you don't have a solid foundation in the theory, the other stuff might not fit together. You know, it might not even make sense, and I think there was some struggle on my part with trying to make sense of what I was learning, because some of it seemed to go against things I learned in my Masters program. You know, and other, you know sources, and so it was only through, like, some intensive conversations with trainers and other resources that I was able to, like, really understand, like, how does this theory fit in to the larger scientific framework, you know, of evidence of research, you know, [brain] research, therapeutic research, etc., you know, brought us to this place. Right, and a lot of people may not think to ask those questions. And really specifically- I guess this is another area where ***I thought would be useful- is to really also explain the limits of CT.*** The known limits, right? Like, we don't really know if CT works well with people with brain injury, right?

Satisfaction with Consultation Models

Question	Individual Model m(sd)	Practicum Model m(sd)	*t*
How would you rate the overall quality of the consultation you received ?	4.88 (1.4)	5.63 (.52)	-1.92†
How comfortable are you are in applying CT in your practice?	3.81 (1.5)	4.88 (.64)	-2.46‡
How comfortable do you feel applying what you have discussed in consultation to your practice?	4.24 (1.3)	4.88 (.64)	-1.65

1=poor/not at all, 3=satisfactory/moderately, 6=excellent/extremely
†=p<.10; ‡=p<.05

Program evaluation data

Did training and consultation change attitudes?

Evidence Based Practice Attitude Scale	Baseline	Post-consultation
	M (SD)	M (SD)
Requirements	1.94 (1.05)	2.14 (1.24)
Appeal	3.27 (.77)	3.40 (.63)
Openness	2.95 (.76)	3.09 (.77)
Divergence	.75 (.47)	.80 (.67)
EBPAS total	2.91 (.46)	3.02 (.43)

Range 0 (not at all) to 4 (to a great extent)

I’m not sure if my thoughts about the intervention, umm, changed too much. Umm, I did, probably in a slightly more positive way, like I do have some, umm, maybe biases going into the training and I felt like in certain situations, whereas at first I thought maybe it wasn’t useful very much at all, at the end I thought, “Well, there are certain circumstances where it may be useful and where it has proven useful in my work.” So, umm, I guess that’s a shift.

I had some reservations, initially, about how we could effectively apply CT to our population, which tends to be the more chronically homeless, drug-addicted, mentally ill clients, and I have to say, um, I still believe that there has to be a healthy balance between some level of stability to even do cognitive therapy. I have seen cognitive therapy work in crisis, um, situations, helping the clients to look at their distorted thoughts, and helping them to do the pros and cons has worked, and I didn't think that it would initially.

- I have, I have two clients [specifically] in mind who had pretty severe delusional disorders, one of [whose delusion remained intact], but the CT that we did, we found a way for her to manage it pretty effectively, um, though, you know, it's kind of like it doesn't matter at that point. She still thought she was being chased by evil spirits and I don't know if that will ever go away, but ***we found some behavioral things that she could do to manage it*** and some of the other anxiety related to it that she could manage in a way that was effective. The other client, uh, nothing was really working with him. He ended up being hospitalized. Part of it for him, his delusion was that people were trying to poison him, and so he kept inducing vomiting whenever he would eat and that's when he took his medications, so he was not off his medication regiments. Things were not, he just wasn't stable. ***I will say this- that for clients who aren't on medication, uh, it's kind of hit or miss***. You know, if the client is bipolar, and they're like entering their [maniac] phase, I don't know. You know, same goes for, you know clients who are schizophrenic or having a psychotic episode. Like, I have clients who… CT around auditory hallucinations, uh, is another area where, you know, ***the management can get better, but the, but the hallucinations won't go away***.

What do they do with all that training?

	How Often	How Helpful
Element of CT	**M (SD)**	**M (SD)**
Entire CT session (e.g., following structure, using interventions)	1.43(.97)	2.17(.94)
Agenda Setting	2.07(.97)	2.42(.74)
Evaluation of automatic thoughts	2.29 (.66)	2.60 (.63)
Discussion of connection between thoughts/feelings	2.36(.83)	2.60(.63)
Problem-Solving strategies	1.93 (1.1)	2.11(.84)
Identification of triggers	2.32 (.77)	2.57 (.63)
Relapse Prevention exercises	.93 (.86)	1.69 (.84)
Solicitation of feedback	2.25 (.84)	2.49 (.64)
Assignment of Homework	1.82 (.82)	2.00 (.77)
Ongoing learning	**n**	**%**
Sought additional training/consultation	7	25%
Continue to consult with colleagues re: CT	29	97%

N=30; 0=Never/Not at all, 1=Rarely/Not very, 2=Somewhat, 3=Often/Very

Types of Consultation

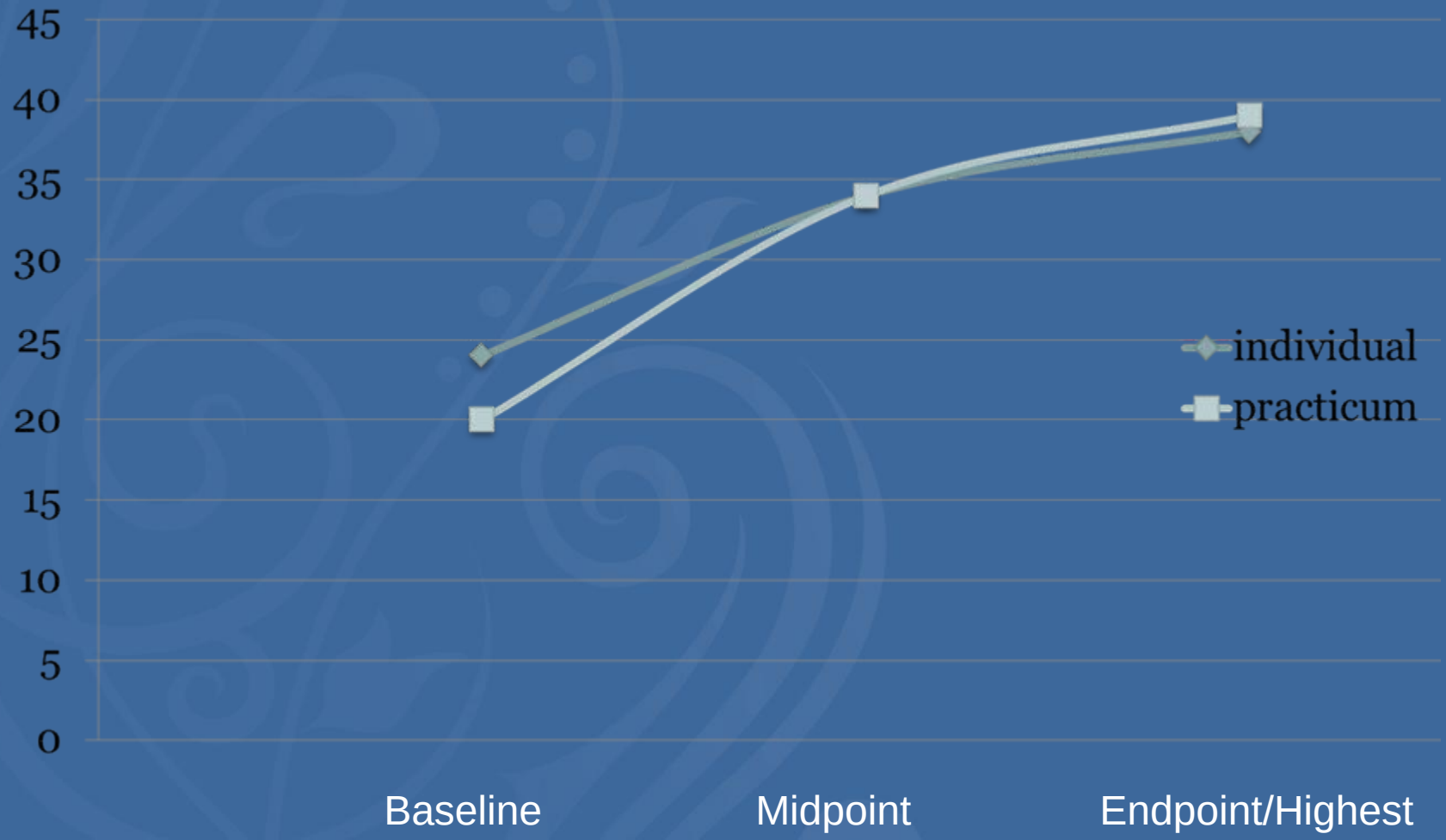
- Individual tape review and feedback is considered the gold standard
  - Time and cost-intensive
  - May not be feasible in many practice settings
- Group session review and feedback "practicum"
  - Same time required as consultation alone
  - Allows some review of in-session behaviors
  - Allows group members to learn from each other's cases

Preliminary Training Outcomes: Program Wide

- Overall, 80% therapists achieved competence (CTS=40+)
- Practicum Model (n=22): 79% competent
- Individual Feedback Model (n=37): 80% competent
- 93% scored over a 35 by their final session

Program evaluation data

Preliminary Training Outcomes (n=59)



Program evaluation data

Reactions to CT Structure

I’ve got a better understanding of CT, I've learned that it’s very structured but it’s structured to keep things focused, and especially me that works… [with] drugs and alcohol, a lot of times clients are all over the place and using CT allows you to really focus and get to the core issues as opposed to going everywhere in the session and that’s really how it has benefited me in terms of my professional, in terms of the orientation that I use while in sessions

- Like I said, that’s one of the things that I like the most is that it is structured, and for people who tend to have, uh, thoughts that are all over the place, they need to learn that structure, and CBT starts there. So, ***it works, and it helps to keep me organized,*** it helps to keep, um, the whole conversation on task.

I don’t know how much of it is just what I tell myself, you know, I think sometimes the idea of having to adhere to a certain structure can be stifling. Umm, not just for me, but for the client.

Sometimes it just seems that it’s more fun to wander than it is to be structured…But I try to remind myself that the goal of the hour is not to entertain the therapist.

Less Formal

I think I use CT, but not as formal … because I didn't start getting the CT training until well after I'd sort of established my rapport and the relationship and established, you know, the flow of therapy with those clients already. So, I mean, where I can, sort of, slide things in- like, I have done the triangle with people, I have, I do check in with people to see where there mood is and have them, sort of, rate it. You know, where are they when they come in versus where are they when they leave out. I don't do agenda-setting as much in that setting… **I do a lot of work around thought-checking**, umm, sort of people keeping track of what it is that they're thinking about, because a lot- a lot of the clients that I see are mood disorder…and it seems to help a lot, umm, especially when there are acute things going on and they really just need a quick- **they need to be able to reframe it**, umm, so when we, kind of, put it out and we put it on the triangle it makes a lot of sense because they can see where, you know, "If I think this about it, then I feel really crappy, but if I think about it this way, hmm, then I don't feel as bad and maybe I can just follow-up with someone and go a different route and…", so, it's not as formal, but I think I wasn't using it at all prior to getting the training.

I don’t know if I’m changing the language as much as I am implementing CT in our conversation in a way that flows with the conversation. [IN: Ok] You know, it doesn’t, again, now, I’m not talking about when I’m formally doing CT. There are times where I have to meet clients out in the community and I’m not in a therapeutic setting [IN: Sure], so at that point I have to just, you know, talk to them like, “Oh, what’s going on now? What are we doing?” And then try to incorporate some of the, “You know, why don’t we, why don’t we [change] how you’re thinking?” You know, just make it in a way where they can receive it and it’s not so therapy-like.

Integrating CT into “what I do”

- I think at this point, even with the people who I don’t, like, I guess use the formal kind of protocol with, and we haven’t sat down and decided that we’re going to do CT together kind of folks- umm, I just find a way to, kind of, meld it into what I’m doing anyway, so I think it works fine.

- I mean I use solution focus but I know that they use that from CT …What evidence should support that, what has been going well lately, I like to be solution focused and use motivational interviewing. I guess I've incorporated those two styles with CT

- Mostly everyone is kind of a hybrid. **….** *As my fatigue level – as I get more mentally tired – starts to slip*. So the percentage where all the points are hit is very low…It's kind of an issue of survivability in terms of managing my own energy level. *So as you're kind of picking up for me, doing CT does take a lot more work. Takes a lot more energy for me to do all of the points* - to try to help the person and collaboratively design homework for them. Making sure that I'm constantly checking in. … I noticed that when I am - when I was just recently talking to a CT therapist - that I tend to do a pure session. …. But then the next day comes, and that's a distant memory. *And I kind of fall back on whatever that thing is that I do* …. It's I guess more of a hybrid model for what I think is helpful to them and CT. … [But] I don't do any psychodynamic work on anybody anymore

- I think I would be much more…much more pure in the way that I deliver it. And I would have time to prepare. I would have time to think about maybe what would be a homework we could kind of steer towards. There's no preparation time here at all. There's no time to even think through your clinical notes, and everything is done super, super fast. And you know, we're trying to cover a large area with very little resources so the delivery that I think we deliver lacks a lot of power here…I can't speak for the other therapists, but I think that's the story here. I see that in the group work - that's why I'm so excited that the CT group is here because I think it's really going to help us on the floor with the quality of the groups

So, I’d say with really disorganized clients it can also be an issue, and I’ll tell you in the drug and alcohol community, if someone’s still using, umm, especially PCP, for some reason, has a serious impact on cognitive ability. I would that it’s almost impossible to implement CT.

- What they want is to just be able to verbalize what is happening in their lives and feel listened to and actually the individuals goal is to have someone validate them, their struggles just by listening to them. Sometimes that's their goal. Really they want something to be different but they don't feel they can do anything about it and if you try to aid them in a small way suggest that perhaps there is something they can do about it sometimes they get very angry …I'm not just understanding them according to them I think I can still do some CT there but it has to be very careful very slow

What they do instead

- Sometimes I do DBT, someti- most of the time normalizing situations, um.. you know just through.. cause a lot of times with trauma they've never told anybody about what happened, so just being that person that they can tell, and talk to, and not judgmental, and you know…strengths based.

- I know that a person is coming in with a spiritual basis, I try to connect with them on that level. Especially if they're a much Christian oriented person. I will shift to becoming a Christian counselor. I do that here. If the person is coming from that orientation. And you know I might relax the delivery of the model a little bit. But the model interestingly enough works really well in what I would consider to be biblical counseling

Um, there are some things that I do that, I mean, I'm not sure if they fit within CT methodology. I do, for a lot of my clients, if they have a substance-abuse history I'll do what's called a ***functional analysis*** with them where I, you know, walk them through a series of questions to kind of find out what their patterns of using were, and from that, pull out, um, you know, situations that might make them vulnerable to using again, and then we come up with behaviors that would protect against either being in those situations or avoiding those situations altogether or how do we deal with not having those things. … I think a lot of stuff with, uh, early-recovery clients work much more with the behavior end of things than the cognitive end of things because it's much more it's kind of a [unintelligible] for their situation, I know…behavior is easier to change than thoughts, and [it will] change the thoughts. I don't know. I don't really know exactly how those things can be separated, but I know that some of them may not be CT [IN: Ok], ***but I do motivational interviewing, I teach mindfulness relaxation techniques***, uh, to clients, um***, I teach my clients how to do reverse planning***. There's a lot of behavioral stuff that I teach clients which would fall under ***psycho-education***, I guess. Um, it's not, strictly speaking, you know, "What was your thought about this? How did it affect your emotion or your behavior?"

Well probably guided discovery is the main one and certainly using the basic concept that the experience that your having relate to the thoughts your having but I may not be setting an agenda I may not be doing a lot of three C's work or having the person do a lot of homework on the three C's and that kind of thing. It may be more - how can I put - it its just not as structured and formal. ***Looking at systems issues*** and what their thinking about and how they're working in the system they live in. I guess I do a lot of stuff I suppose so what I do otherwise ***I fairly often use kind of gestalt techniques*** and talk about parts of the person and integrating parts and which kind of goes back to having a normalizing effect that you have mixed feelings that there's a dialect of things and that that's okay. And oh, gosh it's so much easier to do what I do than describe what I do. I really do take a lot of stuff different various ***a fair amount of interpersonal process kind of stuff***. I look at kind of in my mind I'm ***thinking about the person's attachment issues and how that relates to how they interact with people*** now … I guess I look at things from a lot of different kinds of theories and then I ask a lot of questions and give a lot of support and sometimes try to get people to get it intellectually inside maybe in a dynamic way and sometimes try and do homework, ***use metaphor to help them look at themselves in a new way***. I do a lot of different kinds of things…

Modifying language and materials- client abilities

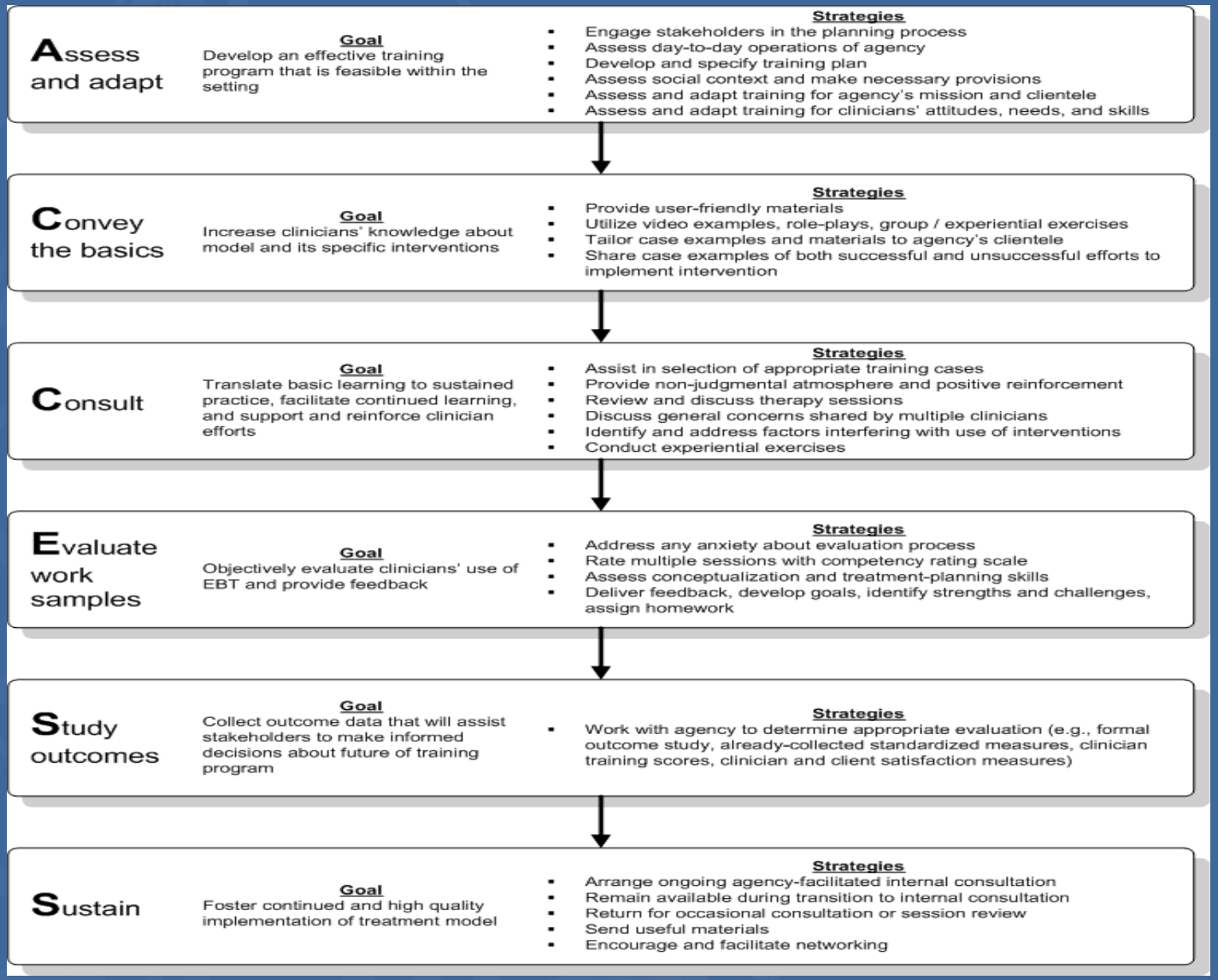
I made handouts for my clients with layman's terminology to help them understand the concepts

I simplified the thought records

There’s a lot of pressure within the agency from funding sources, from the agency itself, for specific formats of paperwork and all sorts of other stuff. ***It can sometimes pull away from doing a completely standard, you know, CT session***. Um, that’s just a fact of working in the agency. I’m sure, yeah, I’m sure that plays a part also. I’m trying to get better without, like, um, you know, ***just easing off on the formalism***, ‘cause I can go really in the direction of formalism and making sure that, um, like structuring the whole session around what I need to do paperwork-wise, you know, for [the mental health system] or whatever. Or, in my head, what has to be in a CT session, and I don’t think that’s always been an [issue] for a client [unintelligible], but you know, just to be more, ***allow the client to steer things a little bit more***, allow the process to unfold a little bit more and just trust that it’s going to be okay.

I think, for the most part, people were fine with [getting trained in CT] Hmm, I think people didn't realize it was going to be as long a process as [laughs] as it has been. So, it's just kind of morphed and grown, and it's just [laughs], you know, it is what it is, but, umm, yeah, and I think- I think it would have been helpful for people to know that upfront- that this wasn't something that they were gonna- 'cause I think a lot of people thought this was something they were gonna get trained in, they were gonna do it, and then it was gonna be over, but it's like, not going away [laughs], …I think the [ongoing consultation] meetings, and the consultation and the, you know, meetings to get re-certified, and the anxiety that comes with that, like, that's the part that people are, kind of, like, "I wish I would have known that I would have to deal with this ahead of time."

ACCESS Model of Training and Consultation



Stirman et al., (2010) PPRP

Life Circumstances

These are folks who really don't have some of the control factors that we do…I still think that it's a great tool, but I think that it has to take into consideration that, for some people, it takes a lot longer to kind of get them into it. For some people **you have to know where and when and how to do it**, because **if you don't**, **you can come across as being really, sort of, condescending and not in touch with what the person is really going through** …I think the risk is for people to be good at it, but not be good at connecting to where the client really is ...

Other demands

[CT can be] labor intensive and there's so much else that we had to do that even though a lot of it is done within the session, there's also a lot of other stuff that we're supposed to be doing within the session. Like treatment plans. I mean certainly you could incorporate treatment plans into the structure but I was the director of the unit so that was very difficult. It would have been very difficult for me because I had about five other things going on at one time.