

Beyond the Label: Relationship Between Community Therapists' Self-Report of a Cognitive Behavioral Therapy Orientation and Observed Skills

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Abstract Policy-makers, payers, and consumers often make decisions based on therapists' reported theoretical orientations, but little is known about whether these labels represent actual or potential skills. Prior to CBT training, therapists ($n = 321$) reported theoretical orientations. Experts rated CBT competency using the Cognitive Therapy Rating Scale Therapy at pre-, mid-, and post-training. CBT- and non-CBT identified therapists showed equivalent, non-competent baseline CBT skills. CBT-identified therapists showed greater CBT skills at mid-training, but by end of training, groups evidenced equivalent achieved competency. Baseline CBT orientations were neither valid, nor useful markers of later competency. Policy, clinical and research implications are discussed.

Keywords Theoretical orientation · Competency · Cognitive behavioral therapy · Community mental health · Implementation

Policy makers have issued mandates, provided incentives, and devoted billions of dollars to bring empirically

supported treatments (ESTs) and evidence based practices to community behavioral health (CBH) in the United States (Karlin et al. 2010; McHugh and Barlow 2010) and around the world (Clark 2011; Layard 2006). With the passage of such policies as the American Affordable Care Act (H.R. 3590—111th Congress: Patient Protection and 2009) and the Improving Access to Psychological Therapies mandate (IAPT, Great Britain Department of Health 2008), demand for care based on science may be growing among people seeking services (Rozenky 2014). In contrast to research settings, therapy that takes place in the community is typically not measured for fidelity to a model, so policy makers, payers, and consumers may depend on a therapist's self-identification of their guiding orientation as a basis for treatment-related decisions. However, little evidence exists regarding whether therapist self-labels of orientation are congruent with the skills displayed in therapy sessions. Dissemination research has suggested a relationship between a therapist's stated orientation and attitudes toward EBPs (Brookman-Frazee et al. 2009) and ESTs (Stewart and Chambless 2007), but little is known about the relationship between stated orientation and uptake of related skills.

Numerous studies have examined whether specific therapist actions actually differ when delivering psychotherapies guided by different theoretical orientations (e.g., Barber et al. 2004; Dimidjian et al. 2006; McCarthy and Barber 2009) and whether those therapist actions in session are associated with the treatment process and outcome (for a review, see Beutler et al. 2004; Orlinsky et al. 2004), supporting the conclusion that therapeutic orientation is associated with differential in session behavior, process and treatment outcome. Among these orientations, a modest number of psychotherapies have been deemed empirically supported treatments, evidencing that the

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treatment, as defined in a manual, has been found efficacious in at least two randomized, controlled clinical trials including at least one conducted by an independent research team (Chambless and Ollendick 2001; Roth and Fonagy 2004). A related but distinct categorization is given to approaches that are empirically based practices (EBPs). Use of EBPs reflects the integration of clinical expertise, patient values, and research that is both clinically relevant and methodologically sound, to make treatment decisions (APA Presidential Task Force on Evidence Based Practice 2006; Sackett et al. 1996). Among the ESTs and EBPs taught in accredited training programs for disciplines that deliver psychotherapy (psychiatry, psychology, social work) in the United States, cognitive behavioral therapy (CBT) approaches have been found to be the most frequently offered and required as a didactic, with 99 % of psychiatry (M.D.) training programs requiring CBT didactics (Weissman et al. 2006). However, among training programs in professional clinical psychology (Psy.D.) and social work (M.S.W.), the disciplines with the greatest numbers of students and greatest emphasis on clinical training, approximately two-thirds of the programs did not require a didactic and supervised clinical experience in any EST or EBP. Given that didactics without clinical supervision have been shown to be ineffective at changing the behavior of clinicians (Davis et al. 1999), questions arise about whether the treatments purported to be delivered by graduates of these training programs are actually being delivered with competency and adherence.

From a policy perspective, deepening the understanding of the care provided in CBH is particularly relevant in these tight economic times. Providing policy makers with an accurate view of the services provided may help with both funding decisions and implementation of evidence based services. In the United States, a national effort was undertaken under the directive of President George W. Bush in 2002 to assess the state of behavioral health care, and the findings were mixed, describing the CBH system as “a patchwork relic—the result of disjointed reforms and policies,” (President’s New Freedom Commission on Mental Health 2003, p. 1). The advent of the American Patient Protection and Affordable Care Act ACA; (R. 3590—111th Congress: Patient Protection and Affordable Care Act 2009) has created long-overdue opportunities to grow the capacity of behavioral health systems and meet the pressing needs of individuals served by CBH, moving focus on EBPs to the forefront. A similar push began in the United Kingdom when Professor Lord Richard Layrad reported economic evaluations related to expanding access to psychological treatment there (2006), ultimately resulting in the IAPT mandate (Great Britain Department of Health 2008). A closer look at what is being delivered in CBH centers today, in the wake of these changes, may help

policy makers make more informed decisions about how behavioral health care funds may be best directed, and the policies guiding those services.

Economically, ensuring that effective psychological treatments are being delivered makes good fiscal sense. Layard (2006) argued that the provision of evidence-based psychotherapies (and CBT in particular) would yield economic benefits that would exceed the cost of implementation, based on savings of benefits payments and other costs for the British system for less effective therapies. In the United States where payers spend \$113 billion annually for behavioral health care (Mark et al. 2011), ensuring the effectiveness of services rendered is also key. Available funds for American behavioral health care have been on an overall decline over the past two decades, outpaced by spending for non-behavioral health issues (Mark et al. 2011), and effective treatments are a better investment for those decreasing dollars. Payers have contributed to some of the momentum behind implementation of evidence-based practices in CBH centers, but successful implementation is still often the exception rather than the rule. Understanding the characteristics of the services in which those billions of dollars are being invested, as well as the degree to which a therapist’s stated orientation may be a sufficient measure of those characteristics, may help to guide payers’ decisions about their reimbursement for services.

From a clinical perspective, refining our understanding of treatment in CBH may be of particular importance. Individuals receiving services in CBH centers have no way of knowing what they will receive as treatment, other than asking for information a priori. Understanding CBH treatment can help people become informed consumers of behavioral health care, perhaps increasing their likelihood to engage in and ultimately benefit from those services.

In relation to dissemination and implementation research, little is known about the relationship between therapists’ orientation and their subsequent uptake and proficiency in EBP or EST skills (Herschell et al. 2010). Studies that have examined the association between therapist characteristics and training often focus on attitudes rather than skill development. For example, research has suggested a relationship between a therapist’s stated orientation and attitudes toward EBPs (Brookman-Frazee et al. 2009) or ESTs (Stewart and Chambless 2007), but little is known about the relationship between stated orientation and uptake of associated skills. Bearman et al. (2013) found that clinicians were no more (or less) likely to follow through on their supervisor’s directives related to an EBP, regardless of whether the EBP was consistent with their own theoretical orientation. Closer examination of the relationship between how therapists describe their orientation, the services they actually deliver, and their success

in developing competency in using an EST or EBP may more directly inform dissemination efforts.

The purpose of this paper is to examine the relationship between clinician self-report of the therapy they deliver and expert observer raters of clinician competency in an EBP. Therapists participated in the Beck Initiative, a large-scale implementation program presented collaboratively by the Philadelphia Department of Behavioral Health and Intellectual disAbilities (DBHIDS) and the University of Pennsylvania (Creed et al. 2014). Data for this report represent the state of the CBH services prior to the beginning of training. CBT was used as the benchmark for three reasons. First, CBT is the EBP most frequently offered and required as a didactic across psychiatry, psychology and social work training programs in the United States (Weissman et al. 2006), which makes it the most likely practice to be identified in a broad sampling of treatment by behavioral health professionals. Second, a broadly used, validated measure of fidelity to CBT (CBT skills) and non-CBT items (general therapeutic skills, structure) known as the Cognitive Therapy Rating Scale (CTRS; Young and Beck 1980) was available as an indicator of treatment components displayed in a therapy session. Finally, these data were collected as a measure of the baseline services provided in a program of implementation of CBT, so beginning levels of CBT were measured for later comparisons of skill development. Of specific interest were the following questions: Among a group of CBH providers, how would therapists describe the guiding orientation of the services they provide? Are therapists' self-reported theoretical orientations (as a cognitive behavioral therapist) actually associated with use of CBT techniques or development of CBT competency?

Methods

The Beck Initiative training model for the implementation of cognitive therapy has been adapted for a number of settings and populations ranging from extended acute care inpatient units to outpatient clinics, and from adults with chronic schizophrenia to children in schools (Creed et al. 2013, 2014). The overall training model has been described in detail elsewhere (Creed et al. 2014), but a brief summary is provided below for context.

The Beck Initiative Training Model

Established in 2007, The Beck Initiative is a public–academic partnership in an urban center of the northeastern United States. This innovative, collaborative training approach aims to advance the quality of care for persons in recovery by teaching CBH clinicians tangible,

empirically-based skills, and then providing ongoing consultation for the application of those skills. Stated broadly, the aims of the Beck Initiative are to improve of outcomes for people receiving services in the DBHIDS system through the broad implementation of CBT, and to contribute to the implementation science literature as a model for other large behavioral health care networks. To date, these objectives have been carried out successfully in the DBHIDS network and replicated across several other states (see Creed et al. 2014 for details).

Participants

Agencies within the urban CBH system were selected for participation in the Beck Initiative by the city's DBHIDS, as described in (Creed et al. 2014). Administrators within a participating agency nominated 6–8 therapists who met the participation prerequisites (current case load, a master's degree or higher in psychology, social work, or a related behavioral health field). Beyond these requirements, administrators were free to select therapists according to the agency's priorities. The nominated therapists who agreed to participate were designated as trainees. This project was reviewed by the University and local City Institutional Review Boards and was determined to be program evaluation rather than research, so informed consent was not required.

Prior to beginning any training, therapists were asked to provide demographic information, including information about their theoretical orientation, education, and licensure status. Each therapist was then required to submit an audiotaped session of themselves providing treatment as usual to an individual on his or her caseload, with the written permission of the individual being recorded. In the context of the Beck Initiative, the audio are used as a baseline against which to compare subsequent audio to assess changes in CBT skill. For the current evaluation, these audio provide a sample of treatment as usual within this large CBH setting.

A sample of 321 therapists submitted session audio in which they delivered treatment as usual. Of the full sample, 229 therapists (71.34 %) completed 6 months of supervised practice and submitted a final audio for an evaluation of competency. Among the 91 therapists who did not submit final audio, 38 (11.84 % of the sample) had not yet reached the end of training and 54 (16.82 %) withdrew from participation in training (e.g., left the agency, promoted to a position with no direct provision of care). Given the nature of the background data as part of program evaluation, participants were able to respond selectively to items. Among the therapists who identified their gender ($n = 248$), 153 (77.3 %) were female. The majority ($n = 232$, 90.6 %) identified themselves as master's-level

clinicians, while 10 (3.90 %) had earned a Ph.D/Psy.D, and 8 (3.1 %) identified as physicians. Mean time since degree completion was 8.25 ($SD = 8.27$) years. Among individuals ($n = 186$) who provided information regarding licensure, 56 (44.1 %) were licensed practitioners while the remaining 104 (55.9 %) therapists were supervised by a licensed provider. Therapists were drawn from 33 CBH agencies. One hundred fifty-seven (48.9 %) therapists had caseloads of primarily adults, served 143 (44.5 %) primarily children/adolescents, and 21 (6.5 %) regularly served both children and adults. Therapists were drawn from a range of practice settings: outpatient behavioral health care ($n = 207$), school-based services ($n = 41$), addictions services ($n = 26$), Assertive Community Treatment teams ($n = 22$), and residential settings ($n = 25$).

Measures

All session audio were rated for baseline CBT competency using the CTRS, (Young and Beck 1980), an 11-item observer-rated measure designed to evaluate therapists' overall and specific CBT competencies. Each item is scored on a 7-point Likert scale, ranging from 0 (*Poor*) to 6 (*Excellent*). The 11 items are summed to yield a total CTRS score from 0 to 66. Items measure General Therapy Skills (feedback, understanding, interpersonal effectiveness, collaboration), CBT Skills (guided discovery, focus on key cognitions and behavior, strategy for change, application of CBT techniques), and Structure (agenda, pacing and efficient use of time, use of homework assignments; see Simons et al. 2010). Scores of 40 or above are considered to be indicative of competent delivery of CBT (Shaw et al. 1999). The CTRS has demonstrated adequate internal consistency and inter-rater reliability (Vallis et al. 1986), and strong inter-rater agreement for general competency (Williams et al. 1991). Raters were doctoral-level researchers and instructors trained on the CTRS according to the following criteria: (1) to be calibrated on a given CTRS session, the rater must be within 1 point of the group consensus rating on 9 of 11 items, and the rater's total score indicating competency (total score ≥ 40) or non-competency (total score < 40) must be in agreement with the consensus total score (total score ≥ 40 or < 40); and (2) to be calibrated overall on the CTRS, the rater must be calibrated on three out of four consecutive sessions.

Information was collected from each participating therapist using the self-report Beck Initiative Questionnaire developed for this purpose. Background data were collected including gender and educational experience (e.g., highest degree, field, licensure held). Data about the

therapist's current position were also collected, including current position title (e.g., therapist, social worker), treatment setting, population served (adult, child/adolescent, geriatric), and treatment modalities employed (e.g., individual, group). Finally, therapists were asked to identify a predominant theoretical orientation, the amount of training they had received in CBT, and a self-assessment of CBT knowledge (nothing, basics, a great deal).

Results

Among therapists ($n = 321$) who submitted audio of treatment as usual, almost two-thirds ($n = 197$, 62.37 % of total sample) reported that they followed a guiding orientation. Sixty-three of the 321 therapists (19.6 %) described their orientation as exclusively CBT, and an additional 76 (23.7 %) described themselves as incorporating CBT strategies along with other non-CBT approaches (i.e., eclectic). Fifty-eight (18.1 %) individuals described their practice as using solely non-CBT orientations (e.g., psychodynamic, play therapy, family systems). The remaining 124 individuals (38.6 %) elected not to provide information regarding theoretical orientation (see Table 1).

Chi square analysis examined the relationship between theoretical orientation defined as exclusively CBT, eclectic CBT (i.e., incorporated CBT strategies with non-CBT approaches), non-CBT, and no orientation reported and attrition from the study. Attrition was defined as failure to submit an audio recording for rating at the 6-month time point. Results were non-significant: $\chi^2 = .75$, $p = .86$.

Therapist competence was assessed via the CTRS, including CTRS total scores, subscale scores (General Therapy Skills, CBT Skills, and Structure), and individual item scores. Therapist audio was rated using the CTRS at

Table 1 Theoretical orientation at baseline, three and six months

	n (%)		
	Baseline	3 (Months)	6 (Months)
Number of participants	321	243	229
CBT	63 (19.6 %)	49 (15.26 %)	44 (13.71 %)
Eclectic CBT	76 (23.7 %)	58 (18.07 %)	53 (16.51 %)
Non-CBT	58 (18.1 %)	47 (14.64 %)	44 (13.71 %)
No orientation reported	124 (38.6 %)	89 (27.73 %)	88 (27.41 %)

$n = 321$

CBT therapist described orientation as exclusively CBT, *Eclectic CBT* therapist described incorporating CBT strategies with non-CBT approaches, *Non-CBT* therapist described their practice using solely non-CBT orientations

baseline ($n = 321$), and after 3-months ($n = 243$) and 6-months ($n = 229$) of consultation (see Table 1). See Table 2 for descriptive statistics. The three CTRS subscales (i.e., General Therapy Skills, CBT Skills, and Structure) were all significantly correlated with one another at baseline. General Therapy Skills was significantly correlated with CBT Skills, $r = .68$, $p < .001$, and Structure, $r = .57$, $p < .001$. CBT Skills was significantly correlated with Structure, $r = .61$, $p < .001$.

Orientation was entered into a repeated measures ANOVA model as four groups of interest: exclusively CBT, eclectic CBT, non-CBT, and no orientation reported. CTRS total scores, the dependent variable of interest, were entered for three time points: baseline, three and six months post-consultation. Repeated measures ANOVA examined CTRS total scores over time (baseline, 3-months, 6-months) across theoretical orientation groups. Mauchly's test indicated the assumption of sphericity had been violated, $\chi^2(2) = 25.66$, $p < .001$, therefore multivariate tests are reported ($\epsilon = .90$). CTRS total scores significantly increased over time, $V = .77$, $F(2, 217) = 358.36$, $p < .001$, partial $\eta^2 = .77$. CTRS total scores were not significantly different for theoretical orientations (regardless of time point), $F(3, 218) = .93$, $p = .43$.

To examine the impact of theoretical orientation on CTRS subscale scores over time, orientation was entered

into a repeated measures MANOVA model with the aforementioned four groups of interest. The three CTRS subscales (General Therapy Skills, CBT Skills, Structure), were entered as the dependent variables of interest for three time points: baseline, 3- and 6-months post-consultation. The multivariate between-subjects effect of the combined CTRS subscale scores across theoretical orientation group (regardless of time point) was non-significant: $V = .05$, $F(9, 654) = 1.10$, $p = .36$. There was a significant multivariate effect across within-subjects time point (regardless of theoretical orientation group): $V = .78$, $F(6, 213) = 127.47$, $p < .001$, partial $\eta^2 = .78$. The multivariate effect across the interaction between theoretical orientation group and time point was also non-significant: $V = .09$, $F(18, 645) = 1.09$, $p = .36$. General Therapy Skills increased from baseline to 3-months, and from 3- to 6-months (regardless of theoretical orientation), $F(2, 436) = 250.33$, $p < .001$, partial $\eta^2 = .54$. Similarly, CBT Skills increased from baseline to 3-months, and from 3- to 6-months (regardless of orientation), $F(2, 436) = 345.83$, $p < .001$, partial $\eta^2 = .61$. Structure scores also increased from baseline to 3-months, and from 3- to 6-months (regardless of orientation), $F(2, 436) = 413.20$, $p < .001$, partial $\eta^2 = .66$.

Among the 229 therapists who submitted final audio for competency rating at the completion of six months of

Table 2 Mean scores of cognitive therapy rating scale items at baseline by theoretical orientation group

Variable	Baseline				
	Overall sample <i>M (SD)</i>	CBT	Eclectic CBT	Non-CBT	No orientation reported
CTRS total	21.29 (8.32)	21.46 (7.45)	21.71 (7.54)	20.12 (7.18)	21.50 (9.62)
General therapy skills	2.59 (.75)	2.53 (.65)	2.58 (.67)	2.58 (.69)	2.62 (.87)
Feedback	1.54 (1.21)	1.30 (1.17)	1.60 (1.12)	1.64 (1.09)	1.57 (1.32)
Understanding	2.75 (.89)	2.76 (.93)	2.76 (.79)	2.69 (.73)	2.77 (.99)
Interpersonal effectiveness	3.51 (.95)	3.46 (.98)	3.52 (.86)	3.48 (1.01)	3.53 (.98)
Collaboration	2.56 (1.02)	2.60 (.99)	2.44 (.99)	2.52 (.78)	2.62 (1.19)
CBT skills	1.69 (.97)	1.75 (.87)	1.76 (.98)	1.55 (.92)	1.67 (1.05)
Guided discovery	2.08 (.97)	2.19 (.84)	2.09 (.83)	2.14 (1.02)	2.00 (1.08)
Focus on key cognitions and behavior	1.92 (1.13)	2.06 (1.05)	1.93 (1.11)	1.83 (1.19)	1.89 (1.17)
Strategy for change	1.47 (1.30)	1.43 (1.16)	1.63 (1.37)	1.24 (1.28)	1.51 (1.34)
Application of CBT techniques	1.28 (1.19)	1.33 (1.08)	1.47 (1.22)	.98 (1.05)	1.28 (1.26)
Structure	1.40 (.89)	1.44 (.91)	1.46 (.75)	1.20 (.75)	1.44 (1.01)
Agenda	1.08 (1.26)	1.14 (1.32)	1.09 (1.08)	.83 (1.05)	1.15 (1.41)
Pacing and efficient use of time	2.10 (1.07)	2.06 (1.03)	2.19 (.97)	1.95 (1.07)	2.14 (1.16)
Use of homework assignments	1.03 (1.21)	1.11 (1.23)	1.12 (1.15)	.83 (1.13)	1.04 (1.27)

$N = 321$. The potential range for the CTRS total score is 0–66. The potential range for all CTRS subscales and items is 0–6

CTRS Cognitive Therapy Rating Scale. CTRS subscale scores (i.e., general therapy skills, CBT skills, structure) reflect mean scores of all items comprising each respective subscale, *CBT* therapist reported orientation as exclusively CBT, *Eclectic CBT* therapist reported incorporating CBT strategies with non-CBT approaches, *Non-CBT* therapist reported their practice was of solely non-CBT orientations

consultation, 178 therapists (77.73 %) evidenced CBT competency (CTRS total score ≥ 40), and 51 (22.27 %) earned a score below the competency cut-off. Multinomial logistic regression analysis examined theoretical orientation (i.e., exclusively CBT, eclectic CBT, non-CBT, and no stated orientation) as a predictor of competency status following 6-months of consultation. Competency status included three groups: competent, not competent, and withdrawn. Results were non-significant (see Table 3).

Discussion

Therapists' identification as CBT therapists proved to be invalid as an indicator or predictor of the CBT skills ultimately demonstrated by this sample of community therapists. Although almost three quarters (71 %) of the therapists who identified a baseline primary orientation cited CBT as part or all of their clinical practice, identification as a CBT therapist was not associated with evidence of CBT in session. Equivalent, non-competent levels of CBT skills were displayed by therapists who identified as CBT- or non-CBT-oriented at baseline. These findings indicate that the therapist reports of the services they provide were not an accurate reflection of those services, and were therefore not an accurate gauge for policy makers, payers, or individuals seeking services to make informed decisions.

The disparity between therapist-labeled orientation and expert-observer ratings was also present at the mid-point

and endpoint of training, as therapists who identified with a CBT orientation fully or in combination with other orientations showed no difference in mean CTRS scores and were no more (or less) likely to reach competency in CBT than their non-CBT colleagues. Therefore, pre-existing identification with CBT, whether as a primary orientation or used eclectically with other orientations, was not a useful marker of therapists who would ultimately be successful in learning or applying CBT skills in this large-scale dissemination effort.

In further examination of the skills that were observed in baseline sessions, therapists' competency in general therapy skills, structure, and CBT skills were comparable regardless of whether those therapists identified themselves as CBT practitioners. Each of these skill sets increased from baseline to the midpoint of training, and again from midpoint to the end of training, and therapists' identified orientations were not related to the extent to which the skill sets grew. These findings further suggest that therapists who do not initially identify themselves as CBT therapists may learn and demonstrate CBT skills as successfully as therapists for whom CBT is consistent with their self-perception. Given that all three subscales increased across time points, regardless of orientation, and that gains on those highly-correlated subscale scores were not significantly different at each time point, the presence of common factors (e.g. strong general therapeutic skills) alone did not account for the non-significant differences in overall scores across orientation groups. The increases in general therapy skills were particularly of note, as skills related to common factors were outside of the scope of the training content. Given the strong correlations among the subscales, one may hypothesize that general therapeutic skills naturally developed as the other skills improved, or that stronger general therapy skills were associated with delivering other CBT skills competently. Alternatively, participation in weekly consultation with the Beck Initiative instructors and peers, or other factors, may account for the improved general therapy skills. These hypotheses should be subject to empirical study before any firm conclusions are made.

These data suggest that therapist report of the services they deliver may be inaccurate, overestimating the amount of evidence based practice present in their work. For payers and policy makers, these findings may add even more force to the push for the implementation of ESTs and EBPs in CBH care, such as the large-scale implementation program for which these baseline data were gathered. To ensure that ESTs are delivered with fidelity, methods other than therapist report should be implemented, perhaps including fidelity checks such as the CTRS with expert raters. Increases in competency may then be found in therapists regardless of whether they originally identified their practice as consistent with the approach. For consumers of services, these findings

Table 3 Multinomial logistic regression predicting competency status by therapist orientation

	95 % CI for odds ratio				<i>p</i> value
	B (SE)	Lower	Odds ratio	Upper	
Competent versus not competent					
Intercept	-1.04 (.24)	-	-	-	<.001
CBT	-.32 (.45)	.30	.73	1.74	.47
Eclectic CBT	-.30 (.42)	.33	.74	1.68	.47
Non-CBT	-.47 (.46)	.26	.63	1.55	.31
Competent versus discontinued data available					
Intercept	-1.08 (.25)	-	-	-	<.001
CBT	-.17 (.44)	.36	.84	1.98	.70
Eclectic CBT	.05 (.39)	.49	1.06	2.26	.89
Non-CBT	-.55 (.48)	.22	.57	1.48	.25

$n = 321$. $R^2 = .01$ (Cox and Snell), .01 (Nagelkerke). Model $\chi^2(6) = 2.81$, $p = .83$

CBT therapist described orientation as exclusively CBT, *Eclectic CBT* therapist described incorporating CBT strategies with non-CBT approaches, *Non-CBT* therapist described their practice using solely non-CBT orientations

may be particularly informative, as they suggest that a CBH therapist's description of his or her treatment approach may not be indicative of the services provided. Despite CBT (in whole or in combination with other approaches) being the most commonly named orientation among therapists, evidence of competent CBT was largely absent from practice. People who are seeking services may need to rely on more objective measures of a therapist's services, such as a board certification (e.g., American Board of Professional Psychology) or certification from a granting body (e.g., Academy of Cognitive Therapy, Dialectical Behavior Therapy Certification and Accreditation) for evidence of competency in specific approaches. In relation to dissemination efforts, therapists' orientation prior to training had no relationship to subsequent competency in this training program. If replication of these findings builds confidence in their generalizability, this may be interpreted as good news for dissemination efforts, as the achievement of competency may not be hindered by profession of another orientation prior to training.

Limitations and Future Directions

Although these findings shed some light on the components of treatment in CBH, caution must be used in interpreting the findings. First, these data represent only the participating therapists, rather than all therapists in the system. Administrators nominated therapists who met the prerequisites based on idiosyncratic criteria (e.g., those who expressed the greatest interest, those deemed to need more training). The Beck Initiative requested that participation be voluntary, but therapists may have felt varying degrees of freedom in declining the nomination. Replication of this study in more contexts is needed to determine whether the findings would extend to other treatment settings and systems. Therapist self-report of competency, in addition to their orientation, may help to broaden interpretation. Given that therapist data were collected as part of program evaluation, missing data were to be expected, but the missing data do present a limitation that could be addressed in future work to more comprehensively study therapist characteristics in CBH settings. Caution must also be used in interpreting null findings such as the non-significant differences among therapist groups. However, the coefficient of determination was very small ($R^2 = .01$) suggesting the model accounted for very little unexplained variance in the data. Treatment outcome data were not available, so examining the association between therapist orientation, characteristics of services delivered, and treatment outcome would illuminate the link between what happens in session and change in a person's functioning.

The measure used to identify therapist skills was based on CBT and therefore would not have effectively captured

other skills of therapists with a non-CBT orientation. However, given that the large majority of therapists identified CBT as at least a part of their practice, this evaluation would have effectively captured the presence of these oft-reported but rarely evidenced practices. The preponderance of CBT reported by the therapists also limited the variation in orientation among groups, with only one group identifying as exclusively non-CBT. The other three groups reported being exclusively CBT, partially CBT, or chose not to report an orientation (but likely included therapists who incorporated CBT into their practice), and the non-significant differences among these groups may be attributed to similarities among them. However, the non-CBT group evidenced a similar high rate of CBT competency by the end of training, suggesting that regardless of where a therapist began on the CBT continuum, they were similarly likely to demonstrate CBT skills by the end of training.

The disparity between therapists' reports of the services they were providing and the content of their sessions indicates that relying on CBH therapists to describe their treatment approach is insufficient. Dissemination and implementation of evidence-based practices are already an area of great interest to the field, and these findings underscore the fact that the need for this work in CBH is great. Independent confirmation of the delivery of these services with fidelity will also be essential, and board certifications may play an important role in this confirmation. As those efforts continue to spread, buyer beware: Being told that a therapist follows an evidence based approach may not be enough to ensure that evidence based practices will be present in the session.

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