Transdisciplinary Education in Cognitive-Behavioral Therapies: Strategies for Training Psychiatry Residents

Barbara W. Kamholz, Ph.D.[1]
Gabrielle I. Liverant, Ph.D.[2]
Cindy J. Aaronson, MSW, Ph.D.[3]
Justin M. Hill, Ph.D.[1]

[1]VA Boston Healthcare System & Boston University
[2]Suffolk University
[3]Icahn School of Medicine at Mount Sinai

ADAA, Miami 2015

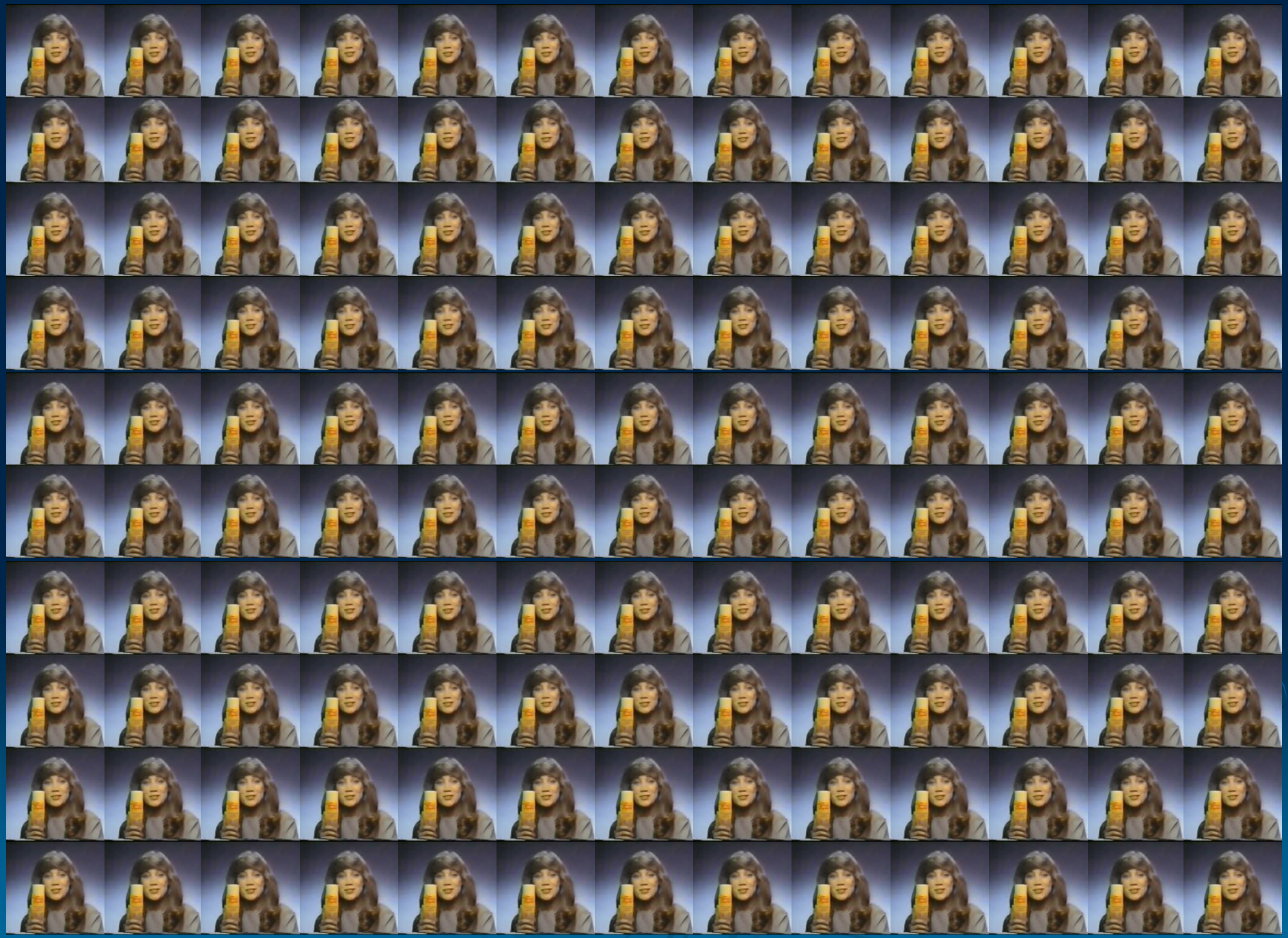
Disclosures

We have nothing to disclose.

Why train residents in CBT?

- Accreditation Council for Graduate Medical Education guidelines (ACGME, 2007)
- Professional collaboration & cross-pollination
- Integrated, evidence-based, patient care
- Potentially more palatable (or even effective?) psychopharmacology
- ADAA's mission "…to promote the … treatment, and cure of anxiety, depression, OCD, PTSD, and related disorders and to improve the lives of all those who suffer from them through education, practice, and research."
- Dissemination…

The Impact of Training



Language

How might a psychologist, psychiatrist, or social worker think about, and define:

Who are our MD and APN colleagues, and what do they do?

- “Doctor”
- “Prescriber”
- “Psychopharmacologist”

What are our Mental Health interventions?

- “Treatment”
- “Psychiatric Care”
- “Counseling”
- “Therapy”

Who are we treating?

- “Patient”
- “Client”
- “Consumer”

Context of Training:

Educational Background
History of Supervision
Future Practice

Psychiatry Education

- 4 years undergraduate studies
- 4 years medical school
  - School of allopathic medicine (M.D.)
  - School of osteopathic medicine (D.O.)
- 4 years psychiatry residency program
  - Psychotherapy training typically starts in PGY 2 or 3
  - Learning all mandated types of therapy simultaneously (psychodynamic, CBTs, and supportive psychotherapy)
- Sub-specialty fellowship

Psychology Education

- 4 years undergraduate studies
- Doctoral degrees in clinical and counseling psychology
- Ph.D. and Psy.D.
  - 4-5 years of coursework and dissertation
  - Practicum placements in years 2, 3, and 4
  - Predoctoral Internship
  - Postdoctoral Fellowship
- Programs have slightly different orientations and approaches to training

Social Work Education

(LICSW, not Ph.D.)

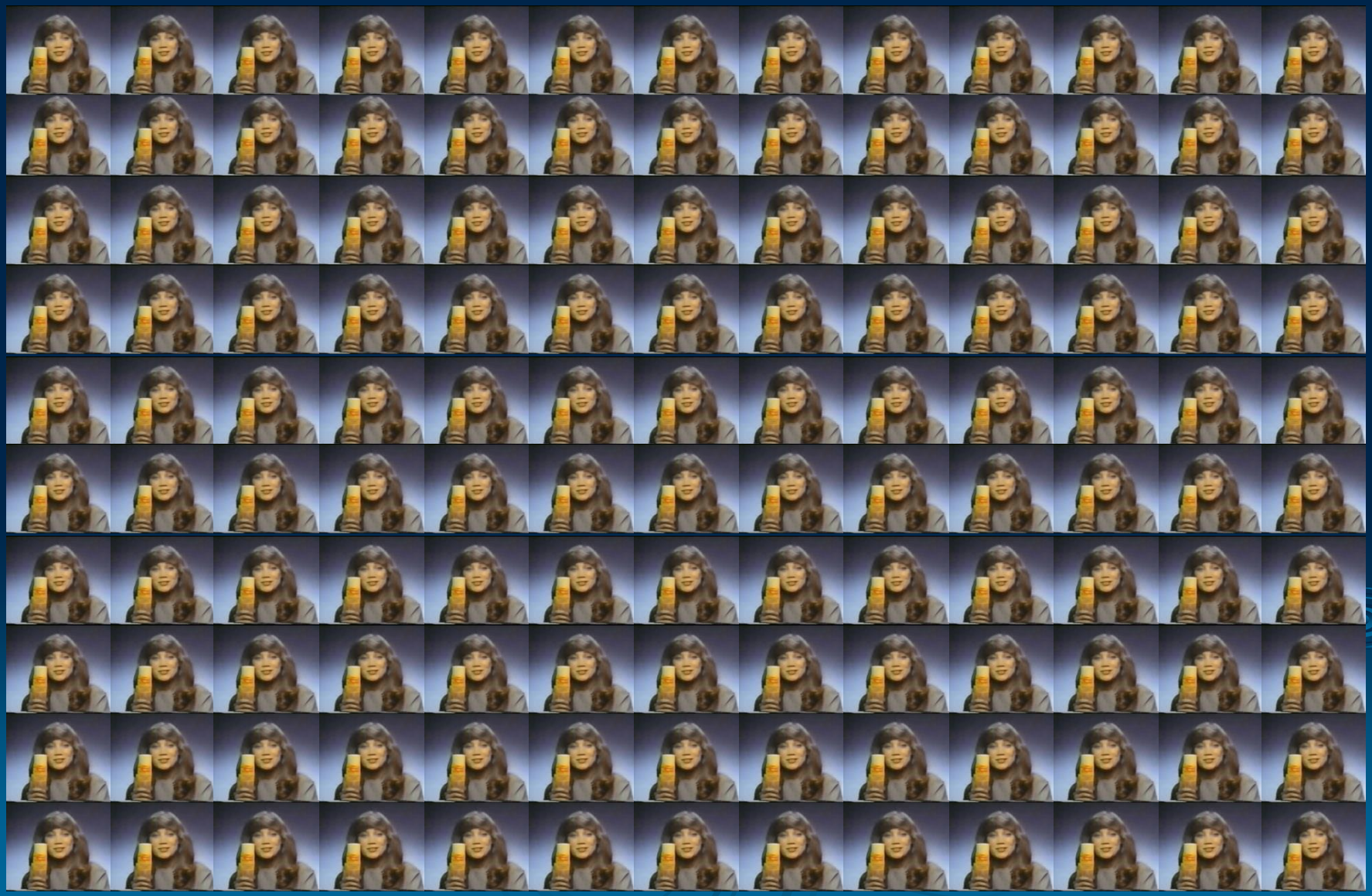
- 2-year Masters in Social Work
  - Yr 1: Course work and clinical training
  - Yr 2: Course work and larger field placement (“clinical internship” 640 hours)
- After MSW, exam to be a Licensed Clinical Social Worker (LCSW)
  - Cannot practice independently
- Licensed Independent Clinical Social Worker
  - Requires 2 years of full-time supervised clinical experience by a LICSW (3000 hours)
  - Exam

Past & Future

(History of Learning/Supervision & Future Practice)

	Psychiatry Residents	Psychology Trainees	Social Work Trainees
Focus	• More biological	• More psychosocial	• More psychosocial
Previous Treatment Experience	• Limited therapy experience (individual/group) • Limited structured interviews	• 4+ years of therapy experience • Likely CBTs, groups • Likely structured interviews	• 2+ years of therapy experience • Often CBTs, groups • Limited structured interviews
Previous Supervision/ Culture	• Often psychopharm. is primary • Less didactic, specific regarding therapy skills • Rounding format, impression management	• Focus on psychotherapy (often CBTs) • More directive, specific regarding therapy skills • Individual/group supervision, typically less impression management	• Focus on both psychotherapy & case management • More directive, specific regarding therapy skills • Individual/group supervision, typically less impression management
Presentation with Supervisors	• More focused on sxs/biology, more succinct, less context • More formal • Less frequent live observation	• More conceptual, more difficulty distilling key information • Less formal • More frequent live observation	• More conceptual, more difficulty distilling key information • Less formal • More frequent live observation
Likely Use of CBTs	• More brief • Resources, referrals	• More extensive • Primary CBT therapist	• More extensive • Primary CBT therapist

Dissemination & Collaboration



Training Challenges

Practical Challenges

- On-call schedules
- Other responsibilities (e.g., teaching)
- Vacations

Conceptual challenges

- Expectations for “competence”
- Who is a “good” or “appropriate” candidate for CBT?
- Anxiety and avoidance
- Biases about CBTs
- Information overload
- Serving many masters

Professional Context

- Journals and conferences
- Hospital hierarchies
- Residents' additional option: medication

Recommendations

- Integrate the basics of therapy knowledge and skills.
- Use data: CBT literature and more basic science to inform case conceptualizations and therapy.
- Provide multiple domains for learning (on- and off-rotation).
- Include modeling of CBTs, and direct observation/supervision.
- Highlight differences *and similarities* across therapy approaches.
- Be a thesaurus.

(More) Recommendations

- Maximize integration across trainees of different disciplines.
- Be respectful.
- Address interpersonal dynamics in the therapy relationship.
- Encourage *professional* vulnerability.
- Keep future applications salient.

Scenario 1:
Panic Treatment

Discussion

- Issues regarding role definition?
- How could the supervisor discuss the exposure rationale in light of the SSRI prescription?
  - Timing of the prescription
  - Type of medication
  - Paradigm shift from symptom control to habituation
- Other challenges?

Scenario 2:
Flexible application of CBTs

Discussion

- How can the supervisor help the resident translate CBT principles and techniques into interventions with the patient?
- What influence does the resident's training history have on his/her understanding on what CBT is, and how s/he approaches these challenges?
- Other challenges?

Syllabus

- **Key principles and interventions.** What key principles and/or interventions would you include?
- **Components of training.** What experiences would you include?
- **Patient load and type.** How many groups and individual patients should the residents see? Should the residents integrate psychopharmacology into treatment? (Pros/cons?)
- **Time.** How much time would you want with the residents? During what year(s) of their residency?
- **Staffing.** Who would staff the program? How many supervisors? Of what discipline(s)?
- **Instruction and Supervision.** How would you approach formal instruction? How would you structure supervision (consider degree of formality, individual vs. group)?
- **Evaluation of competence.** What constructs would you want to assess? What modalities and specific measures would you include?

VA Boston/ BUSM Program

Overview

- Training Focus:

  Theory, practice, and clinical data regarding cognitive-behavioral therapy (CBT) for mood and anxiety disorders
- Duration of training: 6 months
- On Site: All day Wednesdays
- Staff:
  - 3 psychologist supervisors (attendings)
  - 1 psychiatrist attending
  - Advanced psychology trainees/staff as group co-leaders

Structure

- Didactics Series (2x/month)
- Case Conceptualization Seminar (2x/month)
- CBT
  - Individual therapy (4-5 patients)
  - Group psychotherapy
    - Behavioral Activation for Depression
    - Cognitive Restructuring for Depression
- Supervision
  - Small & large group for individual patients
  - Small group for group therapy
  - Small group for skills lab
  - Psychopharmacology

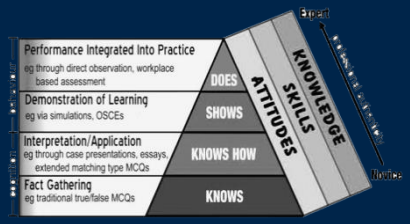
Didactic Series

Topics
Welcome/Orientation
CBT Model & Case Conceptualization
Behavioral Activation & Cognitive Restructuring for Depression
Schema-Focused Therapy
Dialectical Behavior Therapy
Suicidality: Assessment & Safety Planning
Suicidality: Intervention & Follow-up
Exposure Therapy
Acceptance and Commitment Therapy (ACT)
Process Issues in CBT
Interprofessional Issues
Termination Issues

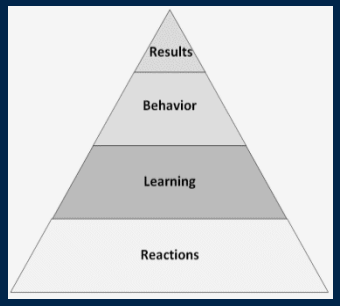
Competence & Its Assessment

Learning Models

Miller's Prism of Clinical Competence

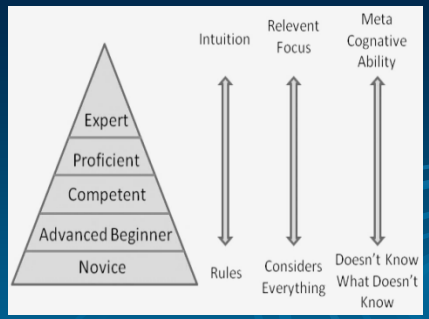


Kirkpatrick's Four Level Evaluation Model



Bloom's Taxonomy

Dreyfus's Model



Bloom, 1956; Dreyfus & Dreyfus, 1980; Kirkpatrick, 1967; Miller, 1990.

Assessment of Competence

- Literature is consistent regarding inclusion of cognitive, behavioral, and efficacy-based assessment.
- No broad, standardized, empirically-based assessment of competence.
- Ideally, include:
  - Tests of content knowledge
  - Performance-based evaluations
  - Outcomes-based assessment

Challenges

- Budget
- Time
- Staffing
- Considerations of level/time in training when setting expectations for “competence”

Recommendations

- Incorporate informal, direct observations of CBT.
- Include multi-method assessment of multiple learning domains (knowledge, attitudes, confidence, behavioral application, efficacy of intervention)
  - Self-report (e.g., Cognitive Therapy Awareness Scale, Wright et al., 2002)
  - Formal, observation-based rating scales (Cognitive Therapy Rating Scale, Young & Beck, 2009)
  - Patient measures of symptoms and/or functioning

Why train residents in CBT?

- Accreditation Council for Graduate Medical Education guidelines (ACGME, 2007)
- Professional collaboration & cross-pollination
- Integrated, evidence-based, patient care
- Potentially more palatable (or even effective?) psychopharmacology
- ADAA's mission "…to promote the … treatment, and cure of anxiety, depression, OCD, PTSD, and related disorders and to improve the lives of all those who suffer from them through education, practice, and research."
- Dissemination

On a more personal note…
(Our Endorsement)

- Fun!
- Challenging – outside our comfort zone, no longer preaching to the choir
- Residents are (mostly) eager to gain therapy & CBT skills
- Incremental gains are bigger
- Paradigm/qualitative shifts in thinking
- Psychopharmacology knowledge

Thanks to…

Colleagues and trainees in psychiatry, psychology, and social work

In particular:

Shimrit Black, Ph.D.

Barbara Cannon, M.D.

Domenic Ciraulo, M.D.

Amy Lawrence, Ph.D.

Janet Osterman, M.D.

John Renner, M.D.

Jason Satterfield, Ph.D.

Questions?

barbara.kamholz2@va.gov
gliverant@suffolk.edu
cindy.aaronson@mssm.edu
justin.hill2@va.gov