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

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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
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)

<table>
<thead>
<tr>
<th>Focus</th>
<th>Psychiatry Residents</th>
<th>Psychology Trainees</th>
<th>Social Work Trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>More biological</td>
<td>More psychosocial</td>
<td>More psychosocial</td>
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</table>

<table>
<thead>
<tr>
<th>Previous Treatment Experience</th>
<th>Psychiatry Residents</th>
<th>Psychology Trainees</th>
<th>Social Work Trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Limited therapy experience (individual/group)</td>
<td>4+ years of therapy experience</td>
<td>2+ years of therapy experience</td>
</tr>
<tr>
<td></td>
<td>Limited structured interviews</td>
<td>Likely CBTs, groups</td>
<td>Often CBTs, groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Likely structured interviews</td>
<td>Limited structured interviews</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous Supervision/Culture</th>
<th>Psychiatry Residents</th>
<th>Psychology Trainees</th>
<th>Social Work Trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Often psychopharm. is primary</td>
<td>Focus on psychotherapy (often CBTs)</td>
<td>Focus on both psychotherapy &amp; case management</td>
</tr>
<tr>
<td></td>
<td>Less didactic, specific regarding therapy skills</td>
<td>More directive, specific regarding therapy skills</td>
<td>More directive, specific regarding therapy skills</td>
</tr>
<tr>
<td></td>
<td>Rounding format, impression management</td>
<td>Individual/group supervision, typically less impression management</td>
<td>Individual/group supervision, typically less impression management</td>
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<table>
<thead>
<tr>
<th>Presentation with Supervisors</th>
<th>Psychiatry Residents</th>
<th>Psychology Trainees</th>
<th>Social Work Trainees</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>More focused on sxs/biology, more succinct, less context</td>
<td>More conceptual, more difficulty distilling key information</td>
<td>More conceptual, more difficulty distilling key information</td>
</tr>
<tr>
<td></td>
<td>More formal</td>
<td>Less formal</td>
<td>Less formal</td>
</tr>
<tr>
<td></td>
<td>Less frequent live observation</td>
<td>More frequent live observation</td>
<td>More frequent live observation</td>
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<table>
<thead>
<tr>
<th>Likely Use of CBTs</th>
<th>Psychiatry Residents</th>
<th>Psychology Trainees</th>
<th>Social Work Trainees</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>More brief</td>
<td>More extensive</td>
<td>More extensive</td>
</tr>
<tr>
<td></td>
<td>Resources, referrals</td>
<td>Primary CBT therapist</td>
<td>Primary CBT therapist</td>
</tr>
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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

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<thead>
<tr>
<th>Topics</th>
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<tbody>
<tr>
<td>Welcome/Orientation</td>
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<tr>
<td>CBT Model &amp; Case Conceptualization</td>
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<tr>
<td>Behavioral Activation &amp; Cognitive Restructuring for Depression</td>
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<tr>
<td>Schema-Focused Therapy</td>
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<tr>
<td>Dialectical Behavior Therapy</td>
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<tr>
<td>Suicidality: Assessment &amp; Safety Planning</td>
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<tr>
<td>Suicidality: Intervention &amp; Follow-up</td>
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<tr>
<td>Exposure Therapy</td>
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<td>Acceptance and Commitment Therapy (ACT)</td>
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<td>Process Issues in CBT</td>
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<td>Interprofessional Issues</td>
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<td>Termination Issues</td>
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Competence & Its Assessment
Learning Models

Miller’s Prism of Clinical Competence

Kirkpatrick’s Four Level Evaluation Model

Bloom’s Taxonomy

Dreyfus’s Model

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?

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- Integrated, evidence-based, patient care
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- 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:

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