

COMPETENCY IN CONDUCTING COGNITIVE–BEHAVIORAL THERAPY: FOUNDATIONAL, FUNCTIONAL, AND SUPERVISORY ASPECTS

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The delivery of cognitive–behavioral therapy (CBT) is described in terms of foundational and functional competencies, with additional attention paid to how these skills are applied in clinical supervision. Foundational competencies include such qualities as ethical behavior, good interpersonal relational skills, a healthy capacity for self-awareness and self-correction, cross-cultural sensitivity, and an appreciation for the empirical basis of clinical procedures. Functional competencies include the ability to think like an empiricist and to teach clients to do the same, to conceptualize cases in terms of maladaptive beliefs and behavioral patterns, to structure sessions in an organized and time-effective manner, and to assign and review homework assignments. CBT supervisors have the multiple responsibilities of serving as professional role models for their supervisees, nurturing the latter’s professional development (although also being ready to identify and remediate problems in the supervisee’s performance), and engaging in ongoing self-improvement and education to function most effectively as clinical mentors. A brief, descriptive supervisory vignette is presented.

Keywords: competence, supervision, empirically supported, cognitive–behavioral, techniques

Attaining and maintaining professional competency is a core value in the field of psychology (American Psychological Association, 2002). Clinicians are expected to receive appropriate education and supervision, to strive to provide a high standard of care to clients, to be mindful of their responsibilities to society at large, and to engage in continuing education over the years. Competent psychotherapy requires an integration of up-to-date knowledge of diagnostics, assessment methods, and interventions, interpersonal relational and communication skills, sense of timing, ethical judgment, self-awareness, acumen in collaborating with clients and colleagues alike, sensitivity toward diversity issues, and a respect for scientific methods of inquiry, among other qualities (Kaslow, 2004).

The “Cube” Model

A positive development in the conceptualization of psychotherapy competency has been the formulation of the “cube model” (Rodolfa, Bent, Eisman, Nelson, Rehm, & Ritchie, 2005), which examines expertise in conducting psychotherapy across three dimensions. In brief, these dimensions include *foundational* competencies that cut across all modalities of psychotherapy and comprise the broad concept of “professionalism,” such as adherence to ethical standards, a willingness to self-reflect and self-correct, cross-cultural sensitivity as it pertains to interacting with clients and supervisees, and interdisciplinary collaboration. The *functional* competencies have more to do with specific skills and knowledge, such as assessment and diagnosis, conducting supervision, and (especially in the case of cognitive–behavioral therapy; CBT) the ability to structure sessions, teach clients to perform rational reeval-

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uations exercises, conceptualize cases in terms of dysfunctional beliefs and behavioral patterns, and assign and review homework assignments that help clients learn durable self-help skills. The *developmental* dimension of the cube pertains to the practitioner's stage of training and experience. It has been argued that the measure of a psychotherapist's competence should not be assessed solely at one point in time, as is often the case when the licensing examination is the primary benchmark (Lichtenberg et al., 2007). Rather, emphasis should be placed on assessing competency in such a way that it is both commensurate with the therapist's experience level (e.g., graduate student or psychiatry resident, postdoctoral fellow, newly licensed practitioner, in practice for many years, in charge of the training and supervision of other clinicians, etc.), and facilitative of the value of lifelong learning (Kaslow, Rubin, Bebeau, et al., 2007).

Competency and Cognitive-Behavioral Therapy

Inherent in the quest to deliver CBT competently is the priority given to conducting clinical procedures that have been shown to be empirically efficacious, or at least are promising enough to be in the process of being evaluated as such. Examples of such methods include behavioral activation (e.g., Dimidjian, Martell, Addis, & Herman-Dunn, 2008) and rational reevaluation (e.g., Strunk, DeRubeis, Chiu, & Alvarez, 2007; Tang, Beberman, DeRubeis, & Pham, 2005) for depressed clients, graded anti-avoidance exercises and interoceptive exposures for clients with panic disorder (e.g., Addis et al., 2006), exposure and response prevention for the rituals of obsessive-compulsive disorder (Wilhelm & Steketee, 2006), repeated processing of trauma memories combined with rational reevaluation for posttraumatic stress clients (e.g., Resick, Monson, & Rizvi, 2008), and an extensive list of others. These CBT procedures are most competently delivered when therapists collect clinical data as a routine part of treatment, conduct well-organized and time-effective therapy sessions, teach clients self-monitoring and coping skills both in session and via homework assignments, offer empathy and support while empowering the clients via the transfer of skills, and explicitly aim to help clients maintain their

gains long after therapy has concluded (Newman & Beck, 2009).

A wealth of outcome data on a wide range of cognitive-behavioral treatments paints an extremely promising picture (Butler, Chapman, Forman, & Beck, 2006), though much work still needs to be done to find ways to help clients who are "nonresponders" to otherwise empirically supported treatments (Coffman, Martell, Dimidjian, Gallop, & Hollon, 2007). The fact that there are so many applications of CBT designed specifically for so many clinical problems and client populations (see Butler et al., 2006), along with the clinical reality that some clients are difficult to help sufficiently or to retain in treatment, begins to shed some light on the difficulties in defining competence in CBT. It is nearly impossible even for seasoned clinicians (much less therapists-in-training) to master literally dozens of separate (though related) treatment protocols (Dobson & Dobson, 2009). Further, though competency in doing CBT has been found to be positively related to client responsiveness (Kuyken & Tsivrikos, 2009; Trepka, Rees, Shapiro, Hardy, & Barkham, 2004), client characteristics still account for a significant proportion of the variance in outcome (Garfield, 1994). Nonetheless, there are identifiable benchmarks of competence in the delivery of CBT that make it more likely that clients will get the maximum benefits of the approach, the likes of which will be reviewed below.

Foundational Competency in CBT

The following is a brief, nonexhaustive summary of some of the key foundational competencies of conducting CBT. Although such competencies typically cut across all modalities of psychotherapy, it is useful to illustrate their application within a specific orientation such as CBT.

Respecting and Understanding the Scientific Underpinnings of the Treatment

Competent CBT practitioners have a fund of knowledge regarding the scientific foundations of cognitive theory of psychological disorders, while at the same time being aware of the limits of the knowledge base in the field (Clark, Beck, & Alford, 1999). They familiarize themselves and keep up-to-date with studies on CBT meth-

ods and outcomes for a range of clinical problems, and stay abreast of empirical developments on concepts such as cognitive styles, selective attention and recall, and schemas, among others. The competent CBT therapist brings a healthy skepticism to bear on his or her own work, being ever mindful of the need to test hypotheses in the manner of a skilled social scientist.

Skill in Managing the Therapeutic Relationship

Although CBT has garnered a stellar reputation as providing a plethora of useful therapeutic techniques, it is also true that the therapeutic relationship is of central importance in CBT (Gilbert & Leahy, 2007). There is recent evidence that the foundational competencies involved in building the therapeutic alliance and the functional competencies of CBT case formulation and interventions interact in compelling and unexpected ways. For example, in an outcome study of CBT for clients with avoidant personality disorder and obsessive–compulsive personality disorder, the most favorable outcomes tended to occur in clients who experienced significant alliance strains with their therapists but then resolved them favorably and completed the treatment protocol (Strauss et al., 2006). In addition, there is evidence that clients who are depressed and who learn the specific skills of CBT and then use them to gain some symptomatic relief often find that their therapeutic relationship improves as a result (DeRubeis, Brotman, & Gibbons, 2005; Feeley, DeRubeis, & Gelfand, 1999). The endeavors involved in the technical skills of CBT and the maintenance of a positive therapeutic relationship seem to act in a positive feedback loop (Newman, 2007).

Cultural Competency

The concept of cultural competency is being increasingly recognized as a critical skill for psychotherapists to appreciate and develop (see Tseng & Streltzer, 2004). For example, culturally competent Anglo American CBT therapists may understand that it is not necessarily a sign of excessive dependency for a man of East Asian ethnicity in his 20s to live with his parents. Rather, he may be fulfilling an important cultural role—that of filial piety. Thus, the CBT therapist will not jump to the conclusion that the client's belief that "I must be close to my parents and take

care of them" is necessarily dysfunctional. This same therapist may ascertain that the use of Socratic questioning with logical conclusions (a well-known feature of CBT) may miss the mark with this client, as an East Asian man may be more receptive to a less linear discussion of the contradictions that are inherent in one's inner and outer life (see Nisbett, 2003).

Intercollegial, Interdisciplinary Collaboration, and Consultation

Yet another related area of foundational competence has to do with the knowledge and facility to interact in a collegial, synergistic manner with health care professionals from other disciplines (Kaslow, Dunn, & Smith, 2008). For psychologists, this can mean consulting in a constructive and mutually enlightening manner with the prescribing psychiatrist on a shared case, coordinating with nursing staff in the logistics of a group therapy session on an inpatient ward, and brainstorming with social work professionals in the proper disposition of cases, including referrals to adjunctive services and treatments.

There is a growing trend toward applying the empirically supported methods of CBT in close coordination with primary care physicians and settings (DiTomasso, Golden, & Morris, 2010). This represents a promising use of the field's knowledge of the "mind–body connection" at the level of professional systems, with the promise of competent use of CBT principles to assist physicians with patients who evince unhealthy lifestyles, addictions, underlying mood disorders, nonadherence to medical advice, and other relevant problems in primary health care.

Functional Competencies of CBT

An overarching aspect of becoming an effective, competent CBT therapist is learning how to think like an empiricist. Collecting clinical data via reliable, valid means, generating and testing hypotheses, and devising sensible interventions based on these hypotheses are central features of being an empirically sophisticated clinician. In addition, one of the hallmarks of CBT is teaching the clients themselves to think more empirically. For example, the competent CBT therapist helps clients learn to make important distinctions between subjective impressions and objective evidence, to self-monitor relevant aspects of their

own functioning, to reduce the tendency to draw causal inferences from correlational circumstances, and to devise hypotheses that can be tested systematically via behavioral experiments and other appropriate means.

One of the clearest examples of clinical empiricism is the clinician's formulation of a case conceptualization as a set of hypotheses (Kuyken, Padesky, & Dudley, 2009) that are subject to testing and revision as new information is sought and attained. Similarly, the empirically minded CBT therapist does not jump to the conclusion that his or her CBT techniques (as summarized below) are in fact helping the clients without considering alternative hypotheses, and without using measures of progress that are suitably reliable, valid, or otherwise corroborated.

Core Techniques

In CBT, there are some core techniques that therapists need to practice and master to teach them to their clients, including:

- Self-monitoring (to take data on their most salient situations, thoughts, behaviors, emotions, and outcomes).
- Asking "guided discovery" questions to rationally reevaluate the automatic thoughts that produce unwarranted distress.
- Practicing new ways of functioning via role-playing in session and designing homework assignments such as behavioral experiments.
- Scheduling activities that have a reasonable chance to stimulate enjoyment and/or a sense of accomplishment.
- Relaxation and controlled breathing exercises to reduce hyperarousal (as in cases of excessive anxiety, fear, or anger), sometimes in the context of exposure to avoided situations or experiences, either in vivo or via guided imagery.
- Practicing and reviewing old skills and old homework assignments in novel situations to increase the chances of therapeutic maintenance.

Similarly, CBT therapists need to be able to reflect on their own skills regarding the above, and to keep them fresh so as to be of maximal fluency when it comes time to impart them to clients (Bennett-Levy, 2006). In keeping with the collaborative philosophy of CBT, therapists should be able to be directive through asking

guided discovery questions and by humbly posing hypotheses, rather than being too passive at the one extreme, or too authoritarian at the other.

There are a multitude of additional CBT techniques that can be creatively derived from the core techniques mentioned above. A review of such techniques goes beyond the scope of this paper, but the reader is referred to recent works that extensively explicate the full range of clinical strategies in the CBT repertory (e.g., Bennett-Levy et al., 2004; Freeman, Felgoise, Nezu, Nezu, & Reinecke, 2005; Leahy & Holland, 2000; O'Donohue, Fisher, & Hayes, 2008). Therapists who become facile in the appropriate and timely delivery of these techniques will be well-positioned to do highly competent CBT, if performed within the context of a collaborative therapeutic relationship and an accurate case conceptualization (Newman & Beck, 2009).

Attaining and Maintaining Functional Competency in CBT

The importance of quantity of practice should not be overlooked. Good CBT therapists should endeavor to practice their methods as much as possible. Having a large, active caseload is one way to achieve this goal over time, but it is just as plausible to improve competency via extensive role-playing (e.g., in supervision), and via the self-application of CBT techniques.

Even among experienced CBT therapists, straying from the active procedures occurs all too frequently, a phenomenon known as therapist "drift." In describing this problem, Waller (2009) hypothesizes that CBT therapists sometimes engage in "safety behaviors," as they reason that the client needs to feel better in the short term as the top priority, and that the rigorous activities of CBT are prohibitively stressful despite the long term benefits. Although this may be true at given moments in a session, it sometimes mistakenly becomes a therapist's general rule. The belief that the clients will not be able to handle or cope with CBT techniques leads therapists to revert mostly to supportive, nondirective methods, with the result that CBT is watered down. This will risk reducing the effectiveness of the treatment (including attenuating long-term maintenance of gains), as well as risking that the therapist will get "out of shape" in doing the more challenging activities of CBT such as exposure exercises, cognitive restructuring, relaxation and guided im-

agery, graded tasks assignments, and the assigning of homework. To develop and maintain expertise in a complicated task, whether it is surgery, sports, the performing arts, or CBT, there is no substitute for regular practice (Levitin, 2006).

According to a comprehensive report compiled by Roth and Pilling (2007) for the Department of Health in the United Kingdom, a competent therapist is respectful of the theory, rationale, structure, and procedures of a CBT manual for a given disorder and/or population, but is not restricted by a sense of rigid mandate to conduct a “one size fits all” treatment. As the authors noted

most of our competence lists for problem-specific interventions include an important metacompetence—the ability to introduce and implement the components of a program in a manner which is flexible and which is responsive to the issues the client raises, but which also ensures that all relevant components are included. (p. 19)

Competencies in the CBT Supervisory Process

Supervisors have multiple responsibilities, as they must be mindful of the well-being of the clients, while simultaneously assisting their supervisees (the therapists of these clients) in learning the skills to become independent practitioners who can deliver competent care. These are challenging concurrent tasks, and yet the field of psychotherapy has been slow to formalize the training of supervisory skills (Falender & Shafranske, 2007).

Foundational Competencies in CBT Supervision

Even a short overview of some of the foundational skills required of psychotherapy supervisors demonstrates the high level of professional functioning that is required. In the area of cultural competence, supervisors need to be aware not only of the special considerations for (and clinical implications of) treating clients of varying ethnic backgrounds, but also how these same factors may affect the supervisory relationship. At a minimum, supervisors need to be prepared to initiate discussions about diversity in supervision, as this modest step alone has been shown to improve the supervisory relationship (Falender & Shafranske, 2007). Supervisors also must be mindful of the power they wield in the lives of their trainees, in that their summative evaluations

of the novice therapists’ performance may have a significant impact on the trajectory of the latter’s career (Kaslow, Rubin, Bebeau, et al., 2007). Thus, supervisors must rise to the occasion in terms of creating, communicating, and sustaining a safe, growth-enhancing climate in which their supervisees can learn optimally to conduct therapy more and more competently. At the same time, supervisors have a very real responsibility to spot serious problems and deficits in their supervisees’ performance, to address them overtly toward the goal of remediation, and to serve as professional gatekeepers to protect the public in the event that the supervisee is unable or unwilling to make the necessary improvements in their professional behavior (Kaslow, Rubin, Forrest, et al., 2007).

Additional foundational competencies that clinical supervisors must demonstrate include (but are not limited to) being role models for ethical decision making, engaging in ongoing self-education about developments in the field, maintaining boundaries so that supervision does not morph into the personal therapy of the supervisee, and being adept at interdisciplinary collaboration and consultation (such as when the supervisor and supervisee both are psychologists, but the client is also seeing a pharmacotherapist whose input is needed). The supervisor also must possess a facile knowledge of diagnostics and related assessment, maintain records of supervision, assume responsibility for the care being received by the clients, and keep up-to-date in providing supervisees with evaluative feedback on their performance and progress.

Functional Competencies in CBT Supervision

In terms of CBT-specific functional skills, supervisors have to teach their trainees how to conceptualize cases in CBT terms (Kuyken et al., 2009), to direct the trainees toward resources (literature, videos, conferences) that will introduce them to a full range of technical skills, and to provide them with opportunities to practice such skills (e.g., role-playing in supervision sessions, participation in special training sessions and/or treatment studies).

Supervisors periodically listen to their supervisees’ recorded sessions with their clients so as to provide the supervisees with highly specific feedback that potentially has maximum instructional value (Beck, Sarnat, & Barenstein, 2008;

Newman & Beck, 2008). To give their supervisees quantitative and qualitative ratings, supervisors often use the Cognitive Therapy Scale (CTS: Young & Beck, 1980), which captures the essential “required elements” of a typical cognitive therapy session, along with the therapist’s proficiency (on a well-described, well-anchored scale of 0–6) in implementing each of these elements. Items include setting an agenda, collaboration, focusing on key cognitions and behaviors, understanding, strategy for change, eliciting feedback, reviewing and assigning homework, and others. It should be noted that the criterion of setting an agenda is particularly important as a means by which to assess how well the session is structured. The CTS has had a major, longstanding influence on how CBT therapists have been trained, and no other extant measure has been as successfully validated against clinical outcomes (Trepka et al., 2004).

Sample CBT Supervision in Action

The following, brief dialogue between a supervisor and supervisee serves as an illustration, with parenthetical commentary in italics below each statement to explicate the competencies that are being addressed in the supervision session.

Therapist: My client, Mr. B., typically fails to do his homework. He says things such as, “I know I should do it, but I just never follow through. Why do I do that?” It’s as if he is putting the burden on me to explain his noncompliance. I feel stuck, and frustrated with this case. *(The therapist is assigning homework—a functional competency in CBT—but feels stymied in managing the client’s avoidance of the homework).*

Supervisor: I totally understand. You are working hard to help this client, spending time devising well-conceptualized homework assignments that fit his needs, and giving Mr. B. good instructions and a rationale, yet he habitually fails to do the work and instead behaves in a helpless manner time after time. No wonder you feel frustrated. *(The supervisor exercises the foundational skill of being supportive of the trainee, giving positive feedback regarding the various ways in which the trainee is successfully utilizing functional competencies, and being empathic about the unexpected difficulties).*

Therapist: Sometimes I seriously wonder if I should just give up on trying to give him homework altogether. *(The therapist feels safe enough in the supervisory relationship to reveal her pessimism about continuing with an important part of the treatment plan).*

Supervisor: Instead of stopping the homework, let’s try to conceptualize what is going on with Mr. B. by hypothesizing the schemas that may underlie his therapy-interfering behaviors. *(The supervisor nicely recommends an alternative strategy that requires the therapist to use conceptual skills, a*

functional competency with special reference to the schema-focus of CBT case formulation).

Therapist: I have already tried to offer hypotheses to Mr. B., such as saying that maybe the thought of trying to do his homework activates his sense of incompetency, but when I ask for his feedback on the matter he just says, “I don’t know, you’re the expert.” *(The therapist has tried to take a conceptual approach to understand the client’s nonadherence, but still feels blocked).*

Supervisor: I think you and I can brainstorm some ways to get past this roadblock. Anecdotal experience tells us that when we ask highly avoidant clients difficult, probing questions, their modal answer is “I don’t know.” The question is, “What can we do with this?” If we can find ways to encourage and reinforce your client to do more of the work in therapy, we may find that not only will his avoidance diminish, but his depression may remit as well. *(The supervisor continues to apply the foundational skills of bolstering hope and facilitating the supervisory relationship, and by extension the trainee’s alliance with her client. The supervisor also utilizes the CBT functional skill of remaining structured, on task, and goal-directed).*

Therapist: I hope we can brainstorm some ways to encourage Mr. B. to be more active and participatory, but I have to admit that I have some doubts about myself. I often get impatient with Mr. B., and I have a tendency to answer my own questions when he gets into “helplessness mode.” I “rescue” him, and then I resent him, and then I start doubting my ability to help him, and I know that all of that can’t be helpful! *(The therapist reveals some of the countertherapeutic patterns she has noticed in her interactions with her client, thus showing the foundational competency of self-assessment).*

Supervisor: Nice self-assessment—I’m very impressed! Let’s use that skill and take it further. What are some rational responses you would give yourself in order to reduce your self-doubts, and maybe even to reduce your resentment toward the client? I think you have the proper attitude to do this well. *(The supervisor’s foundational skills of relationship-building dovetail with the functional skills of positively reinforcing the trainee’s growth-enhancing willingness to monitor herself. The supervisor suggests that the trainee could practice the functional CBT skill of cognitive restructuring to begin to remediate her problems with clients such as Mr. B.).*

Therapist: I guess I can remind myself that “it’s all data,” as you always say (laughs). I can tell myself to turn a problem into a chance to do some problem solving, rather than ruminating about what isn’t going well. *(Therapist responds to the supervisor’s support by mobilizing her functional skill of rational responding, and applying it to herself).*

Supervisor: I would be happy to listen to one of your recordings of your sessions with Mr. B. so I can give you more specific feedback. If you’re okay with this, just make sure that Mr. B. is given informed consent about the use of the recording, and then feel free to give me the CD. *(Supervisor volunteers to monitor and supervise the therapist’s work more directly, showing a commitment to the teaching process, while modeling the foundational competency of the ethical principle of informed consent for clients).*

The competent supervisor identifies the trainees’ personal strengths and encourages them to

use these capabilities in the service of the treatment (e.g., appropriate humor), rather than making them subservient to a monolithic method. Likewise, the competent supervisor identifies areas of weakness and is able to address them directly and tactfully so that the supervisees will be able to improve on these lacunae in functioning as CBT therapists, without feeling unduly discouraged. Good supervisors teach their trainees to use the methods of CBT on themselves to become more adept at teaching the methods to their clients (Bennett-Levy, 2006). At the same time, supervisors know where to draw the line between supervision and therapy, advising troubled supervisees to seek their own counseling, while keeping supervision focused squarely on the wellness of the clients, and the professional development of the supervisee.

Conclusions

The field of psychotherapy has mobilized to address the pressing matter of what comprises “competency” in conducting psychotherapy, and how that concept develops over the course of an individual’s training and career. Practitioners of CBT must strive to achieve and to demonstrate growth in the high levels of foundational competence that cut across different modalities of psychotherapy, such as maintaining ethical attitudes and behaviors, learning about (and therefore practicing with sensitivity to) diversity issues, demonstrating warmth and genuineness in the therapeutic relationship, and exercising professional humility and collaborative communication in consultation with professional peers, among other skills. They must also invest time and energy to repeatedly practice the core functional competencies, which include formulating cognitive case conceptualizations, teaching clients to self-monitor and rationally respond to their dysfunctional thinking, helping clients become more behaviorally active, using guided discovery questions, and assigning and reviewing homework, among other methods.

Good supervision is necessary to help trainees turn raw skills into refined skills, and to learn to integrate the foundational and functional competencies of CBT so as to deliver empirically supported treatments in the manner in which they were conceptualized and intended. Unfortunately, insufficient attention has been paid to the training of the supervisors themselves, a situation

that needs to change, but that also suffers from the same (if not greater) difficulties as in defining, promoting, and measuring competencies among CBT therapists. This paper has presented a brief sample of expert CBT supervision that facilitates the performance of the therapist while promoting the competent care of the client. As such, it serves as a good model for the mentoring of practitioners who are trying to master the methods of CBT.

References

- ADDIS, M. E., HATGIS, C., CARDEMIL, E., JACOB, K., KRASNOW, A. D., & MANSFIELD, A. (2006). Effectiveness of cognitive-behavioral treatment for panic disorder versus treatment as usual in a managed care setting: 2-year follow-up. *Journal of Consulting and Clinical Psychology, 74*, 377–385.
- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, 1060–1073.
- BECK, J. S., SARNAT, J. E., & BARENSTEIN, V. (2008). Psychotherapy-based approaches to supervision. In C. A. Falender & E. P. Shafranske (Eds.), *Casebook for clinical supervision: A competency-based approach* (pp. 57–96). Washington, DC: American Psychological Association.
- BENNETT-LEVY, J. (2006). Therapist skills: A cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy, 34*, 57–78.
- BENNETT-LEVY, J., BUTLER, G., FENNELL, M., HACKMANN, A., MUELLER, M., & WESTBROOK, D. (2004). *The Oxford guide to behavioural experiments in cognitive therapy*. Oxford, England: Oxford University Press.
- BUTLER, A. C., CHAPMAN, J. E., FORMAN, E. M., & BECK, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26*, 17–31.
- CLARK, D. A., BECK, A. T., & ALFORD, B. A. (1999). *Scientific foundations of cognitive theory and therapy of depression*. Hoboken, NJ: Wiley.
- COFFMAN, S. J., MARTELL, C. R., DIMIDJIAN, S., GALLOP, R., & HOLLON, S. D. (2007). Extreme non-response in cognitive therapy: Can behavioral activation succeed where cognitive therapy fails? *Journal of Consulting and Clinical Psychology, 75*, 531–541.
- DERUBEIS, R. J., BROTMAN, M. A., & GIBBONS, C. J. (2005). A conceptual and methodological analysis of the nonspecifics argument. *Clinical Psychology: Science and Practice, 12*, 174–183.
- DIMIDJIAN, S., MARTELL, C. R., ADDIS, M. E., & HERMAN-DUNN, R. (2008). Behavioral activation for depression. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (4th ed., pp. 328–364). New York, NY: Guilford Press.
- DI TOMASSO, R. A., GOLDEN, B. A., & MORRIS, H. (Eds.). (2010). *Handbook of cognitive-behavioral approaches in primary care*. New York, NY: Springer.
- DOBSON, D., & DOBSON, K. S. (2009). *Evidence-based*

- practice of cognitive-behavioral therapy. New York, NY: Guilford Press.
- FALENDER, C. A., & SHAFRANSKE, E. P. (2007). Competence in competency-based supervision: Construct and application. *Professional Psychology: Research and Practice, 38*, 232–240.
- FEELEY, M., DERUBEIS, R. J., & GELFAND, L. A. (1999). The temporal relation of adherence and alliance to symptom change in cognitive therapy for depression. *Journal of Consulting and Clinical Psychology, 67*, 578–582.
- FREEMAN, A., FELGOISE, S. H., NEZU, A. M., NEZU, C. M., & REINECKE, M. A. (Eds.). (2005). *Encyclopedia of cognitive behavior therapy*. New York, NY: Springer.
- GARFIELD, S. L. (1994). Research on client variables in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 190–228). Oxford, England: Wiley.
- GILBERT, P., & LEAHY, R. L. (2007). *The therapeutic relationship in cognitive-behavioral therapy*. London, England: Routledge-Brunner.
- KASLOW, N. J. (2004). Competencies in professional psychology. *American Psychologist, 59*, 774–781.
- KASLOW, N. J., DUNN, S. E., & SMITH, C. O. (2008). Competencies for psychologists in academic health centers (AHCs). *Journal of Clinical Psychology in Medical Settings, 15*, 18–27.
- KASLOW, N. J., RUBIN, N. J., BEBEAU, M. J., LEIGH, I. W., LICHTENBERG, J. W., NELSON, P. D., . . . SMITH, I. L. (2007). Guiding principles and recommendations for the assessment of competence. *Professional Psychology: Research and Practice, 38*, 441–451.
- KASLOW, N. J., RUBIN, N. J., FORREST, L., ELMAN, N. S., VAN HORNE, B. A., JACOBS, S. C., . . . THORN, B. E. (2007). Recognizing, assessing, and intervening with problems of professional competence. *Professional Psychology: Research and Practice, 38*, 479–492.
- KUYKEN, W., PADESKY, C. A., & DUDLEY, R. (2009). *Collaborative case conceptualization: Working effectively with clients in cognitive-behavioral therapy*. New York, NY: Guilford Press.
- KUYKEN, W., & TSIVRIKOS, D. (2009). Therapist competence, co-morbidity, and cognitive-behavioral therapy for depression. *Psychotherapy and Psychosomatics, 78*, 42–48.
- LEAHY, R. L., & HOLLAND, S. J. (2000). *Treatment plans and interventions for depression and anxiety*. New York, NY: Guilford Press.
- LEVITIN, D. J. (2006). *This is your brain on music: The science of a human obsession*. New York, NY: Plume.
- LICHTENBERG, J. W., PORTNOY, S. M., BEBEAU, M. J., LEIGH, I. W., NELSON, P. D., RUBIN, N. J., . . . KASLOW, N. J. (2007). Challenges to the assessment of competence and competencies. *Professional Psychology: Research and Practice, 38*, 474–478.
- NEWMAN, C. F. (2007). The therapeutic relationship in cognitive therapy with difficult-to-engage clients. In P. Gilbert & R. L. Leahy (Eds.), *The therapeutic relationship in cognitive-behavioral psychotherapy* (pp. 165–184). London, England: Routledge-Brunner.
- NEWMAN, C. F., & BECK, A. T. (2009). Cognitive therapy. In R. M. Kaplan & B. J. Saddock (Eds.), *Comprehensive textbook of psychiatry* (9th ed., pp. 2857–2873). Baltimore, MD: Lippincott, Williams, & Wilkins.
- NEWMAN, C. F., & BECK, J. S. (2008). Selecting, training, and supervising therapists in randomized controlled trials. In A. M. Nezu & C. M. Nezu (Eds.), *Evidence-based outcome research: A practical guide to conducting randomized controlled trials for psychosocial interventions* (pp. 245–262). Oxford, England: Oxford University Press.
- NISBETT, R. E. (2003). *The geography of thought: How Asians and westerners think differently: And why*. New York, NY: Free Press.
- O'DONOHUE, W., FISHER, J. E., & HAYES, S. C. (Eds.). (2008). *Cognitive behavior therapy: Applying empirically supported techniques in your practice*. New York, NY: Wiley.
- RESICK, P. A., MONSON, C. M., & RIZVI, S. L. (2008). Posttraumatic stress disorder. In W. E. Craighead, D. J. Miklowitz, & L. W. Craighead (Eds.), *Psychopathology: History, diagnosis, and empirical foundations* (pp. 234–278). Hoboken, NJ: Wiley.
- RODOLFA, E., BENT, R., EISMAN, E., NELSON, P., REHM, L., & RITCHIE, P. (2005). A cube model for competency development: Implications for psychology educators and regulators. *Professional Psychology: Research and Practice, 36*, 347–354.
- ROTH, A. D., & PILLING, S. (2007). *The competences required to deliver competent cognitive and behavioural therapy for people with depression and with anxiety disorders* (Manual prepared for the Department of Health, United Kingdom).
- STRAUSS, J. L., HAYES, A. M., JOHNSON, S. L., NEWMAN, C. F., BARBER, J. P., BROWN, G. K., . . . BECK, A. T. (2006). Early alliance, alliance ruptures, and symptom change in cognitive therapy for avoidant and obsessive-compulsive personality disorders. *Journal of Consulting and Clinical Psychology, 74*, 337–345.
- STRUNK, D. R., DERUBEIS, R. J., CHIU, A. W., & ALVAREZ, J. (2007). Clients' competence in and performance of cognitive therapy skills: Relation to the reduction of relapse risk following treatment for depression. *Journal of Consulting and Clinical Psychology, 75*, 523–530.
- TANG, T. Z., BEBERMAN, R., DERUBEIS, R. J., & PHAM, T. (2005). Cognitive changes, critical sessions, and sudden gains in cognitive-behavioral therapy for depression. *Journal of Consulting and Clinical Psychology, 73*, 168–172.
- TREPKA, C., REES, A., SHAPIRO, D. A., HARDY, G. E., & BARKHAM, M. (2004). Therapist competence and outcome of cognitive therapy for depression. *Cognitive Therapy and Research, 28*, 143–157.
- TSENG, W. S., & STRELTZER, J. (Eds.). (2004). *Cultural competence in clinical psychiatry*. Washington, DC: American Psychiatric.
- WALLER, G. (2009). Evidence-based treatment and therapist drift. *Behaviour Research and Therapy, 47*, 119–127.
- WILHELM, S., & STEKETEE, G. S. (2006). *Cognitive behavioral treatment for obsessive-compulsive disorder: A guide for professionals*. Oakland, CA: New Harbinger.
- YOUNG, J., & BECK, A. T. (1980). *Cognitive therapy rating scale manual*. Unpublished manuscript. University of Pennsylvania, Philadelphia.