

# A Compendium of Counselling & Psychotherapy Resources for Occupational Therapists

Second Edition



**“If you have knowledge, let others light  
their candle in it”**

*Margaret Fuller*



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Ontario Society of  
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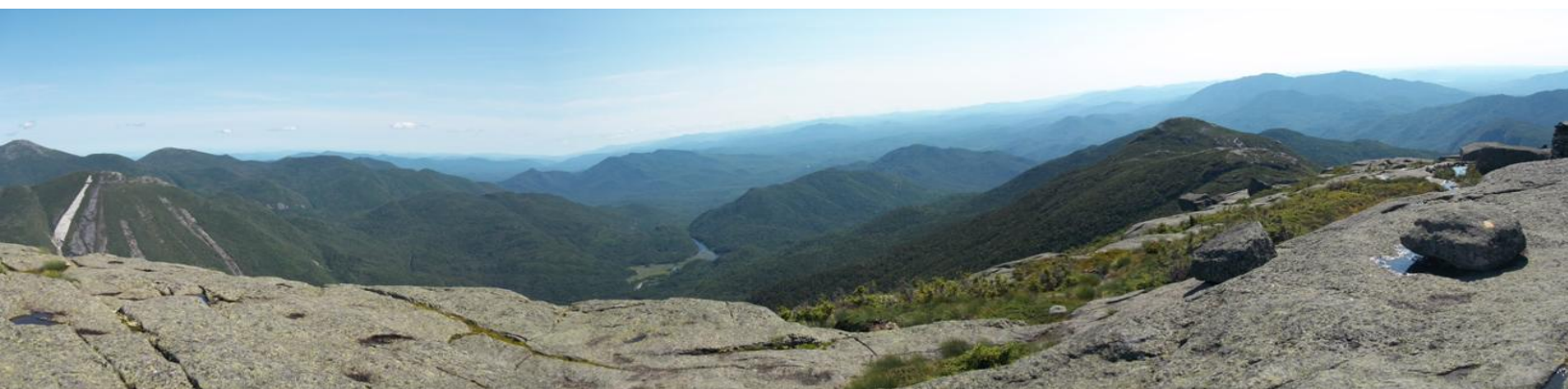
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### Suggested Reference:

Moll, S., Detwiler, L., Marshall, C., Good, C., Eisen, S. & Tryssenaar, J. A Compendium of Counselling and Psychotherapy Resources for Occupational Therapists.

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# Acknowledgements

The development of this compendium would not have been possible without the support and contributions of a large community of contributors. This page acknowledges those who have been involved in various stages of development of the compendium. A big thank you to the bright and talented group of people who have graciously offered their time and efforts!

## **We would like to thank the following occupational therapists who contributed to the development of specific sections of the compendium:**

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## **Thanks to the following individuals who contributed references and resources:**

Sandra Bennett, CAMH Education Specialist  
Jana Kiefl & Jeremy Wong (MSc. OT Students, University of Toronto) [Supervision]  
Jennifer Somers & Kari Isaacson (MSc. OT Students, McMaster University) [CBT & MI]  
Juverya Pathan & Carolyn Wong, (MSc. OT Students, University of Toronto) [MI]

## **Thanks to the following librarians who assisted with the literature search:**

Vicky Lyndham, Mount Sinai Librarian  
Sarah Bonato, CAMH Librarian

## **Thanks to the following professionals who provided feedback and peer review of various sections of this document:**

Carla Giddings, OT Reg. (Ont.), MSc. (OT), MA. (CBT)  
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## **Thank you to the Ontario Society of Occupational Therapists!**

Funding for this project was provided initially by the Ontario Society of Occupational Therapists Research Fund Strategic Priorities Grant (2012-2013). In order to revise and update the document for the second edition, an Ontario Society of Occupational Therapists Research Grant (2014-2015) was provided. Without this support, the compendium would not have been created. This support made both versions of this compendium possible.



**Gestalt Therapy section dedication:**

We would like to dedicate the Gestalt Therapy Chapter to Joanne Greenham, Former Executive Director of the Gestalt Institute of Toronto and Occupational Therapist. Joanne touched many lives with her passion, humor, incredible talent and powerful teachings of Gestalt therapy.



# Development of the Compendium

This document was originally created for Ontario occupational therapists as one of the products of an OSOT Research Fund Strategic Priorities Grant for 2012-2013 entitled “Psychotherapy: Advancing the Competence of Ontario OTs.” As part of the project, a provincial survey was completed by over 300 occupational therapists in the fall of 2012 that explored the psychotherapy practice trends and learning/support needs of occupational therapists who work in the area of mental health, addictions and/or chronic pain. The top five psychotherapy approaches reported by therapists included (in order of frequency of use in practice): Cognitive-Behavioural therapy, Motivational Interviewing, Mindfulness (including Mindfulness Based Stress Reduction/Mindfulness Based Cognitive Therapy), Solution-Focused therapy, and Dialectical Behaviour Therapy. When asked about learning needs, a similar same rank ordering was evident. As a result, these five psychotherapy approaches were the focus for the first version of the compendium. The information included in this document is based on a review of the literature as well as internet sites related to each psychotherapy approach. Input was gathered from Ontario occupational therapists who have expertise and advanced training in each of the approaches that have been explored in the various sections of the compendium.

## *Changes Introduced in this Edition*

The current version of this document was developed through the support of an OSOT Occupational Therapy Research Grant for 2014-2015. The primary intent of this revision was to subject the existing sections of the compendium to a peer review process, as well as to expand upon its breadth. This involved introducing new sections that focus on Gestalt therapy, as well as Supervision in the development of psychotherapy competency. Additional changes in this version include enhanced formatting, and the addition of a new and consistent format. In terms of content, new headings were included in each of the sections to enhance navigation and readability including ‘key terms,’ and ‘key components’ sections. Key terms are only listed in each section are defined in a ‘key terms defined’ section in the appendix. A further heading was added to each section of the compendium to tailor the content to reflect the practice of occupational therapists. This section is entitled ‘relevance to occupational therapy,’ in order to identify the ways in which the approach may be applied within the context of OT practice.

## *How to use this Document*

This resource is intended to be a starting point for therapists who practice or intend to practice specific forms of psychotherapy. In each section, an overview of the approach is provided, including evidence supporting its use in practice followed by general information about competency development, practice resources, and references. It should be noted that although we had input from librarians to gather information, we have not conducted a systematic review or critical appraisal of the literature, therefore readers are encouraged to critically examine the information presented. Appendix A includes a tool to facilitate critical reflection on training opportunities. Also, it should be noted that training and supervision in the identified approaches is required to be competent to practice. We hope that the information provided will help you to navigate the resources to build your competence and credibility as an OT who practices psychotherapy. The field of psychotherapy is rapidly evolving; therefore it is important to be aware of changes to practice, and in the evidence-based literature to ensure that you are implementing best practice principles of the psychotherapy approach.

## *Key Terms*

Key terms listed in each section of the document are defined in a 'key terms defined' section in the appendix. Please refer to this section when a definition is sought. Users of the compendium are encouraged to seek out further information with respect to these terms in other sources as well.

## *Feedback*

This compendium is not intended to be a static document, but a dynamic tool that will continually be updated and improved upon over time. Input and feedback is welcome and will be considered in revised versions of the compendium. Please send your feedback to the following email address: [otpsychotherapy@hotmail.com](mailto:otpsychotherapy@hotmail.com)



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# Introduction

The psychotherapy act was proposed in 2007. In 2006 when the Health Professions Regulatory Advisory Council (HPRAC) proposed a number of recommendations regarding the regulation of psychotherapy as a controlled act under the Regulated Health Professions Act, extensive lobbying by the Ontario Society of Occupational Therapists (OSOT) resulted in the exemption of occupational therapy from the restriction of the protected scope of practice of psychotherapy.

On April 1, 2015, the psychotherapy act was proclaimed, which elicited the full implementation and operation of the newly created College of Registered Psychotherapists of Ontario. Proclaiming Psychotherapy as a controlled act, however, has been postponed. This period will provide the time necessary to identify the implications of this proclamation on the mental health system, and implications for professionals who are not given access to this controlled act. The title of psychotherapist, however, is now a protected title, and only those who are members of the College of Psychotherapists of Ontario may refer to themselves as Psychotherapists. Occupational therapists who perform psychotherapy will continue to refer to themselves as occupational therapists who perform psychotherapy unless they have formally registered with the College of Psychotherapists of Ontario.

## *Psychotherapy Definition*

The practice of psychotherapy as defined by HPRAC legislation is “the assessment and treatment of cognitive, emotional or behavioural disturbances by psychotherapeutic means, delivered through a therapeutic relationship based primarily on verbal or non-verbal communication.” (HPRAC, 2007, c. 10, Sched. R, s. 3.). According to the legislation, psychotherapy is a controlled act only as it applies to individuals who have a “serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual’s judgement, insight, behaviour, communication or social functioning.’ (HPRAC, 2007, c. 10, Sched. R, s. 4).

The College of Occupational Therapists of Ontario has adopted a more detailed definition of psychotherapy; “any form of psychological intervention for psychiatric or emotional disorders, behavioural maladaptations and/or other problems that are assumed to be of a psychological nature, in which a practitioner deliberately establishes a professional relationship with a patient/client for the purposes of removing, modifying or retarding existing symptoms, or attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development. ” (COTO, 2010, p.3). Psychotherapy is not one approach, but a collection of many potential approaches, including psychoanalysis, cognitive-behavioral therapy, and dialectical-behaviour therapy to name a few. Defining the difference between psychotherapy and counselling is an issue that many therapists find difficult. Although there is some overlap, the COTO standards stipulate that psychotherapy typically focuses on clients’ emotional issues and a deeper process of change, adopting a theoretical approach that may include development of insight about thoughts, feelings and behaviors. Counseling, on the other hand, is typically less formal with less emotional intensity and may involve education, guidance,

supportive problem solving, or advice giving. The process may be less theory driven and focused more on short-term solutions to a specific problem or issue. There is typically less psychological and emotional risk associated with counseling as opposed to psychotherapy.

### *College of Occupational Therapists of Ontario Standards*

Given the profession's responsibility for the controlled act of psychotherapy and the risks associated with improper application of psychotherapy techniques, occupational therapists must ensure that they are competent to practice. The College of Occupational Therapists of Ontario (COTO) has developed Standards of Practice for Psychotherapy (COTO, 2010). The Standards identify the required knowledge, training, skills, attitudes, abilities and judgment that therapists need to perform this intervention safely, ethically and effectively. The Standards were amended in 2013 to include the standard for use of the title psychotherapist (COTO, 2013). Therapists are encouraged to read the COTO guidelines to understand the standards of practice.

The COTO document outlines general standards for practice, but does not provide guidance for therapists on how to meet these standards. A provincial survey conducted by COTO revealed significant variability in the knowledge and skill of practicing clinicians (Chan & Nanda, 2009). The survey results revealed that the top two concerns identified by 80-90% of the respondents were "attaining competency," and "performing psychotherapy within the scope of OT practice." These concerns prompted the authors of this document to conduct another survey of therapists in the fall of 2012 to explore the practice and support needs of therapists, and to explore the literature regarding approaches to training and supervision. Findings from the survey are outlined in an article in the Canadian Journal of Occupational Therapy (Moll, Tryssenaar, Good & Detwiler, 2013).

### *Defining Competence*

In this document, we have made an effort to note competency standards that are outlined in the literature. There are a number of basic competencies that seem to be generic to most forms of psychotherapy, including an ability to establish a therapeutic alliance, manage treatment boundaries, listen nonjudgmentally, ask questions, understand and address emotions, provide support, deal with resistance, assess readiness to change, tailor interventions to client needs, and manage termination (Manring, Beitman & Dewan, 2003). Training in these core skills is typically part of occupational therapy education. In addition, however, there are many specialized skills associated with specific psychotherapy approaches. For example, CBT incorporates many specific techniques with more than 50 specific competencies such as the use of thought records or core belief work that require specialized training (Roth & Pilling, 2007). There is considerable variability from one approach to the next in terms of the clarity and specificity of this information, but competence requirements and tools for self-evaluation of competence have been listed when available. Competency is a process of moving from novice to expert with many intermediate stages. Training and supervision are critical to ongoing competency development.

## *Training*

It should be noted that there is variability in terms of the type and availability of training opportunities. The chart in Appendix C is a summary of the range of training programs found using internet searching and input from therapists. Details regarding the programs are included in each section. Please note that inclusion in this compendium does not imply endorsement of the training approaches. See Appendix B for questions that could be used to evaluate the credibility of a training opportunity.

## *Supervision*

There is consensus in the literature that training alone is not sufficient for maintaining competence. Psychotherapy supervision is an expectation in the COTO Standards, with recommendations for supervision and training for a minimum of two years (COTO, 2010). Supervision is a formal process that focuses on theorizing and case conceptualization, skill training, clinical professional and ethical reflection, mentoring, professional development and personal support (Schofield & Grant, 2013). Psychotherapists often view clinical supervision as a key method for continual improvement of professional competence and engage in supervision throughout their careers (Schofield & Grant, 2013). The quality of supervision, however, is essential to success. Supervisors should be supportive, yet appropriately challenge therapists to reflect on and improve their skills (Klein, Bernard & Schermer, 2010).

It is of concern that in our survey of Ontario therapists, 54% of the respondents indicated that they never received either formal or informal psychotherapy supervision and over 65% did not currently have access to supervision (Moll et al., 2013). In the compendium, we have tried to note expectations and opportunities for supervision in relation to each approach. Many survey respondents expressed an interest in supervision from other occupational therapists. Although we searched for OT-specific training and supervision, we found few resources cited in the literature. Over time, we hope that this situation will change, particularly as therapists continue to build credibility and expertise in using psychotherapy within the context of occupational therapy practice.

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# Cognitive Behavioural Therapy (CBT)

## Overview of Approach

CBT is an evidence-based form of psychotherapy that has become increasingly popular in recent years as research evidence has mounted to support its use as an intervention for a variety of conditions including anxiety (Borkovec & Ruscio, 2001; Stewart & Chambless, 2009), mood disorders (Cuijpers, Berking, Andersson, Quigley, & Kleiboer, 2013; Otto, 2005), psychosis (Zimmerman, Favrod, Trieu, & Pomini, 2005), personality disorders (Davidson, Norrie, Tryer, Gumley, & Tata, 2006), and chronic pain (Morley, Eccleston, & Williams, 2009). CBT focuses on the interactions between thoughts, feelings and behaviours. It is a structured approach, involving education, skill building and problem solving in order to help clients change their patterns of thinking, behaviour and/or emotional response (Academy of Cognitive Therapy, 2013). A systematic, best practice approach is often 10-20 sessions in length (Somers, 2007).

CBT was originally developed by Aaron Beck as a response to criticism of the psychoanalytic tradition (Beck, 2011). CBT is a relatively brief therapy that is typically 10-20 sessions in duration (Leichsenring, Hiller, Weisberg, Leibing, 2006). It is a primarily present focused, symptom oriented therapy in the sense that it encourages therapists and clients to address problems identified in the present moment, without placing the primary focus of therapy on past events (Beck, 2011; Leichsenring et al., 2006). Although CBT involves identifying and modifying problematic 'schema' (Padesky, 1994) or 'core beliefs' (persistent, underlying beliefs that are held either consciously or subconsciously), which can involve exploring events in one's past, this is typically addressed briefly, and linked to events and related emotions experienced in the present moment. The development of more adaptive core beliefs or schema as a way of achieving wellness is typically the focus of this form of therapy (Padesky, 1994).

In contrast with the psychodynamic tradition, persons receiving psychotherapy using a CBT approach will focus on how their thoughts and beliefs affect them in the present moment (Leichsenring et al., 2006), then engage in a variety of therapeutic activities to challenge these thoughts and beliefs in an effort to change perspectives and ultimately their behaviour as a result. Therapeutic activities may include systematic desensitization, use of behavioural experiments in which persons intentionally immerse themselves in a real world scenario while taking on or challenging perspective, or intentionally exposing oneself to benign stimuli that are pathologically distressing, in order to address problematic patterns of behaviour such as through exposure and response prevention (ERP) (Beck, 2011; Leichsenring et al., 2006).

Ideally, persons engaged in CBT will begin to recognize and challenge their own problematic thinking, behaviour, and associated emotions over time. Thereby, a person engaged in CBT will develop independence in the context of therapy, eventually taking on a leadership role in the therapeutic encounter as they become enculturated in the cognitive model (Beck, 2011). CBT is most successful when



persons who have been engaged in this form of therapy learn to examine their thinking and behaviour using the cognitive model, then begin to independently identify and implement strategies to challenge their own thinking and elicit behavioural changes (Beck, 2011). As CBT is primarily focused on building independence in clients through skill building (Beck, 2011), it is an excellent fit for occupational therapists whose practice is similarly focused on building skill and capacity as a way of promoting independence (Townsend & Polatajko, 2007)

### *Variations on CBT*

In its simplest terms, the original version of CBT, or the Beck model is based on a client case conceptualization developed through identification of core beliefs through the examination of automatic thoughts (ATs) (immediate thoughts arising without examination) that are informed by core beliefs (Beck, 2011). ATs are considered clues to fully identify the core beliefs that they relate to. By using ATs to identify core beliefs, these core beliefs can be identified and strategies to modify these beliefs can be implemented through behavioural strategies facilitated by a therapist utilizing CBT.

Modifications to the Beck model have been developed in response to perceived weaknesses, particularly with respect to applying CBT to complex cases (Binnie, 2012). Termed third wave CBT, a term originally described by Hayes (2004), it is a form of therapy which utilizes the strategies employed in CBT to assist persons to change the ways in which they regard or respond to their cognitions and behaviour in the individual and social context (Tai & Turkington, 2009). Some of these therapies incorporate mindfulness and/or compassion based components into therapy as a way of tailoring therapy specifically to the client context. One example of a systematized form of third wave CBT, Acceptance and Commitment Therapy (ACT), demonstrates this development (Cristea, Montgomery, Szamozkozi, & David, 2013). Although a description of ACT is beyond the scope of this review, it should be noted that third wave approaches are currently criticized for their lack of evidence-based support, and for arguable weakness in their underlying theory (David & Hofman, 2013).

## Key Components

CBT accounts for 4 main elements of the person's experience, namely thoughts/cognitions, behaviour, feelings, and the body and the ways in which it responds in the context of a person's various experiences. The process of therapy typically involves talk therapy over several sessions. CBT usually expects persons engaging in therapy to complete 'homework' in which they apply or practice what they have learned in therapy sessions in the context of their everyday lives with the hope that their learning will inform therapy sessions.

## Key Terms

ABC Model ▪ Automatic Thoughts ▪ Core Beliefs ▪ Thought Records ▪ Behavioural Experiments ▪ Cognitive Restructuring ▪ Cognitive Distortions ▪ Socratic Questioning ▪ Systematic Desensitization

## Research Evidence to Support CBT

Research evidence with regard to children and adolescents is inconclusive, whereas evidence to support the use of CBT with the general adult population is much more consistent in favour of CBT as an effective intervention for a variety of disorders.

### *Children & Adolescents*

While some studies indicate that CBT for children and adolescents is an effective intervention for anxiety and mood disorders (Compton, March, Brent, Albano, Weersing et al., 2004), and for generalized anxiety disorder, depression, obsessive compulsive disorder (OCD), and posttraumatic stress disorder (PTSD) (Munoz-Solomando, Kendall & Whittington, 2008), other studies have identified that this approach has resulted in marginal reductions in symptoms within this age group. Some studies identify that other treatments outperform CBT in the treatment of childhood mental health conditions. For example, in one study, Eye Movement Desensitization and Reprocessing (EMDR) outperformed CBT in the treatment of behavioural and self-esteem problems in children, however, the effect size difference between the two treatment conditions was marginal (Wanders, Sera, & De Jongh, 2008). Munoz-Solomando et al. (2008) suggest that there is little evidence to support the use of CBT to treat antisocial behaviour, psychosis, eating disorders, substance abuse, and self-harm behaviour in children despite the fact that an evidence base supporting the use of CBT for adults presenting with these symptoms is established.

### *Older Adults*

Evidence for the use of CBT for typically functioning older adults is similar to that of the general adult population for most disorders. When compared with supportive counselling (SC), one study found that CBT resulted in greater symptom reduction in a sample of older adults receiving treatment for anxiety (Barrowclough, King, Colville, Russell, Burns et al., 2001). Another study identified no significant differences among CBT and SC conditions in the treatment of generalized anxiety disorder in a sample of older adults (Stanley, Beck, & Glassco, 1996).

### *Group CBT*

CBT delivered in the group setting has been validated by a variety of research involving a range of study populations. Group CBT has been found to be an effective strategy for promoting health among women diagnosed with breast cancer (Hassanzade, Janbabaie, Salavati, Moonesi, Khaleghi et al., 2012), treating depression (Furlong & Oei, 2002), and is recommended as a treatment strategy with bariatric populations (McVay, 2012).

Individual CBT, however, has been demonstrated to have a greater level of effectiveness when compared with group treatments. In a study comparing individual and group CBT for insomnia, it was discovered that the individual treatment was significantly more effective for a variety of sleep domains including sleep quality and latency of sleep onset (Yamadera, Sato, Harada, Iwashita, Aoki et al., 2013). Another study comparing group and individual CBT for children diagnosed with anxiety disorders found that 73% of children treated using an individual

approach and 50% of children treated with a group approach no longer met diagnostic criteria for anxiety post treatment (Flannery-Schroeder & Kendall, 2009). Although not considered less effective, in a study comparing group and individual CBT for obsessive compulsive disorder, one study discovered that participants receiving individual CBT enjoyed a more rapid response rate than participants assigned to a group CBT treatment condition (Anderson & Rees, 2007). Despite these findings, group therapy may be the only option in the context of limited resources due to the cost effectiveness of therapy delivered in group, when compared with individual therapy.

## Relevance for OT Practice

CBT focuses on enhancing a person's awareness of the ways in which thoughts affect behaviour and one's perspective of the world and towards others. Ways of thinking and perceiving influence how a person functions in his or her everyday life, as well as the experience of participating in occupations. CBT can be used by occupational therapists to enhance effectiveness in performing meaningful and necessary occupations when challenges in performance are related to the link between cognitions and behaviour. For example, a person who is attending social events, but experiences a high level of anxiety when socializing with others due to low self-esteem may avoid interacting with others at social events, or attending social events at all, leading to a poor experience and decreased function in daily life. An OT using CBT may help a person to develop an awareness of the thoughts that are leading to their low self-esteem, help them to challenge those problematic thoughts, and practice behaviours that will help them to socialize with others with greater ease and decreased anxiety. In some cases, thoughts and behaviours are the cause of decreased performance and engagement in occupations, and in these cases, CBT can be a helpful approach to improving occupational performance and engagement.

## Competency Development

Although competence in CBT is not uniformly defined or measured, there have been a number of initiatives focused on itemizing core CBT competencies. Developing a list of competencies for CBT is a recent initiative of the American Association of Directors of Residency Training, for example. Perhaps most notably, a project in the UK led to formation of a framework of core competencies for providing CBT to people with depression and anxiety disorders (Roth & Pilling, 2007). The framework outlines 5 domains of competence (generic therapeutic competencies, CBT competencies, CBT techniques, problem-specific competencies, and meta-competencies). There are 50 specific competencies within these five domains, ranging from generic skills (e.g. engaging the client, using supervision), to CBT-specific skills and techniques (e.g. exposure techniques, thought records, Socratic questioning). See the following link for details: [http://www.ucl.ac.uk/clinical-psychology/CORE/CBT\\_Competences/CBT\\_Competence\\_List.pdf](http://www.ucl.ac.uk/clinical-psychology/CORE/CBT_Competences/CBT_Competence_List.pdf). There are a number of tools cited in the literature that could be used to evaluate CBT competence, which are summarized in Table 1.1 below.

**TABLE 0.1.1--CBT COMPETENCE ASSESSMENT TOOLS**

The Cognitive Therapy Scale (Young & Beck, 1980)	The CBT Supervision Checklist (Sudak, Wright, Bienenfeld & Beck, 2001)	Collaborative Case Conceptualisation Rating Scale (CFRS) (Padesky, Kuyken & Dudley, 2010)	Cognitive Therapy Awareness Scale (Wright et al., 2002)
<p>Includes 11 items divided into two domains: General Therapeutic Skills (e.g., agenda setting, interpersonal effectiveness, collaboration), and Conceptualization, Strategy, and Technique (e.g., guided discovery, focusing on key cognitions and behaviors, strategy for change, and homework). Each item is rated on a 0—6 scale and there is a cutoff score for competence. This is one of the most widely used scales with adequate psychometric properties. Source for the manual: Academy of Cognitive Therapy website (<a href="http://academyofct.org">http://academyofct.org</a>)</p>	<p>A 21-item scale that supervisors can use to rate competence over several sessions. It is based on the American residency training competencies. The tool is retrievable from: <a href="http://www.docstoc.com/docs/20194050/Cognitive-behavior-Therapy-Supervision-Checklist">http://www.docstoc.com/docs/20194050/Cognitive-behavior-Therapy-Supervision-Checklist</a></p>	<p>A tool to evaluate a competency in formulating a case. Inter-rater reliability (ICC = .91-.97) and internal consistency (<math>V = .94</math>) are strong and it also has good convergent validity with the Cognitive therapy Scale (<math>r = .44</math>). The tool evaluates abilities in four key concepts: conceptualization, collaboration, empiricism, and strengths / resilience focus. The tool is retrievable from: <a href="http://66.147.244.137/~padeskyc/newpad/wp-content/uploads/2012/08/CCCRS_Coding_Manual_v5_web.pdf">http://66.147.244.137/~padeskyc/newpad/wp-content/uploads/2012/08/CCCRS_Coding_Manual_v5_web.pdf</a></p>	<p>Involves 40 true/false questions to assess knowledge. It was used as a standardized pre/post-test of knowledge with psychiatry residents.</p>

Many studies have been conducted examining the effectiveness of various training approaches to develop CBT competence. A review study by Rakovshik and McManus (2010) synthesized the findings of over 35 clinical trials, noting that more extensive training (i.e. more than 137 hours) leads to increased therapist competence, and this in turn links to better patient outcomes. They noted that traditional dissemination approaches (i.e., workshops and manuals) did not produce significant change, unless it was followed by experience-based training through practice cases, co-therapy or supervision. For therapists who are initially learning techniques, actively monitoring treatment adherence with feedback and instruction from an experienced supervisor was recommended. Over time, however, a “scaffolding” approach was recommended where therapists have an opportunity to consolidate their skills with supervision and support before moving to the next skill. Ongoing supervision was seen as an essential part of the process of maintaining and continuing to develop competence. As will all psychotherapy approaches, developing competency in CBT requires quality educational opportunities, supervision of one’s developing CBT practice, and self- reflection on an ongoing basis.

## Training

There are a variety of training opportunities for developing skill in CBT for occupational therapists. Available types of training include certificate programs, workshops, online training, and professional supervision. Please note that this is not an exhaustive list, and interested OTs are encouraged to seek out further opportunities as needed.

### *Workshops & Certificate Programs*

Workshops are courses that are offered on a time limited, less intensive basis, whereas certificate programs include the completion of a series of courses or modules in CBT. Many certificate programs offer CBT levels 1 to 3, with opportunity for application, feedback and supervision at the higher levels. We have listed a range of these programs offered in Ontario and beyond.

## Training Opportunities

### *In-Person and Online CBT Training*

Organization	Course Name	Description	Cost	Contact
Hincks-Dellcrest Centre – Gail Appel Institute	CBT Foundational Skills	In this two day workshop, key features of CBT will be explained and demonstrated so that participants gain an excellent foundation in CBT and are able to apply CBT techniques in their clinical work with adults. Participants will learn specific CBT interventions and the application of these in the treatment of various disorders, including depression and anxiety.	\$550 + HST for 2 days (2016)	<a href="http://www.hincksdellcrest.org/Home/Training-and-Consultation/About-the-Institute.aspx">www.hincksdellcrest.org/Home/Training-and-Consultation/About-the-Institute.aspx</a>
McMaster University	Post-Professional Program in Clinical Behavioural Sciences	CBT for anxiety and mood disorders: Level 1 (12 weeks), Level 2 (12-16 weeks), Level 3 (20 weeks) and includes application and supervision with 2 cases from your own work.	Varies. Refer to website for further details.	<a href="http://fhs.mcmaster.ca/cbs/">http://fhs.mcmaster.ca/cbs/</a>
Centre for Addiction and Mental Health (CAMH)	Summer Training Institute	Three Day Course/12 Hour Course	\$650-\$750	<a href="http://www.camh.ca/en/education/about/AZ/Courses/Pages/cbt_si.aspx">http://www.camh.ca/en/education/about/AZ/Courses/Pages/cbt_si.aspx</a>
University of Toronto (OISE)	Fundamental Skills	“Certificate in Cognitive Behavioral Therapies (CBT): Fundamental Skills” is an 8 week course with three hour sessions.	\$775	<a href="http://conted.oise.utoronto.ca/Certificate_in_Cognitive_Behaviour_Therapy/index.html">http://conted.oise.utoronto.ca/Certificate_in_Cognitive_Behaviour_Therapy/index.html</a>

Beck Institute – Philadelphia, PA	Certificate Programs	Certificate Programs include: CBT for Children & Adolescents, Advanced CBT for Children & Adolescents, CBT for PTSD, CBT for Depression & Suicidality, CBT for Personality Disorders & Challenging Problems. Courses are 3 day intensives held in suburban Philadelphia, PA.	\$1200	<a href="http://www.beckinstitute.org/calendar-of-workshops/">http://www.beckinstitute.org/calendar-of-workshops/</a>
Association for Psychological Therapies introductory online CBT courses	Online	Module based + written projects	\$199-259/course module	<a href="http://www.cbtfromapt.com/ca">www.cbtfromapt.com/ca</a>
SDS Seminars	Online	3 modules (30 training hours) US & UK accredited	\$1100	<a href="http://www.skillsdevelopment.co.uk">www.skillsdevelopment.co.uk</a>
CBT Certificate Program- Tape Studies University of Toronto	Online	6 modules to complete certificate with 20 courses to choose from modules primarily 2 days in length & pre-scheduled	Varies— Contact for further information	<a href="http://www.tapestudies.com/our-programs/certificate-programs/cognitive-behavioural-therapy">http://www.tapestudies.com/our-programs/certificate-programs/cognitive-behavioural-therapy</a>
Zur Institute	Online	CBT nuts & bolts online course – reviewing 10 articles	\$39/course	<a href="http://www.zurinstitute.com/cbtcourse.html">www.zurinstitute.com/cbtcourse.html</a>
Douglas College	Online		\$1500/course	<a href="http://www.douglascollege.ca/programs-courses/continuing-education/health/cognitive-behaviour-therapy">http://www.douglascollege.ca/programs-courses/continuing-education/health/cognitive-behaviour-therapy</a>
National Association of Cog-B'oral Therapists	Online	Home study programs –CBT group therapy, CBT with children (DVD based)	Varies—see Website for details	<a href="http://nacbt.americanmercer.com/store/c/4-Home-Study-Trainings-for-Professionals.aspx">http://nacbt.americanmercer.com/store/c/4-Home-Study-Trainings-for-Professionals.aspx</a>

## CBT Supervision

A study by Prasko et al. (2011) highlighted the importance of supervision during CBT skill development. Although the most common training provided in CBT is the brief workshop, this form of training is unlikely to result in significant skill development in therapists without the ongoing support of an experienced mentor (Beidas, Edmunds, Marcus & Kendall, 2012). Therapists with greater tenures of supervision and those with more extensive education reportedly provide more effective therapy than therapists who do not have extensive training and supervision (Wykes, Hayward, Thomas, Green, Surguladze et al., 2005). Types of supervision include professional



(either in person or online) and peer supervision. Professional supervisory opportunities may exist in one's local community either on a volunteer, or paid basis. These opportunities may be organized through one's own workplace as well, in which more experienced cognitive behavioural therapists enter into a mentoring relationship with developing online CBT Training therapists within the same organization.

Distance supervision is often a convenient option for many therapists; however, these opportunities are usually offered at a cost to the therapist seeking supervision. A variety of these opportunities are listed below. Please see Appendix A for details of each.

### *Supervision Opportunities*

Organization Name	Format	Cost	Link
Beck Institute	Options of 23 or 46 sessions – via phone, email or Skype	Cost \$4,000 for 23 sessions or \$8,000 for 46 sessions	<a href="http://www.beckinstitute.org/cognitive-behavioral-therapy-training-supervision/">http://www.beckinstitute.org/cognitive-behavioral-therapy-training-supervision/</a>
National Association of Cog B'oral Therapists	Telephone supervision – frequency negotiated; often monthly. Supervisee provides cases & supervisor suggests how to apply CBT to client's concerns/problems.	Cost \$150/hour	<a href="http://nacbt.org/cbt_supervision.htm">http://nacbt.org/cbt_supervision.htm</a>
Christine Padesky – consultation	Range of formats (telephone, Skype, individual, group). Frequency can be negotiated.	Contact	<a href="http://padesky.com/cbt-consultation/">http://padesky.com/cbt-consultation/</a>

## Resources (2016)

Resource	Resource Type	Description	Link
Academy of Cognitive Therapy	Organization/Association	This is an international organization that connects members to an international multidisciplinary community of CBT therapists. This organization offers certification in CBT. Certifying with the Academy allows members to be placed in a referral network. Registration requirements include: <ol style="list-style-type: none"> <li>1. Completing a required reading List (3 books)</li> <li>2. Providing proof of professional liability insurance</li> <li>3. Completing 40 hours of CBT education</li> </ol>	<a href="http://www.academyofct.org/">http://www.academyofct.org/</a>

		<p>4. Practicing for a minimum of 1 year of practice in CBT with at least 10 clients</p> <p>5. Evaluation of clinical competency by submission of a case write-up and an audio file of a CBT session conducted by the applicant</p>	
Canadian Association of Cognitive & Behavioural Therapies (CACBT)	Organization/Association	This is a Canadian association that can provide access to networking with other CBT therapists in Canada (multi-disciplinary). Registrants receive information about educational opportunities such as conferences and workshops. A credentialing process is currently being developed. Membership cost is \$50 for professionals and \$20 for students.	<a href="http://cacbt.ca/en/index.htm">http://cacbt.ca/en/index.htm</a>
Association for Behavioral and Cognitive Therapies	Web	Many resources including podcasts, webinars, fact sheets, and mentorship directory.	<a href="http://www.abct.org/Home/">http://www.abct.org/Home/</a>
Essential CBT Skills Series	Video	Set of 8 DVDs -Demonstrations of Essential CBT Techniques followed by a detailed analysis and informed explanation by Accredited CBT therapists.	<a href="http://www.psychotherapyvideos.com/CBT-Set">www.psychotherapyvideos.com/CBT-Set</a>
CBT training resources for therapists	Web	Includes training DVD & audio CD's, assessment tools, articles.	<a href="http://padesky.com/">http://padesky.com/</a>
Psychology Tools	Web	Free resource sharing –includes worksheets, assessments and educational materials	<a href="http://www.psychologytools.org/">http://www.psychologytools.org/</a>
Simon Fraser University—CBT Handbook	Print	Somers, J. (2007). Cognitive Behavioral Therapy: Core Information Document. Center for Applied Research in Mental Health and Addiction. Faculty of Health Sciences Simon Fraser University	N/A
Get Self-Help	Web	Free downloadable CBT worksheets	<a href="http://www.getselfhelp.co.uk/freedownloads2.htm">www.getselfhelp.co.uk/freedownloads2.htm</a>
Living CBT Bookshop	Web	CBT Books & Resources	<a href="http://www.livingcbt.com/">http://www.livingcbt.com/</a>

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# Dialectical Behaviour Therapy (DBT)

## Overview of Approach

DBT was originally developed by Marsha Linehan as a treatment for women diagnosed with borderline personality disorder (BPD) (Robins, Ivanoff, & Linehan, 2001), and is based on Linehan's biosocial model of personality disorder. This model suggests that the primary challenge faced by persons experiencing BPD involves dysregulation of the emotional system. The emotional regulation system is a part of a larger system that includes the self, cognition, behaviour, and interpersonal communication (Feigenbaum, 2008). These systems are interrelated, and changes in one of these systems elicits fluctuation in the other systems (Feigenbaum, 2007). Feigenbaum (2008) suggests that persons with BPD possess emotional systems that "...respond to stimuli with greater speed and strength than other individuals, and a slower speed to baseline"(p. 112).

Emotional dysregulation is not only associated with BPD, but a feature of other diagnoses such as: attention deficit hyperactivity disorder (ADHD) (Reimherr, Marchant, Strong, Hedges, Adler, 2005), major depression (Beauregard, Paquette, & Levesque, 2006), and anxiety disorders (Turk, Heimberg, Luterek, Mennin, & Fresco, 2005). For this reason, use of DBT has expanded for use in treating persons experiencing other mental health challenges. An evidence base supporting the use of DBT has been established for use with persons experiencing BPD with co-morbid substance use, binge eating, forensic clients, attention deficit hyperactivity disorder (ADHD), chronic depression in older adults, adolescent suicidal behaviour, and crisis settings (Feigenbaum, 2007).

Difficulty associated with poor emotional dysregulation and poor social cognition can place strain on social relationships, and decrease one's ability to function in a variety of capacities, including employment, education, and social activities, thereby decreasing one's opportunities in these contexts. These individuals may develop mal-adaptive coping behaviours such as self-harm behaviours (i.e. cutting, burning, overdosing), impulsive behaviours (overspending, sex, reckless driving), engagement in addictions as well as the experience of chronic suicidality. Developing the ability to regulate one's emotions more effectively, or to cope with extremes in emotion in a more effective way is likely to result in improvements in one's ability to engage in social relationships and in occupations that are necessary and meaningful to a person. In addition, the emphasis of DBT on developing functional and coping skills to improve social function and social cognition in persons engaged in this therapy are likely to result in improvements in occupational performance and mental health and wellbeing.

DBT combines elements of cognitive behavioural therapy, dialectics, and mindfulness approaches to address problematic cognitions and behaviours as a way of assisting those engaged in this therapy to more effectively regulate



emotion, build coping capacity to manage extremes in emotion, and improve social cognition. It explicitly targets suicidal and self-harm behaviours (Swales, Heard, & Williams, 2000) due to the fact that it was primarily developed as a treatment for persons diagnosed with BPD who struggle with such behaviours. In practice, DBT focuses on improving a person's adaptation to changes in a real world context, and uses the therapeutic relationship to reflect this real world context as much as possible (Swale et al., 2000). As this therapy was created to address problems experienced by those who are frequently in crisis, the structure of this form of therapy reflects both a need to treat persons frequently involved in crisis situations, while ensuring that DBT therapists receive adequate support and peer mentoring on an ongoing basis.

## Key Components

DBT is a unique therapy not only in its focus, but also in how it is structured. It is comprised of three main components—individual therapy, a skills training group, and professional consultation meetings (Dimeff & Linehan, 2001). A fourth component, telephone consultation, involves clients contacting their therapist by telephone to ask questions in a moment of need, and enhance their learning of skills developed in individual therapy sessions and the skills training group. Telephone contact is meant to be brief and skills directed. Therapists may need to conduct a suicide risk assessment during this interaction. Thereby, DBT is typically delivered using a team based approach, however, adaptations to the DBT model have been proposed that allow for the provision of DBT to those who would benefit in the absence of the components of a DBT team. Swales et al. (2009) suggest that DBT can be competently delivered by an individual therapist who incorporates skill development into individual therapy sessions. A brief description of each component of DBT is provided below.

### *Individual Therapy*

The individual component of DBT involves meeting on an individual basis with a trained psychotherapist who helps a person integrate their learning from the skills training group into the context of their individual lives. Primarily, however, this is an individual psychotherapy informed by cognitive behavioural therapy, mindfulness, and a dialectical approach that is the hallmark of DBT. Sessions are highly structured and involve reviewing diary cards, performing behavioural chain analysis of problem behaviours and helping the client to integrate skills. Therapists must also be skilled in commitment and validation strategies.

### *Skills Training Group Therapy*

Group therapy is an essential component of a DBT program of therapy. It involves assisting persons to develop social and interpersonal skills to manage emotional instability and to promote success in the interpersonal context. It is practical in focus, focusing on skill development, and has been demonstrated when compared with standard group therapy to be significantly more effective in decreasing symptoms in persons diagnosed with BPD (Soler, Pascual, Tiana, Cebria, Barrachina, 2009). Four modules are taught in a standard DBT program. These include mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance.

## *Professional Consultation*

This component of DBT is a structured opportunity for therapists providing DBT within a mental health service to seek support and receive feedback from other therapists in that same service. This not only promotes skill development among therapists, but is also an opportunity in which individual therapists may receive support from like-minded colleagues providing service to the same or different clients in the same service. The professional consultation group is structured in the sense that it typically follows a protocol wherein members follow a set of rules during communication, and that the group itself is structured by team members who take on various roles during the consultation meeting. Examples of rules that are followed by consultation team members include taking on a dialectical approach (ie: all is connected, there is no central truth in the world), embracing the provision of varying perspectives to clients rather than expecting consistency, and agreeing not to challenge the decision making of other team members during the provision of therapy.

## Key Terms

Mindfulness ▪ Wise Mind ▪ Dialectics ▪ Distress Tolerance ▪ Emotion Regulation ▪ Interpersonal Effectiveness ▪ Life-Threatening Behaviour ▪ Therapy-Interfering Behaviour ▪ Quality of Life Behaviours ▪ Skill Acquisition

## Research Evidence to Support DBT

The majority of research focusing on DBT has demonstrated it to be an effective treatment for the symptoms experienced by persons diagnosed with borderline personality disorder (BPD) in inpatient, community, and crisis intervention settings (Robins & Chapman, 2004). This makes sense, as this therapeutic protocol was developed for persons who are challenged by this diagnosis. In terms of symptoms of BPD, this form of therapy has been demonstrated to be effective in the treatment of substance use (Linehan, Schmidt, Dimeff, Craft, Kanter, et al., 1999), self-harm & suicidal ideation (Stanley, Brodsky, Nelson, & Dulit, 2007). Efficacy has also been demonstrated for DBT's use in the treatment of depression. In one pilot study, the authors identified that an application of DBT to the treatment of major depression in older age study participants outperformed standard pharmacotherapy in terms of self-rated depression scores (Lynch, Morse, Mendelson, & Robins, 2003). In addition, Koons, Robins, Tweed, Lynch, Gonzalez et al. (2001) discovered that female veterans with a diagnosis of BPD who were receiving DBT, experienced greater reductions in self harm behaviours and depression scores than those assigned to a 'treatment as usual' group.

Research comparing standard DBT with modified versions is important to consider. In a study comparing a DBT approach developed specifically for persons with a co-morbid substance use disorder, and a standard DBT program for those with a single diagnosis of BPD, it was discovered that the treatment developed

specifically for those with substance use challenges was no more effective than standard DBT. This led the authors to conclude that DBT programs should be broadly targeted to all persons experiencing symptoms of BPD rather than those persons with specific symptoms predominating their diagnosis (van den Bosch, Verheul, Schippers, & van den Brink, 2002). DBT has been successfully adapted for use in treating persons struggling with binge eating disorders, ADHD, couples therapy, and incarcerated males (Robins & Chapman, 2004). It has also been found to be an effective strategy when delivered through digital applications. One study piloted a mobile phone 'app' for persons diagnosed with BPD, and discovered that engagement with this intervention decreased substance use behaviour and other maladaptive coping strategies (Rizvi, Dimeff, Skutch, Carroll, & Linehan, 2011).

An important finding in the literature that further supports the use of DBT for persons with a diagnosis of BPD indicates that those who are enrolled in a DBT programme are more likely to be retained in therapy for a longer period of time than if enrolled in therapy using other approaches (Linehan, Comtois, Murray, Brown, Gallop, 2006; Dimeff & Linehan, 2001). This is an encouraging result, as persons with a diagnosis of BPD frequently experience difficulty with adhering to therapeutic interventions that are offered to them, and in maintaining healthy and sustained relationships with their caregivers (Beck, 2005). This suggests that retention in therapy may increase the likelihood that persons receiving treatment are more likely to benefit from therapy due to their adherence to the therapeutic approach.

## Relevance for OT Practice

DBT focuses on increasing the independence of persons who struggle with challenges relating to emotional regulation, mood challenges, and interpersonal skills by teaching coping and social skills and supporting the development of these skills in individual therapy sessions. The skills learned in DBT are likely to improve occupational performance by supporting one's competency in performing self-care, productivity, and leisure activities through enhancing interpersonal and coping skills. Self-care is likely to improve through emotional regulation, whereas productive and leisure occupations are likely to improve through interpersonal effectiveness and enhanced social problem solving skills. DBT's integrated strategies of acceptance and change in order to help clients feel more understood and committed to their own therapy parallel occupational therapy's client-centred approach and goal to enable clients to achieve independence and learn new behaviours by engaging in occupation. Central to the individual component of DBT is the careful and detailed examination of the sequences of learning using a behavioural chain analysis. The occupational therapist's training in activity analysis and their ability to view component parts of occupation which identifies personal strengths and challenges along with

environmental supports and barriers is an excellent match for DBT psychotherapy. Research investigating the ways in which DBT may enhance occupational performance is needed.

## Competency Development

The development of DBT skills as an occupational therapist involves completion of formal course work, as well as accessing competent supervision from an experienced therapist. A major advantage of the DBT model is that it has built peer supervision into the provision of service through professional consultation meetings. When working on an individual basis, accessing an experienced DBT therapist is essential for therapists providing this form of therapy to their clients, and who are developing this competency at the same time. The client populations that benefit from DBT can often be related with stress and burnout in their careers, particularly in those presenting with self-harm behaviours. In one study, the development of DBT skills in therapists resulted in a significant decrease in reported stress on the part of therapists (Perseus, Kaver, Ekdahl, Asberg, & Samuelsson, 2007).

## Training

A number of training opportunities exist for occupational therapists who are interested in developing DBT skills. These opportunities include in-person and online workshops and certificate programs, and supervision opportunities. The following offers information about training opportunities in DBT. This list is not comprehensive, however, and interested therapists are encouraged to seek training opportunities independently.

## Training Opportunities

### *In-Person CBT & Online Training*

Organization	Course Name	Description	Cost	Contact
Centre for Addiction & Mental Health (CAMH)	DBT Levels A-D	Part A—An Introduction to DBT Part B—An Introduction to DBT Part C—DBT: Practice Based Learning Part D—DBT: Supervised Applications	\$395-795/ Module	<b>Contact:</b> Janey Haggart, Education Assistant Tel. 416-535-8501 x 6021 janey.haggart@camh.ca <b>Web:</b> <a href="http://www.camh.ca/en/education/about/AZCourses/Pages/dbt_part_a.aspx">http://www.camh.ca/en/education/about/AZCourses/Pages/dbt_part_a.aspx</a>

Behavioural Tech LLC	Various	Online, in-person, consultation and comprehensive training options are offered ranging from days to 2 years. Courses available for newly developing consultation teams, as well as individual therapists interested in developing a DBT practice in the absence of a consultation team. Supervision opportunities are available.	Various— Contact for Pricing	<b>Address:</b> 4746 11 <sup>th</sup> Avenue NE, Suite 102, Seattle, WA 98105 <b>Phone:</b> 206.675.8588 <b>Email:</b> <a href="mailto:info@behavioraltech.org">info@behavioraltech.org</a> <b>Web:</b> <a href="http://behavioraltech.org/index.cfm">http://behavioraltech.org/index.cfm</a>
Oshawa Psychotherapy Institute	DBT Levels I-III & DBT Skill Training Course	4 DBT courses for professionals with varying levels of previous experience.  DBT Skills Training Course explores DBT skill development instead of learning DBT in its entirety.	Varies— Contact for Pricing	<b>Address:</b> Oshawa Clinic, 2 <sup>nd</sup> Floor, East Wing 117 King St. E Oshawa, ON  <b>Tel:</b> 905-721-7723 1-866-568-9476  <b>Web:</b> <a href="http://www.oshawapsychotherapytraining.com/home">http://www.oshawapsychotherapytraining.com/home</a>

## Supervision

As DBT has a distinct and unique structure in comparison to most forms of psychotherapy, supervision is also unique. Ongoing supervision is typically supported within the context of the DBT consultation team, where team members help each other to maintain a non-judgemental, dialectical approach, and provide one another with input and feedback on strategies with clients (Swales, 2010). By doing so, supervision is essentially ‘built-in’ to the team structure. When expertise is not available within the team, for example, with a particularly complex situation, other DBT programs can be used as resources to help to problem-solve through challenging scenarios. Professional consultation is also available through the Linehan Institute whose contact information can be found at the following web address: <http://behavioraltech.org/training/consultation.cfm> .

## Resources (2016)

Resource	Resource Type	Description	Link
DBT Skills Handbook	Online	Online manual developed for Fulton State Hospital 2004	<a href="http://www.bipolarsjuk.se/pdf/Handbook%20in%20DBT%20Group.pdf">http://www.bipolarsjuk.se/pdf/Handbook%20in%20DBT%20Group.pdf</a>
DBT Self-Help	Online	Worksheets and self-help printable resources for DBT practice or for self-help. Many of these resources would be useful in clinical practice.	<a href="http://www.dbtselfhelp.com/Decider_pdf.pdf">http://www.dbtselfhelp.com/Decider_pdf.pdf</a>
Doing Dialectical Behavior Therapy: A Practical Guide	Print	Koerner, K., & Linehan, M. (2012). Doing Dialectical Behavior Therapy: A Practical Guide. New York: Guilford Press.	N/A
Cognitive-Behavioral Treatment of Borderline Personality Disorder	Print	Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.	N/A
Skills Training Manual for Treating Borderline Personality Disorder	Print	Linehan, M. (1993). Skills training manual for treating borderline personality disorder. New York: Guilford Press.	N/A
The Dialectical Behavior Therapy Skills Workbook: Practical DBT Exercises for Learning Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance	Print	McKay, M., Wood, J., & Brantley (2007). The Dialectical Behavior Therapy Skills Workbook: Practical DBT exercises for learning mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. Oakland: New Harbinger.	N/A
The Expanded Dialectical Behavior Therapy Skills Training Manual: Practical DBT for Self-help, and Individual and Group Treatment Settings	Print	Pederson, L. (2011). The Expanded Dialectical Behavior Therapy Skills Training Manual: Practical DBT for Self-help, and Individual and Group Treatment Settings. Eau Claire, WI: CMI Education Institute.	N/A
Dialectical Behaviour Therapy National Certification & Accreditation Association	Organization/ Association	An American body that promotes the use of DBT, fosters education for practicing therapists in collaboration with other organizations, and provides a certification process for DBT practitioners, and an accreditation process for organizations. See <b>DBTNCAA website:</b> <a href="https://www.dbtncaa.com/">https://www.dbtncaa.com/</a> for specific details on the certification and accreditation process. <i>Cost:</i> \$199 membership fee <i>Contact:</i> DBTNCAA, 6600 France Avenue South, Suite 230 Edina, MN 55435	<a href="http://www.dbtncaa.com/">http://www.dbtncaa.com/</a>

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# Mindfulness

## Overview of Approach

'Mindfulness' is a concept that has been derived from Eastern philosophical traditions, and is most often associated with mindfulness meditation (Shapiro, Carlson, Aston & Freedman, 2006). It is often described as a way of maintaining presence in the moment, in a non-judgemental way (Desrosiers, Vine, Klemanski & Nolen-Hoeksema, 2013). It is a practice or a habit that those practicing psychotherapy can encourage and foster in their clients through tangible exercises and practices that help to promote a mindful state. Mindfulness is itself an approach, and is known to promote psychological well-being (Brown & Ryan, 2003). Its principles have been incorporated into a group of mental health therapies including Mindfulness Based Stress-Reduction (MBSR), and cognitive therapies such as Mindfulness Based Cognitive Therapy (MBCT), and Acceptance and Commitment Therapy (ACT). Shapiro et al. (2006) identify mindfulness using three distinct components—*Intention*, or doing 'on purpose;' *Attention*, or the ability to attend in the present moment; and *Attitude*, or approaching the world in a particular way (p. 175). Therapy that is based on mindfulness has been demonstrated to be helpful in improving symptoms of depression and anxiety (Hofmann, Sawyer, Witt & Oh, 2010), and improving overall function and psychological impact among persons experiencing chronic pain (Rosenzweig, Greeson, Riebel, Green, Jasser et al., 2010) among a variety of other conditions.

The most common forms of mindfulness-based programs are MBCT and MBSR. MBSR was developed in the late 1980's by Jon Kabat-Zinn, who is often regarded as introducing the integration of mindfulness into mainstream health care settings. MBCT integrates MBSR with psychological understandings drawn from Cognitive Behavioural Therapy. MBCT has grown from its original focus on prevention of depressive relapse and has been adapted for other particular clinical populations such as anxiety, bipolar disorder and general stress. MBCT was once used only in the clinical context, but is now offered in community based settings such as in the workplace. Additionally, it is promoted as a strategy to prevent burnout among health care workers (Bangor University, Centre for Mindfulness Research and Practice, n.d.).

## Key Components

Mindfulness describes a group of practices that help a person to achieve a mindful state. According to Kabat-Zinn (2012), it is one of many forms of meditation (p. 1). It incorporates a variety of strategies aimed at achieving a state of mindfulness. Acceptance, an approach that helps a person to recognize the way things *are* as they exist in the present moment (Brach, 2003), helps a person to develop a realistic view of the world and self-awareness. Structured meditation is used to promote presence and acceptance. Breathing exercises are used to both foster a state of presence, and also as a way of regulating one's level of arousal. Strategies used in mindfulness approaches include guided visual imagery, in which a person is guided by a therapist to imagine a series of images for a therapeutic purpose, and progressive muscle relaxation, in which a person is guided to progressively tense and relax muscle groups in the body as a way of achieving presence and relaxation.

## Key Terms

Non-Attachment ▪ Progressive Muscle Relaxation ▪ Guided Visual Imagery ▪  
Self-Compassion ▪ Non-Judgement ▪ Attention ▪ Wakefulness ▪ Awareness ▪  
Observation ▪ Meditation ▪ Presence ▪ Acceptance

## Research Evidence to Support Mindfulness Approaches

The UK National Institute of Clinical Excellence (NICE) has recently endorsed MBCT as an effective treatment for prevention in the relapse of depression. Even among those with chronic depression, learning MBCT skills reduces the risk of recurrence (Teasdale, Segal, Williams, Ridgeway, Soulsby & Lau, 2000). One randomized-control trial identified that MBCT is as effective as anti-depressant medication in preventing relapse in persons experiencing depression (Segal, Bieling, Young, MacQueen, Cooke et al., 2010). MBCT is being implemented with an increasing number of diagnostic populations and demonstrating utility as a treatment. A 2010 meta-analytic review of the effects of MBSR and MBCT on anxiety and depression concluded that mindfulness based therapy is a promising intervention for treating anxiety and mood problems in clinical populations (Hofmann et al., 2010).

Mindfulness represents a variety of approaches and philosophies, and as a practice is grounded in a larger context. MBCT and MBSR protocols were developed from this larger context, and are the most researched forms of mindfulness meditation in a clinical setting. As research and clinical practice with mindfulness expands, so does information on the theory and practice of mindfulness.

A variety of mindfulness based approaches exist, and new protocols are being developed as mindfulness is integrated into the practice of therapists and evaluated in research. One example of this is a study in which the authors found mixed results in a MBSR group for gay men living with HIV (Gayner, Esplen, DeRoche, Wong, Bishop et al., 2012). The results of this study led the authors to identify the need for adapting one's approach to MBSR to better address the emotional challenges

associated with internalized stigma through self-compassion and acceptance of their experiences. Gayner has since adapted the intervention to develop Emotion Focused Mindfulness (EFM), of which Recollective Awareness Meditation (RAM) is an integral component. RAM includes the practice of sitting meditation with minimal cues, writing/recollecting about the meditation experience, then discussing these recollections. This form of meditation can be easily integrated into other therapeutic approaches as the memories, sensations, emotions that arise during a meditation session can be worked within various psychotherapy modalities. Jason Siff was a Buddhist monk in Sri Lanka in the 1980s when he started developing RAM, (Siff, 2010). As an open form of meditation, it is inclusive of other meditation practices, such as those included in MBSR and MBCT. It differs from these protocols in the act of recollection through journaling and the more psychologically oriented inquiry that can follow in therapy.

### *Mindfulness Based Therapy Contraindications*

Despite the usefulness of mindfulness based approaches for a variety of mental health challenges, and to promote overall mental health wellbeing, the strategies used in a mindfulness based practice may be contraindicated in some clinical scenarios. Although mindfulness has traditionally been viewed as contraindicated in psychosis, recent evidence suggests that in an adapted form, it can be a helpful approach to treating this constellation of symptoms (Chadwick, 2014). Dobkin, Irving & Amar (2012) suggest that there is little evidence in the research literature to suggest that mindfulness approaches are contraindicated for specific clinical populations, and that any adverse events have been described in little detail in the current body of the literature on mindfulness. It should be noted that any form of therapy should be properly evaluated by a clinician who wishes to use it in the context of the literature supporting the approach as well as his or her own clinical judgement with respect to each clinical case. Careful attention to the client's response to the intervention should be accounted for when delivering mindfulness based approaches.

## **Relevance for OT Practice**

Mindfulness helps to improve a person's independence by helping them to view themselves and the world in a more accepting and adaptive way. This, in turn, is likely to help a person to function more effectively in social situations, spiritually, and in the context of productivity occupations. Research focusing on persons who live with chronic pain demonstrates the ability of mindfulness interventions to reduce the perception of pain, while improving overall function in everyday life (Rosenzweig et al., 2010). Improving one's function in everyday life, whether through the reduction of symptoms or the impact of symptoms, and providing ways to adapt occupations and the ways in which they are performed to overcome a limitation is the *raison d'être* of the occupational therapy profession. Mindfulness approaches appear to be a useful strategy that occupational therapists can use to help to target everyday life function and participation and performance of occupations for some populations. More research that identifies how occupational therapists uniquely approach mindfulness based therapies is needed, as is research exploring the ways in which mindfulness based approaches help to enhance occupational performance and engagement in persons receiving occupational therapy.

## Competency Development

Developing competence in providing mindfulness based approaches involves the completion of formal course work, practice involving supervision, and the development of one's own mindfulness practice. A therapist's practice of mindfulness is an important consideration in the development of competency in this area, and it is strongly recommended that a clinician develop and maintain their own meditation practice. The value of this cannot be understated, and can have an important impacts on one's therapeutic effectiveness. In one study, clients were assigned to a psychotherapist in training who practiced meditation, and a control group that was assigned to a psychotherapist in training who did not. The participants who were assigned to therapists in training who practiced mindfulness experienced greater symptom reductions when compared to those who were assigned to therapists who did not practice meditation (Grepmaier, Mitterlehner, Loew, Bachler, Rother et al., 2007). Based on these preliminary results, mental health clinicians may consider cultivating their own mindfulness practice in order to optimize clinical outcomes for the clients with whom they work. This is particularly the case if the therapist wishes to use mindfulness strategies in his or her practice, or if a mindfulness based approach forms the basis of one's approach. Many options exist, including enrolling in an MBCT group themselves, participating in mindfulness MBCT training retreat, or attending the great variety of available mindfulness retreats. For the purposes of continuing professional development the creators of MBCT recommend:

1. Participating in residential, teacher-led mindfulness retreats.
2. Engaging in ongoing peer supervision with mindfulness-based colleagues, built and maintained as a means to share experiences and learn collaboratively.
3. Keeping up to date with the current evidence base for mindfulness-based approaches by engaging in on-going professional development (Segal, & Williams, & Teasdale, 2013).

At a minimum, in order to develop and maintain competence as an MBCT teacher, the developers of this approach suggest the following:

1. An ongoing commitment to a personal mindfulness practice through daily formal and informal practice.
2. A professional qualification in clinical practice and mental health training that includes the use of structured, evidence-based therapeutic approaches to treating affective disorders (e.g. CBT, interpersonal psychotherapy, behavioural activation).
3. Knowledge and experience of the populations to which the mindfulness-based approach will be delivered, including experience of teaching, therapeutic, or other care provision with groups and individuals.
4. Completion of an in-depth, rigorous, mindfulness-based teacher training program, or supervised pathway with a minimum duration of 12 months. (A "supervised pathway" might include attending three 8-week courses, the

first as a participant, the second as trainee, and the third as co-teacher, as well as attending workshops on theoretical and practical aspects of teaching the core practices and curriculum.)

5. Ongoing adherence to the framework for ethical conduct as outlined within his or her profession.

6. Engagement in an ongoing peer supervision process with an experienced mindfulness-based teacher(s), which should include receiving periodic feedback on teaching from an experienced, mindfulness-based teacher through video recordings, a supervisor sitting in on teaching sessions, or co-teaching including scheduled feedback sessions (Segal, & Williams, & Teasdale, 2013).

## Training

A number of training opportunities are available for occupational therapists who are interested in developing skills in providing mindfulness based approaches. Due to the importance of personal development with respect to mindfulness, training opportunities identified in this compendium will include courses that will assist occupational therapists to develop their own mindfulness practice. Additionally, courses that will help to develop professional skills in mindfulness based therapy and training to teach mindfulness to professionals will be presented.

## Training Opportunities

### *Personal Development Courses*

Organization	Course Name	Description	Cost	Contact
University of Toronto	Mindful Self-Compassion	This course is a prerequisite for the mindful self-compassion program at the School of Social Work, and will “introduce the three components of self-compassion: mindfulness, common humanity and self-kindness. Participants will learn how to bring this directly into their lives through experiential exercises, meditations, movement practices, and small and large group work”	\$850 + HST for a 5 day, full time course	<a href="http://socialwork.utoronto.ca/cont-ed/programs-and-workshops/certificates/mind/mindc/msc2016/">http://socialwork.utoronto.ca/cont-ed/programs-and-workshops/certificates/mind/mindc/msc2016/</a>
Oasis Institute at the University of Massachusetts (Worcester, Massachusetts)	MBSR & MBCT Training Opportunities	Courses offered involve a personal development component prior to developing skills in MBSR & MBCT.	Varies	<a href="http://www.umassmed.edu/cfm/Training/">http://www.umassmed.edu/cfm/Training/</a>

Centre for Mindfulness Studies (Toronto, ON)	Mindfulness for Health Care Professionals: Stress, Resiliency & Burn-out Prevention	“Participants will learn practical stress management skills and be introduced to the clinical applications of mindfulness.”	Contact	<a href="http://www.mindfulnessstudies.com/introductory-courses/">http://www.mindfulnessstudies.com/introductory-courses/</a>
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### *Professional Development Courses*

Organization	Course Name	Description	Cost	Contact
University of Toronto— Faculty of Social Work	Applied Mindfulness Meditation— Levels A-D	A progressive certificate program providing a grounding in the historical and theoretical underpinnings of mindfulness, as well as practice in using mindfulness strategies with various practice populations. The program consists of 4 levels of progressive competency development. 5 modules must be completed at each level in order to progress to the next. No prior experience is required to enrol.	\$325 per module	<a href="http://socialwork.u-toronto.ca/conted/programs-and-workshops/certificates/mind/">http://socialwork.u-toronto.ca/conted/programs-and-workshops/certificates/mind/</a>
UCSD Centre for Mindfulness	Mindfulness Based Professional Training	A variety of professional training opportunities and certification programs to qualify practitioners to gain the competency to teach mindfulness to other professionals. See website for a full description of training opportunities.	Varies. Refer to website for further details.	<a href="http://mbpti.org/">http://mbpti.org/</a>
The Centre for Mindfulness Studies	Introductory and Professional Development Courses	The centre provides a variety of introductory and continuing professional development courses in mindfulness for practicing professionals. These include beginner courses, courses for educators, mindfulness for health care professionals and silent retreats.	Varies. Refer to website for further details.	<a href="http://www.mindfulnessstudies.com/">http://www.mindfulnessstudies.com/</a>
University of Massachusetts Medical School—Centre for Mindfulness in Medicine, Health Care, and Society	Mindfulness Based Stress Reduction (MBSR) Teacher Training	The Center for Mindfulness in Medicine, Health Care, and Society is a visionary force and global leader in mind-body medicine. For thirty years, they have pioneered the integration of mindfulness meditation and other mindfulness-based approaches in mainstream medicine and healthcare through patient care, research, academic medical and professional education, and into the broader society through diverse outreach and public service initiatives. Directed by	Contact for further details	<a href="http://www.umassmed.edu/cfm/training/training-pathways/">http://www.umassmed.edu/cfm/training/training-pathways/</a>



		Saki F. Santorelli, EdD, MA, since 2000 and founded in 1995 by Jon Kabat-Zinn, the Center is an outgrowth of the acclaimed Stress Reduction Clinic – the oldest and largest academic medical center-based stress reduction program in the world.		
Sunnybrook Health Sciences Centre	Sunnybrook Mindfulness	Courses in mindfulness based group practice, which is a six-day interprofessional course for clinicians who wish to lead mindfulness-based groups as well as a supervisory series for mindfulness based group practice for those who have completed the mindfulness based group practice course.	Contact for further details	<a href="http://sunnybrook.ca/content/?page=mindfulness-meditation-stress-therapy">Http://sunnybrook.ca/content/?page=mindfulness-meditation-stress-therapy</a>  Email: <a href="mailto:mindfulness@sunnybrook.ca">mindfulness@sunnybrook.ca</a>
The NeuroNova Centre for Mindfulness Based Chronic Pain Management (Toronto, ON)	Variety of Courses (see Description)	Mindfulness-Based Chronic Pain Management courses are offered in Toronto at Sunnybrook Health Sciences Centre and St. Michael's Hospital and via Telemedicine to hospital sites across Ontario. 6 modules have been offered in the past. These 13 week modules include: <ul style="list-style-type: none"> <li>▪ Mindfulness Based Chronic Pain Management Levels I &amp; II</li> <li>▪ Emotional Skills</li> <li>▪ Mindfulness for Health Care Professionals</li> <li>▪ Mindfulness Maintenance</li> <li>▪ Lumina Spark</li> </ul>	Contact for further details	<a href="http://neuronovacentre.com/courses">http://neuronovacentre.com/courses</a>
Mount Sinai Psychotherapy Institute (Toronto, ON)	Mindful Psychotherapy	A series of courses to help clinicians to find ways of incorporating mindful approaches in psychotherapy practice.	\$995 for a full 6 day training course	<a href="http://events.r20.constantcontact.com/register/event?oeidk=a07eawfafow71c8352a&amp;llr=z89hqxqab">http://events.r20.constantcontact.com/register/event?oeidk=a07eawfafow71c8352a&amp;llr=z89hqxqab</a>

## Supervision

Supervision of mindfulness practice can occur in a variety of ways. MBCT training requirements suggest that engagement in an ongoing peer supervision process with an experienced mindfulness-based teacher(s), which should include receiving periodic feedback on teaching from an experienced, mindfulness-based teacher through video recordings, a supervisor sitting in on teaching sessions, or co-teaching including scheduled feedback sessions is necessary to develop the requisite skills to become an MBCT teacher (Segal, & Williams, & Teasdale, 2013).

## Resources (2016)

Resource	Resource Type	Description	Link
The Mindful Path to Self-Compassion: Freeing Yourself from Destructive Thoughts and Emotions	Print	Germer, C. ( 2009). The Mindful Path to Self-Compassion: Freeing Yourself from Destructive Thoughts and Emotions. New York, NY: Guildford Press.	N/A
Mindfulness & Psychotherapy	Print	Germer, C. K., Siegel, R.D., & Fulton, P. (2005). Mindfulness and Psychotherapy. New York, NY: Guildford Press.	N/A
Research Article	Print	Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. Journal of Psychosomatic Research, 57(1), 35-43.	N/A
Research Article	Print	Hofmann, S.G., Sawyer, A.T., Witt, A.A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. Journal of Consulting and Clinical Psychology, 78(2), 169-183.	N/A
Bangor University, Centre for Mindfulness Research and Practice	Web	Educational website exploring issues related to mindfulness personal and professional practice.	<a href="http://www.bangor.ac.uk/mindfulness/about.php.en?menu=21&amp;catid=8458&amp;subid=0">http://www.bangor.ac.uk/mindfulness/about.php.en?menu=21&amp;catid=8458&amp;subid=0</a> <a href="http://www.bangor.ac.uk/mindfulness/training.php.en?subid=0">http://www.bangor.ac.uk/mindfulness/training.php.en?subid=0</a>
Mindfulness meditation for pain relief: Guided practices for reclaiming your body and your life	Audio	Kabat- Zinn, J. (2010): Audio CD to help develop a personal mindfulness practice, as well as a resource for clients to use for at-home practice.	<a href="http://www.soundstrue.com/shop/Mindfulness-Meditation-for-Pain-Relief/2112.pd">http://www.soundstrue.com/shop/Mindfulness-Meditation-for-Pain-Relief/2112.pd</a>

Research Article	Print	Segal, Z.V., Bieling, P., Young, T., MacQueen, G., Cooke, R., Martin, L., Bloch, R., & Levitan, R. (2010). Antidepressant monotherapy vs. sequential pharmacotherapy and mindfulness-based cognitive therapy, or placebo, for relapse prophylaxis in recurrent depression. Archives of General Psychiatry,67(12), 1256-1264.	N/A
The Mindfulness Solution: Everyday Practices for Everyday Problems.	Print	Siegel, R. (2010). The mindfulness solution: Everyday practices for everyday problems. New York, NY: Guilford Press.	N/A
Research Article	Print	Teasdale, J.D., Moore, R.G., Hayhurst, H., Pope, M., Williams, S. & Segal, Z.V. (2002). Metacognitive awareness and prevention of relapse in depression: Empirical evidence. Journal of Consulting and Clinical Psychology, 70, 278-287.	N/A
What Time is It? Inspiring a Shift from Tic-Toc to Lub-Dub	Web	Online educational article	<a href="http://ucsdcfm.wordpress.com/">http://ucsdcfm.wordpress.com/</a>
Your Guide to Mindfulness-Based Cognitive Therapy	Web	Educational resource for MBCT	<a href="http://www.mbct.com/">http://www.mbct.com/</a>
The Free Mindfulness Project	Web	Free downloadable resources to support mindfulness personal and professional mindfulness practice.	<a href="http://www.free mindfulness.org/download">http://www.free mindfulness.org/download</a>
Guided Mindfulness Meditation Practices with Jon Kabat-Zinn	Audio	Audio recorded mindfulness meditations	<a href="http://www.mindfulnessstapes.com/">http://www.mindfulnessstapes.com/</a>
Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness	Print	Book by Jon Kabat-Zinn (1990)	N/A
The Mindful Way Through Depression	Print	Book by Mark Williams & John Teasdale (2007)	N/A
The Mindful Way Through Anxiety	Print	Book by Susan Orsillo, Lizabeth Roemer & Zindel Segal (2011)	N/A

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# Motivational Interviewing

## Overview of Approach

Motivational Interviewing (MI) is a counseling approach that was originally developed in the field of addictions to support individuals with substance abuse disorders to make behavioural changes in their lives (Miller et al., 2006). MI is both a philosophy and a specific way of working with individuals to help people explore and resolve ambivalence about engaging in behavioural changes (Lundahl, Tollefson, Kunz, Brownell & Burke, 2010). It has been defined as:

"A collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion" (Miller & Rollnick, 2013, p. 29).

More briefly stated, MI has been described as: "A collaborative conversation style for strengthening a person's own motivation and commitment to change" (Miller & Rollnick, 2013, p. 12).

MI recognizes that ambivalence is a normal part of making any behavioural change and acknowledges that people approach change with varying levels of readiness. Individuals can and do get stuck in ambivalence for extended periods of time. The role of professionals is to assist clients to become more aware of the implications of change and/or of not changing through non-judgemental and guided conversations. Another important feature of MI is that these are conversations in which the client is encouraged to do most of the talking. The MI style is that of guiding vs. directing, or following. Another way to state this is that "MI is not done 'to' or 'on' someone at all. MI is done 'for' and 'with' a person" (Miller & Rollnick, 2013, p.15).

Central to the MI approach is a strong, collaborative relationship between the professional and the client. Within the context of this relationship, five key communication skills are used including: asking open questions, affirming, reflecting, summarizing, and, providing information and advice with permission (Rosengren, 2009). One critical component of a motivational interviewing approach includes *change talk*, which is a sign to MI trained professionals that a client is in the process of contemplating change (Rosengren, 2009). Professionals trained in MI will focus on eliciting change talk, and to utilize it as a means of facilitating a positive change process in their clients (Rosengren, 2009).



# Key Components

## *MI Process*

The four key processes of MI are engaging, focusing, evoking and planning.

- ✓ Engaging – process of establishing a helpful connection and working alliance
- ✓ Focusing – process by which clinician and client develop and maintain a specific direction in the conversation about change
- ✓ Evoking – process that elicits the client’s own motivations for change
- ✓ Planning – process which encompasses both developing commitment to change and formulating concrete plan of action (Miller & Rollnick, 2013, p.38).

## Key Terms

Change Talk ▪ Sustain Talk ▪ Resistance ▪ Rolling with Resistance ▪ Spirit of MI ▪ Ambivalence ▪ Engaging ▪ Evoking ▪ Focusing ▪ Planning

## Research Evidence to Support Motivational Interviewing

Motivational interviewing has been used both as a stand-alone intervention and alongside other interventions to help individuals with a wide range of problems. While MI is best known within the realm of substance use treatment, it has been used, researched and shown promise in many different health practice settings (Lundahl, Tollefson, Kunz, Brownell & Burke, 2010). A large body of evidence demonstrates that MI is effective in helping people to change very hard-to-change behaviors. There are more than 1,200 publications on MI as a treatment method which include 200 randomized clinical trials and reflect a diversity of issues, professions, practice settings and countries (Miller & Rollnick, 2013).

This body of literature reflects a diversity of issues, professions, practice settings and countries and includes a number of systematic reviews and meta-analyses of MI (for a complete list of systematic reviews, please refer to Miller & Rollnick, 2013, Appendix B). It must also be noted that the effectiveness of MI varies widely across clinicians, studies and sites within studies (Lundahl et al., 2010; Miller & Rollnick, 2013). Future research is required to understand better where and when MI is most effective. Key questions that need to be further investigated include in what context and with what levels of MI training, MI skills, or MI duration will behavioural changes be effectively addressed (Knight et al., 2006). Miller & Rollnick (2013) note that fidelity of delivery of MI is an important consideration in understanding outcomes of MI because many studies use adapted forms of MI. As such, proficiency and fidelity to MI should be well documented in future studies using reliable observational coding measures to help improve knowledge of this intervention.

## Support for Various Practice Populations

Evidence for effectiveness of MI varies across treatment settings and populations. While a comprehensive review of the literature on MI is beyond the scope of this document, the following outlines a few areas in which MI has been and continues to be researched.

### *Addictions*

MI is an intervention that has solid evidence of effectiveness for the treatment of substance use disorders (including alcohol dependence) and other addictions such as problem gambling. It has been studied in the treatment of a wide range of substances, including cocaine, cannabis and alcohol (Hettinga, Steel & Miller, 2005).

### *Mental Health*

Early research exploring the application of MI as an adjunct to current practices in supporting clients with anxiety disorders, depression, eating disorders and concurrent disorders has already shown promising results (Westra, 2011). While more research into the application of MI in the treatment of major mental health issues is needed, early findings support the continued integration of MI and demonstrate the potential of MI to enhance client engagement and response to treatment (Westra, 2011). Also, Steinberg et al (2004), conducted a study that examined brief MI interventions for motivating smokers with schizophrenia to seek tobacco dependence treatment. In this study, a greater proportion of participants who received a single session of MI contacted a tobacco dependence treatment provider within 1 month post-intervention than those who received brief psycho-educational intervention.

### *Health Promotion*

Weight loss, exercise, smoking cessation, safer sex has been a focus of health promotion using MI. A review article by Martins & McNeil (2009) identified that clients who received MI reported increased self-efficacy to diet and exercise; increased physical activity; reduced caloric intake and increased consumption of fruits and vegetables. Although MI was not always found to be more effective than other treatments, the review findings supported clinical utility of MI in these areas (Martins & McNeil, 2009).

### *Medical Treatment Adherence*

Studies have investigated MI's impact on medication adherence for individuals with schizophrenia. Drymalski & Campbell (2009) reviewed five studies and concluded that while two studies found an increase in antipsychotic adherence following an MI-based intervention, the other three had no impact. Drymalski & Campbell (2009) conclude that future research is required with regards to MI's impact on medical treatment adherence. In addition, Laakso (2012) highlights the potential that MI could play in supporting clients with bipolar disorder in addressing ambivalence to improve medication adherence.

## *Other Populations*

MI has also been practiced with other vulnerable groups in society including the homeless population, aboriginal communities, and correctional settings with sex offenders and inmates. Research has occurred in other practice areas including physical health conditions and self-management of chronic diseases including diabetes, asthma, hypertension, hyperlipidaemia and heart disease (Lundahl et al., 2010; Knight, et al., 2006).

## **Relevance for OT Practice**

Motivational interviewing is an approach that is often used in settings where OTs work, such as mental health and addictions programs. It also has an application in physical health settings where health promotion and treatment adherence are used in OT practice. OTs working in case management roles may find MI to be a particularly useful tool to work collaboratively with clients to identify goals and strategies for achieving them. The nature of MI, which focuses on facilitating client motivation towards change may be used to promote client independence, and motivation to engage in behaviours that will increase occupational performance and engagement. An MI approach may also enhance client-centred practice by helping OTs to identify client articulated strategies for change. The emphasis in MI on the development of listening skills that can help one to detect motivation for change in client language may enhance OT practice by providing structure to a therapist's observations in practice, thereby enhancing an OTs ability to time interventions more effectively.

## **Competency Development**

Miller & Moyers (2006) identify eight distinct steps in the development of MI competency among professionals:

- ✓ Getting the spirit of MI
- ✓ Using client centered skills (OARS)
- ✓ Recognizing change talk
- ✓ Eliciting and reinforcing change talk
- ✓ Rolling with resistance
- ✓ Developing a change plan
- ✓ Consolidating client commitment
- ✓ Integrating MI with other intervention methods

Acquiring proficiency in motivational interviewing (MI) may be more difficult than generally believed. There are diverse ways for student occupational therapists and practicing clinicians to gain knowledge and skills in MI available through face-to-face training, on-line learning formats, MI blogs & podcasts, videos & DVDs, simulation & virtual learning and blended learning.

Training research suggests that the standard one-time workshop format may be insufficient (Bohman et al., 2013). Additionally, individual and self-study is a very common method for exploring MI for many health care professionals including occupational therapists. This involves studying print materials and viewing videotapes. While this method can provide some understanding of the basic approach, research by Miller and colleagues has found that these strategies alone are generally not effective in improving clinical skillfulness in MI. Self-study and

single clinical workshop require additional support for skill acquisition and retention (Miller et al., 2004; Weerasekera et al., 2010).

Current research suggests that the most effective approaches to obtain, increase and maintain proficiency in the use of motivational interviewing over time include a blended approach with a combination of traditional workshops or online training followed by extended (post course) coaching/feedback and clinical supervision (Weerasekera et al., 2010). Barwick et al. (2012) suggest that further research is required to understand the impact of various coaching delivery methods, in addition to training, on the competency of those trained in MI. Certain studies on MI training conclude that the most effective method to retain clinical proficiency over time includes multiple components, specifically a two-day workshop plus feedback and/or coaching (Weerasekera et al., 2010; Barwick et al., 2012). A review article by Madson, Loinon and Lane (2009) provides a thorough account of MI trainings and comments on who is receiving training in MI, what methods are used and training outcomes.

A systematic review of motivational interviewing training for general health care practitioners found that MI can be used to improve client communication and counseling concerning lifestyle-related issues in general health care (Söderlund et al., 2011). However, the authors stated that results must be interpreted with caution due to inconsistent methodological quality of the studies. The authors recommend that higher quality research is needed to identify the best practices for training in MI (Söderlund et al., 2011).

Evidence-based practice also requires the evaluation of clinicians in terms of their adherence to practices as well as their competency in implementing these therapies. Competency can be subjectively measured using a self-report questionnaire related to MI skills and strategies incorporated into clinical practice; however respondents tend to under represent their skills in self report (Barwick et al., 2012). Alternatively, in a study by Young & Hagedorn (2012) in which the authors examined the effect of student-based training in MI, participants reported a greater level of optimism in relation to how well they learned MI than was measured through observational assessment of them. These findings suggest that trainees may be overly confident in their ability to demonstrate MI strategies in sessions with clients than is actually the case. Consequently, relying solely on self-reporting of MI in practice could be unreliable.

Competency can also be objectively measured using a variety of measures which have been developed for this purpose. Madson & Campbell (2006) wrote a review article on five measures including the Yale Adherence and Competence Scale (YACS); the Motivational Interviewing Skill Code (MISC); the Motivational Interviewing Process Code (MIPC); the Motivational Interviewing Treatment Integrity Scale (MITI) and the Motivational Interviewing Supervision and Training Scale (MISTS). However, the clinical utility of these measures is limited because of the extensive training required to administer the tools, the time required to score the measures, and the suitability of these measures more to research contexts vs. practice environments (Barwick et al., 2012; Madson & Campbell, 2006). Weerasekera (2010) advises that the MISC be used in conjunction with other forms of evaluation for the most comprehensive evaluation of competency.

# Training

## **Brief Introductions to MI**

Individual study & self-training, or introduction to MI courses (1 hr – 3 days) provide a basic understanding of MI concepts and methods, but are not generally effective in improving clinical skillfulness.

## **Intermediate & Advanced Training**

It is cautioned that those undertaking intermediate and advanced training may become over-confident with feelings of mastery. 2 -3 day training should include analysis of practice, audio & videotapes and more demonstration with practice exercises. Such training should also include the following:

- ✓ An understanding of MI spirit and method of MI, as well as practical experience. The objective should be to “learn how to learn” MI from ongoing practice, and to ignite an interest for further learning.
- ✓ More demonstration & practice exercises. These courses should be less didactic, and focus on differentiating change talk from commitment language while learning how to elicit and shape the two.

## **Ongoing consultation and supervision (open-ended)**

It is strongly suggested that consultation and supervision be an active process following intermediate & advanced training activities to ensure fidelity to the MI model.

## **MI Supervisor Training**

Designed for people who provide clinical training and supervision MI clinicians. Includes expertise in systems for monitoring and coding session tapes for clinical practice. Prior proficiency and experience in the practice of MI is assumed of all participants.

## **MI Coder Training**

Focus on fidelity monitoring of MI and process of coding MI in research protocols. Extensive opportunity for coding practice is necessary. This training does not focus on the delivery of MI but rather how to code therapy tapes reliably. As such, clinical expertise in MI is not a requirement of participants.

## Training Opportunities

Organization	Course Name	Description	Cost	Contact
Centre for Addiction & Mental Health	Motivational Interviewing Courses Level 1-3	<p>This is an on-line course that follows a collaborative clinical education model. The course includes mentoring/coaching of MI to assist with clinical application of MI as well as to give participants evidence of learning of the techniques. Healthcare professionals of diverse backgrounds and practice settings who either provide direct client care or are consulted on behavioural change participate in the course.</p> <p>This course can be taken on its own. It also qualifies as an elective of CAMH's Concurrent Disorders Certificate program.</p> <p>The course is accredited by: The College of Family Physicians of Canada; The Royal College of Physicians &amp; Surgeons of Canada and the Canadian Addiction Counsellors Certification Federation (CACCF).</p>	\$250	<a href="http://www.camh.ca/en/education/about/AZC_courses/Pages/mi_ol.aspx">http://www.camh.ca/en/education/about/AZC_courses/Pages/mi_ol.aspx</a>
University of Toronto (OISE)	Motivational Interviewing Program Spirit to Skills: An Introduction to Motivational Interviewing for Professional Practice	This course is an introductory level course on MI and provides learning on key concepts, skills and techniques and the underlying spirit of MI. It uses mixed methodologies including: didactics, videotaped demonstrations, experiential exercises and practice, with opportunities for reflection and feedback on the use of MI in practice. Registrants have basic clinical and counseling skills and come from various health care professions and/or have a Master's degree in a counseling related field.	\$925	<a href="http://conted.oise.utoronto.ca/Certificate_in_Motivational_Interviewing/index.html">http://conted.oise.utoronto.ca/Certificate_in_Motivational_Interviewing/index.html</a>
Canadian Training Institute	Motivational Interviewing Courses	<p><b>Motivational Interviewing and Stages of Change</b> (1 day, 2 day) Introductory course for MI principles and practices. Participants will learn key concepts regarding readiness to change; stages of change; spirit of MI and have opportunities to learn and practice key MI skills.</p> <p><b>Advanced Strategies in Motivational Interviewing</b> (1 day) Practical and interactive workshop for individuals with advanced knowledge and experience in motivational interviewing. Participants will learn how to enhance their MI skills and incorporate MI into brief counseling interactions.</p>	Contact for pricing	<a href="http://www.canadiantraininginstitute.com/motivational-interviewing-and-the-stages-of-change">http://www.canadiantraininginstitute.com/motivational-interviewing-and-the-stages-of-change</a>



Humber College	An Introduction to Motivational Interviewing	Two-day (16-hour course) provides an overview of motivational interviewing, core principles and techniques along with practice opportunities.	Contact for pricing	<a href="http://www.humber.ca/continuingeducation/courses/introduction-motivational-interviewing">http://www.humber.ca/continuingeducation/courses/introduction-motivational-interviewing</a>
The Monarch System	Multiple Courses	<p><b>Level 1:</b> Intensive Introduction to Motivational Interviewing (MI) is a two-day session that introduces participants to an overview of MI and MI tools and techniques. It provides opportunity for skill practice and feedback opportunities that support the integration of learning into clinical practice.</p> <p><b>Level 2:</b> Advanced Motivational Interviewing Workshop for Health Practitioners builds on the first workshop. Aims to support clinicians with clients that are experiencing difficulties with making health-related behaviour changes. This 2-day training provides additional practice and feedback opportunities.</p> <p>*Both courses are designed for health care professionals from diverse backgrounds and practice settings.</p>	Contact for pricing	<a href="http://www.monarchsystem.com/the-monarch-system-workshops/">http://www.monarchsystem.com/the-monarch-system-workshops/</a>
McMaster University	Motivational Interviewing Level I & II	<p><b>Level 1 (25hrs)</b> Motivational Interviewing Level I will focus on understanding the theoretical underpinnings and evidence supporting the use of this therapeutic approach for clients who are ambivalent about change. Students will develop and practice beginning and advanced motivational interviewing skills through discussion, case studies and practice in class in pairs and small interprofessional groups.</p> <p><b>Level 2 (25hrs)</b> This course will focus on the advanced motivational interviewing skills, further exploring ethical use of motivational interviewing, eliciting change talk and developing an action plan with clients who are ambivalent about change. Motivational Interviewing Level 2 will expect that learners understand the theoretical underpinnings and evidence supporting the use of this therapeutic approach for clients who are ambivalent about change. Students will further develop advanced practice and motivational interviewing skills through discussion, case studies and practice in class. Students will participate in pairs and small interprofessional groups to develop and practice advanced motivational interviewing skills.</p>	Contact for pricing	<a href="http://fhs.mcmaster.ca/cbs/motivational_interviewing.html">http://fhs.mcmaster.ca/cbs/motivational_interviewing.html</a>

Kiepek Health Counselling	Motivational Interviewing for Occupational Therapists	2 day workshops specifically designed for occupational therapists, nurses, and other professionals.	Contact for pricing	<a href="http://www.kiepekhealthcounselling.ca/Introduction.html">http://www.kiepekhealthcounselling.ca/Introduction.html</a>
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## Supervision

For the purposes of continuing professional development it is recommended that the above comments on competency development and training guidelines be considered. In addition, individuals should consider:

1. Ongoing supervision with MI trained colleagues be built and maintained as a means to share experiences, learn collaboratively and enhance fidelity to the practice.
2. Engagement in further training to develop skills and understanding in delivering motivational interviewing, which includes keeping up to date with the current evidence base for MI.
3. Teleconferencing supervision (TCS) is another option that provides remote, live supervision for training in motivational interviewing. TCS shows promise for promoting the knowledge translation and the clinical application of new counseling behaviors following workshop training. However, further research is needed to improve supervision methods that translate to high levels of MI proficiency in clinical practice and facilitate the dissemination of evidence-based practices (Smith et al., 2012).



## Resources (2016)

Resource	Resource Type	Description	Link
MINT (Motivational Interviewing Network of Trainers)	Organization	<p>An international organization of trainers from diverse backgrounds that apply MI in a variety of clinical and practice settings. Their central objective is to improve the effectiveness of counseling/consultation about clients and behaviour changes. MINT was started in 1997 by trainees of William R. Miller and Stephen Rollnick and now represents 35 countries.</p> <p>The MINT website has a list of MINT affiliated trainers, an international training calendar, multiple resources for online/distance training and a wealth of resources on MI. A particularly useful resource on the MINT website is a link that provides citations to recent research articles on MI.</p> <p>If you are looking to enroll in a live training program, the Motivational Interviewing network of Trainers (MINT) website provides listings of trainings being provided by MINT members around the world. For people interested in inviting MI trained clinicians to their organization, they can see a list of people who are members of The Motivational Interviewing Network of Trainers (MINT). This website allows you to search for trainers by country.</p>	<p>MINT:  <a href="http://motivationalinterviewing.org/">http://motivationalinterviewing.org/</a></p> <p>Trainer Listing:  <a href="http://www.motivationalinterviewing.org/trainer-listing">http://www.motivationalinterviewing.org/trainer-listing</a></p>
Motivational Interviewing: Helping People Change	Print	Miller, W.R., & Rollnick, (2013). Motivational Interviewing: Helping People Change 3rd edition. The Guilford Press, New York.	N/A
Motivational Interviewing	Print	Miller, W.R., & Rollnick. S. (2012) Motivational Interviewing (3rd edition). New York, Guilford Press.	N/A
Building Motivational Interviewing Skills: A Practitioner's Workbook	Print	Rosengren, D. (2009). Building motivational interviewing skills: A Practitioner's workbook. New York, Guilford Press.	N/A

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# Solution Focused Brief Therapy (SFBT)

## Overview of Approach

Solution Focused Brief Therapy (SFBT), also referred to as Solution Focused Therapy (SFT), can be described as a counselling approach which emphasizes interventions related to client goals for their future, with minimal exploration of their presenting “problems” (de Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, Weiner-Davis, 1986). Originally developed by Steve de Shazer, Insoo Kim Berg and colleagues of Milwaukee, Wisconsin in the 1970’s, this approach focuses on identifying and developing solutions independent of past, or current concerns, to efficiently enable clients to achieve desired future life outcomes (Gingerich & Peterson, 2013). Through increasing client awareness of their own abilities and life successes that already exist and have been present during times of *exception* from their current problem(s), SFBT aims to encourage further repetition and expansion of these existing successful behaviours into a client’s life. The “brief” component of this therapy is based on the assumption that repeating an individual’s own past and familiar successful behaviours, even if they have been infrequent, would be easier and take less time to implement, than for a client to learn new strategies and incorporate them into their own lives (deShazer et. al., 1986).

In practice, SFBT uses interview methods to help clients build solutions as opposed to solving problems through a process of “listen, select, build”, which involve becoming aware of past successful solutions, identifying inner/outer strengths, and formulating goals (De Jong & Berg, 2008). The approach assumes the client is their own expert on what strategies and abilities they already have, which can improve their lives once they increase awareness of these strengths, through solution-building therapy (Walter & Peller, 1992). Techniques used include use of direct and indirect compliments, identifying exceptions, posing *scaling questions*, and the “*miracle question*” (Kim, 2008).





## Key Components

Solution Focused Brief Therapy (SFBT) focuses on a client's strengths, and solutions to challenges that they face, rather than focusing on problem solving. The approach is brief, typically lasting for sometimes only 5 sessions, hence its name. SFBT is characterized by the following:

- ✓ Developing solutions rather than problem-solving
- ✓ Focus on the client's desired future, rather than challenges from the past or present
- ✓ The client's useful behaviours are encouraged
- ✓ A SFBT therapist coaches the client to identify times when problems may have occurred but didn't as a way of developing solutions in collaboration with one another
- ✓ Clients are encouraged to use effective strategies that they currently use, and discouraged from using strategies that are maladaptive
- ✓ A belief that clients possess solutions to their life challenges
- ✓ The acknowledgement that small changes are parts of a larger potential change
- ✓ Solutions identified by clients are not necessarily related to a problem identified
- ✓ A therapist's communication skills elicit solution building strategies in the client rather than for the purposes of diagnosis and treatment

(Trepper et al., n.d.)

## Key Terms

Coping Questions ▪ Scaling Questions ▪ The 'Miracle' Question ▪ Exception Question ▪ Coping Question ▪ Skeleton Keys

## Research Evidence to Support the Approach

SFBT has been used as a treatment approach for a variety of clinical populations with diagnoses affecting physical and mental health, as well as in different practice contexts. Individuals with autism have used SFBT both in child (Lloyd & Dallos, 2008) and adulthood (Stoddart, McDonnell, Temple & Mustata, 2001). Individuals with mental health concerns have benefitted from SFBT interventions including those with depression and anxiety (Hanton, 2008; Kim, 2008; Gingerich, 2013; Knekt & Lindfors, 2004), schizophrenia (Eakes, Walsh, Markowski, Cain & Swanson, 1997; Panayotov, Anichkina & Strahilov, 2011) and substance abuse (Smock, Trepper, Wetchler, McCollum, Ray & Piece, 2008; Berg & Miller, 1992; Carroll & Nuro, 1997; McCollum & Trepper, 2001). Furthermore, individuals working in correctional facilities have utilized SFBT to support their rehabilitation (Lindfors & Magnusson, 1997; Shin, 2009).

### *Individuals and Groups*

Solution Focused Brief Therapy has been studied and applied on both an individual and group level including use with couples (Seedall, 2009; Murray & Murray, 2004; Hoyt & Berg, 1998; Christensen, Russell, Miller & Peterson, 1998), families (Trepper, 2012; Lloyd & Dallos, 2008; de Shazer, 1992; McCollum & Trepper, 2001; Zimmerman, Jacobsen, MacIntyre & Watson, 1996) and other groups (Newsome,



2004; Kim & Franklin, 2009; Ko, Yu & Kim, 2003; Smock, Trepper, Witchler, McCollum, Ray & Pierce, 2008). This approach may be referred to as Solution Focused Group Therapy or Solution Focused Counseling Groups while maintaining its essential tenants (i.e., miracle question, exceptions) (LaFountain & Garner, 1996). Processes and questioning techniques in SFBT groups can be addressed through individual or collaborative methods such as working together to identify applications of the miracle question (Trepper et. al., n.d).

### *Developmental Stages*

SFBT has been employed within pediatric populations to address academic (Gingerich & Peterson, 2013; Kim, 2013; Kim & Franklin, 2008; Lethem, 2002; Daki & Savage, 2010; Franklin, Moore & Hopson, 2008), emotional (Green & Grant, 2007; Daki & Savage, 2010; Kyarme, Selseth, Sorum, Luth-Handsen, Hauglan & Natvig, 2010) and behavioural concerns (Bond, Woods, Humphrey, Symes & Green, 2013; Moore, 2012). As well, specific child and adolescent populations/topics that have utilized SFBT include abuse and domestic violence (Georgiades, 2008; Corcoran & Franklin, 1998), chronic illness (Frels, Leggett & Larocca, 2009), substance abuse (Froeschle, Smith & Ricard, 2007), bullying (Kvarme, Aabo & Saeteren, 2013) and foster care (Koob & Love, 2010; Gostautas, Cepukiene, Pakrošnis & Fleming, 2005; Cepukiene & Pakrošnis, 2011). While there have been several studies related to SFBT and its uses among adults (see below), few studies have been conducted on uses for elderly individuals (Seidel & Hedley, 2008; Bonjean, 2003; Dahl, Bathel & Carreon, 2000; Ingersoll-Dayton, Shroepfer & Pryce, 1999).

## **Relevance for OT Practice**

While SFBT can be used in a variety of occupational therapy practice contexts including mental health, research connecting the profession and this approach has been predominantly in the area of return to work (Cockburn, Thomas & Cockburn, 1997; Nystuen & Hagen, 2006; Wells, Devonald, Graham & Molyneaux, 2010; Knekt, Lundfors, Laaksonen, Renlund, Haaramo, Harkanen & Virtala, 2011; Gingerich & Peterson, 2012). The focus of SFBT on client-centredness fits well with the philosophy of occupational therapy, which prides itself on such an approach (Townsend & Polatajko, 2007), and the emphasis of this counselling approach on improving a person's ability to function more effectively and more positively in an emotional sense can help occupational therapists to support their clients towards positive change. Attention to developing solutions to one's life challenges, rather than taking on a problem solving focus may enrich the overall practice of OTs interested in developing competency in this approach.

## **Competency Development**

The *Institute for Solution Focused Therapy* offers certification to international practitioners of SFBT. The following list of criteria must be met in order to receive certification. Although not required to practice SFBT, the following is a list of the procedures for acquiring the International Solution-Focused Practitioner Certificate. For further information, the following link will provide more detailed information on this process—

<http://www.sfbta.org/research.pdf> (2016).

1. Possess a terminal degree in a service field (counselling or therapy, education, social services, business consulting).
2. Be licensed or credentialed to practice in your field within your jurisdiction, or be working in an organized system under supervision.
3. Contact an IASTI-affiliated Solution-Focused training institute and register for an approved training Solution-Focused training course.
4. Complete 50 hours of formal training.
5. Complete 100 hours of Solution-Focused educational and practice activities subsequent to the 50 hours of formal training and document these in a law provided by the IASTI affiliate Institute where you completed the majority of your Solution-Focused training (These activities may include viewing Solution-Focused training videos, reading books, articles etc. on the Solution-Focused approach).
6. Schedule an examination with a staff member at the IASTI affiliate Solution-Focused institute where you completed the majority of years of training.
7. Pass the exam successfully, pay a \$150 processing fee. Once the Direct Training and Personal & Professional Activities are approved, the exam is discussed and scheduled.
8. Upon successful completion of these requirements, the International Solution-Focused Practitioner Certificate is awarded.

## Training

Training opportunities to develop competence in providing SFBT are available, but more limited compared to other modalities. Opportunities and resources to develop skills in SFBT are listed in the following sections.

## Training Opportunities

Organization	Course Name	Description	Cost	Contact
University of Toronto— Faculty of Social Work	Solution Focused Counselling	A certificate program aimed at developing specialist level competency in solution focused counselling. This is a 6 module certificate program offered in short intensives over a one year period. Each module represents 14 hours of instruction.	\$325 per module including HST	<a href="http://socialwork.utoronto.ca/conted/programs-and-workshops/certificates/sfc/">http://socialwork.utoronto.ca/conted/programs-and-workshops/certificates/sfc/</a>
University of Wisconsin	Online Training in Solution Focused Brief Therapy	A 16-week online non-credit course offered internationally for practitioners to learn, discuss, and practice strategies used in solution focused brief therapy. Participation requires approximately 3 hours of online participation per week.	\$1295	<a href="http://www4.uwm.edu/sce/course.cfm?id=1361">http://www4.uwm.edu/sce/course.cfm?id=1361</a>

## Supervision

Live supervision is recommended for SFBT therapists to ensure therapy session focus on solutions, and do not revert back to discussing the problem clients present. When live supervision is not possible, telephone, videoconference or video recording supervision are recommended. For more information regarding supervision, visit

<http://www.sfbta.org/research.pdf>

## Resources (2016)

Resource	Resource Type	Description	Link
Institute for Solution Focused Therapy	Organization	An organization based in the United States which focuses on the provision of training, certification, and promoting research in the interest of SFBT.	<a href="http://www.solutionfocused.net/solutionfocusedtherapy.html">www.solutionfocused.net/solutionfocusedtherapy.html</a>
European Brief Therapy Association (EBTA)	Organization	EBTA promotes, advocates and develops solution-focused theory, research and practice within psychotherapy, counseling, education and related areas of work as well as in other professional contexts like rehabilitation, specialized fields of health and social care in Europe and beyond.	<a href="http://www.ebta.nu">www.ebta.nu</a>
SolWorld	Organization	A UK based association aimed at promoting training and networking among practitioners of SFBT.	<a href="http://www.solworld.org/">http://www.solworld.org/</a>
SFBT Discussion List	Discussion List	Listserv to discuss issues related to SFBT.	<a href="mailto:SFT-L@listserv.icors.org">SFT-L@listserv.icors.org</a>
SFBT Evaluation List	Web	An online annotated bibliography of studies supporting the use of SFBT.	<a href="http://www.solutionsdoc.co.uk/sft.html">http://www.solutionsdoc.co.uk/sft.html</a>
A Selected Review of Research of SFBT	Web	A narrative literature review of research in SFBT.	<a href="http://www.solutionsdoc.co.uk/mckeel.htm">http://www.solutionsdoc.co.uk/mckeel.htm</a>
Solution Focused Approaches—Dr. Alasdair Macdonald, Consultant Psychiatrist, UK	Web	A summary of the body of literature published by Dr. Macdonald. Includes a reference list of these publications for further review.	<a href="http://www.solutionsdoc.co.uk/">http://www.solutionsdoc.co.uk/</a>

Northwest Solutions	Web	An online educational resource focused on asking solution focused questions.	<a href="http://www.northwestsolutions.co.uk/questions-res.php">www.northwestsolutions.co.uk/questions-res.php</a>
Centre for Addiction & Mental Health (CAMH)— Problem Gambling Institute of Ontario	Web	An online educational resource focused on SFBT.	<a href="http://www.problemgambling.ca/EN/ResourcesForProfessionals/Pages/SolutionFocusedBriefTherapy.aspx">http://www.problemgambling.ca/EN/ResourcesForProfessionals/Pages/SolutionFocusedBriefTherapy.aspx</a>
Solution-Focused Therapy Treatment Manual	Web	Trepper, T., McCollum, E., De Jong, P., Korman, H., Gingerich, W., & Franklin, C.  A pdf resource produced by the Research Committee of the Solution Focused Brief Therapy Association. This manual provides some guidelines on training, competency, and supervision.	<a href="http://www.sfbta.org/Research.pdf">www.sfbta.org/Research.pdf</a>
Solution Focused Brief Therapy Association	Organization/ Web	A listing of online pdf training manual resources.	<a href="http://www.sfbta.org/trainingLinks.html">http://www.sfbta.org/trainingLinks.html</a>

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# Gestalt Therapy (GT)

## Overview of Approach

Gestalt therapy (GT) has its foundation rooted in an experiential and humanistic psychotherapy framework. As outlined by Whelton (2004), "humanistic and experiential therapies emphasize the expansion of an individual's awareness and tacit experience and the responsibility to discover and create meaning from this awareness". A Gestalt Therapist engages with the client's awareness in the present moment rather than relying on classical psychoanalytic interpretations of the unconscious and/or a focus on past events. The main elements of Gestalt Therapy are the focus on the here and now, therapist-client relationship, environmental/social context, and the self-regulating adjustments that the client makes to achieve balance. Gestalt therapy more historically, has used present-centered experiments to increase the individual's awareness and his/her awareness of the process of awareness itself (Yontef & Simkin, 1989). The process focuses on how the individual makes or avoids contact (with self, other, environment) and to clarify how the present moment is experienced (Wagner-Moore, 2004). The paradoxical theory of change in Gestalt Therapy and the focus on present moment awareness highlights how GT is influenced by Buddhist and Taoist philosophies. Principles of Gestalt psychology and existential philosophy are also foundational to Gestalt Therapy.

Gestalt Therapy was founded by Frederick (Fritz) Perls and Laura Perls. Fritz Perl was originally a Freudian analyst. He and his wife developed the psychotherapeutic approach of GT in the 1940's. In developing Gestalt Therapy, they retained some elements of traditional psychotherapy such as the concepts of character structure and defenses. In the 1960's GT became the most visible of the humanistic existential therapies and a very prominent alternative to psychoanalysis and behavior modification (Latner, 1986).

**Contemporary Gestalt Therapy** has moved from its individualist focus in the early years to its roots in a relational-field approach to psychotherapy (D. Bloom, 2011). Along with this evolution, there are other theoretical and relational changes in contemporary Gestalt Therapy. Yontef outlines some these shifts as "more direct self-expression by the therapist, more of a dialogic emphasis, decreased use of stereotypic techniques, increased emphasis on description of character structure (with utilization of psychoanalytic formulations), and increased use of group process, an emphasis on self-acceptance, more trust of the patient's phenomenology, and more explicit work with psychodynamic themes". The contemporary evolution in Gestalt Therapy also impacts group therapy in that "there has also been an increase in emphasis on group process, including relations between group members, and a decrease in formal, one-to-one work in groups (Yontef, 1993)." In summary, contemporary Gestalt therapy has evolved much more towards a focus on the relationship (sometimes referred to as "the space between") between therapist and

client as one of the most important aspects of psychotherapy (Wagner-Moore, 2004).

## Key Components

Fundamental principles and practices of Gestalt Therapy include: holism and field theory, awareness, paradoxical theory of change, contact dialogue principles and present moment experiential experiments.

### Key Terms

Field Theory ▪ Awareness ▪ Contact ▪ Gestalt Experiment ▪ Dialogical Contacting ▪ Present-Focused Experiment ▪ Paradoxical Theory of Change

## Research Evidence to Support GT

### *Different Populations*

Gestalt Therapy has been shown to be an effective psychotherapeutic intervention for a broad range of populations including people with depression, anxiety, chronic illness, and grief related concerns (Tillett, 1994), and borderline and narcissistic patients (Yontef & Jacobs, 2010). Gestalt Therapy has been shown to be effective also with all ages and can be used in conjunction with other approaches both individually and in group therapy (Hatcher & Himelstein, 1976; Marcus, E., 1979, Knez, Gudelj & Svesko-Visentin, 2013; Kelly, Howie, 2011; Tillet, 1994).

Gestalt therapy is used in different practice settings and with different populations. For example, its application can range from working with children and adolescents, to families and couples. The theory and practice of Gestalt therapy can be incorporated into community mental health/recovery settings and in educational settings. We direct the reader to Gestalt Therapy: History, Theory and Practice (Woldt & Toman, 2005) for a selection of articles that discuss Gestalt Therapy's application to different populations and practice settings.

Research about process oriented humanistic psychotherapy is more difficult to conduct using experimental designs such as randomized control protocols. The psychotherapy method does not lend itself to RCT research as therapies that are based on a more manualized/systemized process. Hence, there are numerous anecdotal accounts of the efficacy of GT (Bretz, Heekerens & Schmitz, 1994; Knez et al., 2013, Kelly & Howie, 2011) and there are fewer accounts using an RCT experimental design.

Research investigating the effective elements in psychotherapy consistently points to the importance of therapeutic alliance (Wampold, 2001). Therapy success is best predicted by the client properties and the therapy relationship, and only 10-15% of outcome is accounted for by any treatment technique (Norcross, 2002). When

qualitative is included there is much evidence for the efficacy of Gestalt Therapy (Yontef & Jacobs, 2010). Often empirically validated treatments have been restricted to randomized control studies; this research design is not suitable for GT due to its inherent focus on dialogical contacting, and present moment experiential experiment based interventions.

Some researchers have found that RCT research designs and data collection methods favour behavioral philosophies and therapies. Strumpf (2004) found in a meta-analysis and literature review that, there were no significant differences between GT and CBT except for one study where process/experiential GT led to greater improvements in mastery of interpersonal problems, when compared to CBT.

An area that has attained much research efficacy using GT techniques is the work done by Greenberg on process-experiential therapy. Studies in this area support the central tenet of GT, integration of both techniques and the relational focus. Contemporary relational gestalt therapy is equivalent to Greenberg's process experiential therapy in many ways, although GT includes a broader base of work.

In a series of meta-analyses by Elliot, Greenberg and Lietaer (2004) examined studies comparing humanistic and behavior therapies and they found that when the "school of therapy factor" (humanistic versus behavioral) was taken out of the calculations that there were no differences in effectiveness between the practices. Results from a meta-analysis of 38 studies conducted by Bretz et al (1994) indicated that Gestalt Therapy is an effective treatment modality, with overall outcomes similar to other forms of psychotherapy (as cited in Joseph, 2008). The empty chair technique used in GT was shown to be more effective than therapy using the process of desensitization (Johnson & Smith, 1997). Watson et al (2003) compared the effectiveness of process-experiential with cognitive-behavioral psychotherapy in the treatment of depression and found greater improvement in treating depression with effect sizes comparable to CBT. In addition, Greenberg and Watson (1998) found both client-centered therapy and Process Experiential therapies (PET) groups were effective in treating depression with effect sizes comparable to CBT.

Greenberg, Elliot and Lietaer (1994) found in a review of 13 studies comparing experiential therapies with behavioral and cognitive interventions using meta-psychological statistics that 7 of the 13 studies that compared process-experiential with cognitive or behavioral interventions that a statistically significant difference was evident in support of the experiential based treatments. Similarly, Strumpf (2006) showed that significant results were found more frequently in a series of comparative studies by Elliot (2001) and Elliot et al (2004) in support of humanistic therapies (like GT) than for behavioral and psychodynamic approaches.

Finally, in a classic study of emotionally focused couples therapy by Johnson and Greenberg (1985) it was demonstrated that cognitive behavioral therapy and gestalt approaches, in a comparison, were equivalent and that GT showed benefits to cognitive therapy such that those receiving GT continued to improve after the end of therapy rather than just holding the progress that they made.

## *Gestalt 2-Chair Technique*

The Gestalt 2-Chair chair technique is the subject of greater empirical research by Greenberg and colleagues. The research is framed in context of emotion focused therapy (EFT), and the technique is founded in Gestalt Therapy. The research is methodologically well controlled and demonstrates the 2-chair technique reducing indecision, self-criticism, and improves marital adjustment and intimacy (Wagner-Moore, 2004; Shahar, Carlin, Engle, Hegde, Szepsenwol & Arkowitz, 2012). Two-Chair technique can appear quite simple, and yet there are cautions to using this technique without sufficient training. Discussions and cautions for therapists using the 2-Chair technique include: a) not to use the technique unless they have had personal experience with the technique, b) be ready for “explosions or strong emotional responses”, and c) know how to provide follow-up support; and when not to resolve an intense conflict” (Fagan et al., 1974 as cited in Wagner-Moore, 2004 pg. 185). Contemporary Gestalt therapy uses less of an emphasis on techniques such as 2-Chair technique, and the self-awareness component of this technique. There is more of a focus on the context of the environment of the client and the therapeutic relationship between therapist and client.

## *Depth of Emotional Experiencing*

Depth of emotional experiencing and the role of emotion are central to humanistic psychotherapies, Gestalt Therapy being one of them. Some research discusses that depth of experiencing, is as critical a feature of effective psychotherapy as is the therapeutic alliance. Greater empirical studies that investigate emotional processing and depth of experiencing demonstrate evidence for the effectiveness of experiential therapies. We refer the reader to a review of the research thoroughly discussed by Whelton (2004).

## *Neurobiology & Mindfulness*

Gestalt therapy is indirectly supported by evidence based research on interpersonal neurobiology and the mindfulness studies of Daniel J Siegel (The Mindful Therapist) and Daniel Stern (2004). Brain research supports the experiential and relational efficacy that is central in Gestalt Therapy.

In discussing the neurobiology of trauma, Van Der Kolk (2014) cites recent studies by Pat Ogden and Peter Levine about the neuroscience of trauma recovery which support the following therapeutic approaches that are integral in the theory and practice of Gestalt therapy:

- to draw out sensory information that is blocked and frozen by trauma
- to help patients befriend (rather than suppress) the energies released by the inner experience
- to complete the self-preserving physical actions that were thwarted when they were (immobilized) by terror

Neuroscience discoveries such as mirror neurons and the relational brain are proving the long term efficacy of the therapeutic relationship, and working with the client

“from the bottom up” in changing brain patterns compared to the older behavioral models (Van der Kolk, 2014, p.78).

## Relevance for OT Practice

### *Holism & Humanism*

The concepts of humanism and holism are central underpinnings of both occupational therapy and Contemporary Gestalt Psychotherapy. *“Humanistic and experiential therapies emphasize the expansion of an individual’s awareness of both conscious and tacit experience and the responsibility to discover and create meaning from this awareness” (Whelton, 2004).* Humanism views people as growing, developing, creating beings, with the ability to take full self-responsibility. This includes taking responsibility for maintaining their own health and for making choices that determine what they become (Creek, 1997). Humanism underlies all of the psychosocial occupational therapy frames of reference (Stein & Cutler, 1998). Hemphill-Pearson MS & Hunter (1997) explore the concept of holism in OT and mental health. They state that Bing (1981) concluded in his Eleanor Clark Slagle Lectureship that there is a "belief in the wholeness of the human--that the mind and body are inextricably conjoined" (Hemphill-Pearson & Hunter, 1997, pg. 42).

### *Client Centered and Therapeutic Alliance*

“The Gestalt therapist uses active methods that not only develop patient’s awareness, but also develop patients’ repertoires of awareness and behavioral tools. The active methods and active personal engagement of gestalt therapy are used to increase the awareness, freedom, and self-direction of the patient and are not used to direct patients towards pre-determined goals as in behavior therapy...” (Yontef & Jacobs, 2005). This quote highlights: a) active role of the client, b) the collaborative therapeutic alliance, and c) working with different aspects of the individual within their specific context, that are present in both GT and within an occupational framework.

### *The Canadian Model of Occupational Performance and Engagement (CMOP-E) & Gestalt Therapy*

The CMOP-E is one of the key models of occupational performance. When reviewing the CMOP-E there are many similarities of philosophy and practice between OT and GT. The humanist influence on both OT and GT are evident in the inclusion of spirituality (meaning making), engagement, and the active role of the client. The experience of contact in Gestalt Therapy finds a certain kinship in the concept of engagement within the CMOP-E. Both contact and occupational engagement are based on awareness and the relational element between self and other/environment. Finally, the therapist suggests the present moment experiential exercise to explore emotions, awareness, sensations, thoughts. In Gestalt Therapy, both the therapist and client co-create to adapt the present moment experiment to the specific context. This is similar to one of the core skills of OTs, activity analysis. Finally, the scope of the CMOP-E is a strong parallel for the relational field theory that is foundational to Gestalt Therapy.

### *A brief description of the CMOP-E*

- A. **The person**, the main aspects being: cognitive, affective and physical. Spirituality is positioned in the centre/core of the person and acknowledged to be an element of human occupation.
- B. **The environment**: classified into four components: physical, cultural, institutional and social. The environment influences the person and how occupations are engaged.
- C. **The occupation**: the 3 categories of occupation are self-care, productivity and leisure, and are referred to as occupational purposes. *“It is through occupation that the person interacts with the environment; therefore occupation becomes the link between the person and the context, as well as a means through which the environment is acted upon”* (Polatajko, H.J., Townsend, E.A. & Craik, J. 2007).
- D. **Engagement**: *“is also an outcome of the dynamic interdependent relationship between the person, occupation and environment”* (Polatajko, H.J., Townsend, E.A. & Craik, J. 2007)

Both OT and GT share mutual values in that some risk taking may be necessary for positive change and that the therapeutic process between the client and therapist is collaborative and central to the success of the interventions. Finally, both OT (Christiansen & Baum, 1991) and GT share the premise that recovery is based on the lens of unity between mind and body.

Values of bringing an occupational perspective (OP) to GT include:

- OP would further enhance the belief in GT that health is about enabling active engagement in daily life, having choice and control in one’s life and that people are shaped by their environment and can grow and change.
- GT teaches an advanced level of skill in areas of interpersonal communication, group leadership, transference/counter-transference, awareness and overall interviewing. These skills are crucial to OT and mental health especially in very challenging interpersonal relationships.

Challenges of bringing an occupational perspective to GT:

- GT is contraindicated for some people with severe and persistent mental illness (e.g. active psychosis, moderate cognitive impairment etc.) and some limits to application with some clients receiving acute psychiatric treatment.
- Need for further research on the OT and Gestalt Therapy as little research exists in this specific area.
- The application of the traditional “core skills” of GT (i.e. hot seat, empty chair, and psychodrama) requires thorough training and experience, especially when integrated with other perspectives. In contemporary Gestalt therapy models, such techniques are emphasized much less and rather replaced with the work of direct client contact with the therapist in a relational way.



## Competency Development

The development of core competencies in psychotherapy is one critical aspect of ensuring safe and effective use of self, and adherence of effective practice. To better understand the importance of competencies, the American Association for Marriage and Family therapy (AAMFT), states that: "...core competencies encompass behaviors, skills, attitudes and policies that promote awareness, acceptance and respect for differences, enhance services that meet the needs of diverse populations, and promote resiliency and recovery" (Northey, 2011).

The development of skills as a Gestalt Therapist involves completion of formal course work, as well as accessing qualified supervision from an experienced Gestalt therapist. Skillful use of dialogical contacting and designing present moment experiential experiments is essential to the psychotherapy process and requires thorough training. The depth of emotional experiencing is a key feature in humanistic process-experiential therapies such as Gestalt Therapy. For this reason on-going supervision is recommended to maintain skills and to process counter-transference that arises.

Non- manualized therapies such as Gestalt Therapy may use different methods to evaluate adherence and competence compared to manualized therapies. A recent dissertation by Meghan Case (2011) examined a method for evaluating process research in Gestalt therapy using the Psychotherapy Process Q-Set, with a panel of Gestalt therapy experts. This process involved examination of the most highly rated psychotherapy processes and least rated characteristics of Gestalt therapy. The outcome of her research included "a prototype for ideally conducted Gestalt therapy and a systematic method for evaluating treatment adherence" (Case, 2011).

The outcome of Case's dissertation suggests that the top six most highly rated processes of Gestalt therapy (of twenty characteristics) include: "A therapist's focus of attention to the clients' nonverbal behaviour (body posture, gestures), b) a therapist conveys a sense of non-judgemental acceptance, c) Is sensitive to client's feelings, and is empathic, d) Identifies a recurring theme in client's experience e) Responds to changes in a client's mood or affect, f) the therapeutic relationship is a focus of the sessions" (Case, 2011).

For the purpose of continuing professional development it is recommended that clinicians seek ongoing supervision with Gestalt therapy trained colleagues, engagement in further training to keep up to date with current evidence, and follow the requirements of, and comply with the College of Registered Psychotherapists of Ontario. The supervision of the clinician is vitally important for maintenance of a strong therapeutic use of self, for managing counter-transference and ensuring overall adherence to effective practice.

## Training

There are Gestalt Institutes in various cities in North America; Vancouver, Pittsburgh, Cleveland, New York, Los Angeles, Colorado and Cape Cod. The Gestalt Institute of Toronto is the only training program in Ontario, as such only its training program is featured in this section.

The Gestalt Training Program consists of five years of part-time study. The Gestalt Institute of Toronto Five Year Training Program received formal recognition from the College of Registered Psychotherapists of Ontario. This means that graduates of the five year psychotherapy education and training program will meet the entry –to-practice competencies as outlined by the College of Registered Psychotherapists of Ontario.

### *The 5-Year Part Time Training Program*

The Training Program offers a coherent experiential and didactic training in the practice of relational Gestalt psychotherapy within such competencies as transference and counter-transference, safe and effective use of self, professional resources and boundaries (a map of competencies throughout the program is available from the GIT) as well as clinical practice and supervision.

To graduate, a student is required to complete 30 hours of one-to-one supervision and 150 hours of direct client contact over and above those hours included within the training program. In addition, 40 clinical group supervision hours are provided within the program.

### *Requirements for Admission to the GIT Program:*

1. Completion of undergraduate degree.
2. Completed application - for greater detail visit the website:  
<http://gestalt.on.ca/training-programs/five-year-training-program-for-professionals/>
3. Successful completion of a standardized Faculty interview prior to commencing the program.

### *One Year Training for Professionals Program*

This program has been expanded in response to many inquiries from professionals desiring a foundational, intensive training in Gestalt Therapy that is combined with supervision. The experience is designed for therapists and counselors, trainers and facilitators, consultants and leaders who are currently practicing. Gestalt theory and methods will be taught as they apply to the particular client groups and responsibility areas of the participants. This is an excellent opportunity for professionals to learn the Gestalt method to apply to the skills and understanding within their own disciplines. Personal development is an integral part of this training.

Over the past three to four years, there has been a fundamental shift in how Gestalt therapy is taught at the Gestalt Institute of Toronto (GIT). More recently, this shift has been a movement away from the focus on the self, to a focus on a relational framework that address self-awareness and creative adjustment "in the field." The first year of the five year program begins with the exploration of the creative adjustments as within a field of the person. This exploration process stems from the belief that without support in the field, no change is possible. The former framework put more emphasis on the individual to change although the context a person was in was always important. The relational approach is based in developmental therapy which suggests in part that a person is born into a community and learns how to be

through the responses of other people. In the contemporary Gestalt program, the therapist is trained to see the client's creative adjustment as a function of a larger system (personal communication, Tropianskaia, June 24, 2015).

The foundational learning in the "One Year Training program for professionals" includes:

- Foundational theories of Relational Gestalt therapy
- Working with Resistance
- Theory of the Creative Adjustment in the field
- Introduction to Gestalt Assessment and Safe and effective use of self
- Relational therapy and making contact: employing the dialogic encounter
- Understanding body language
- Creativity, creating the Experiment
- Clinical practice and supervision

Participants are awarded a Certificate of Completion of One Year Training in Gestalt Theory and Methodology following 135 hours of course time.

### *Tuition Fee*

\$2,450 per year plus residential fee of \$555

(Residential Fee includes: accommodation and all meals. Travel arrangements are the responsibility of the individual.)

*Contact information:* [www.gestalt.on.ca](http://www.gestalt.on.ca) Telephone: 416-964-9464

## Supervision

### *Gestalt Supervision Guidelines as per head of faculty at Gestalt Institute of Toronto:*

- Supervision is provided in the 5 year training program
  - Clinical supervision groups are limited in size to 8 persons. Currently 20 hours of clinical group supervision is provided in Year 4 as part of the curriculum as well as in Year 5. These groups are faculty led.
- To become a supervisor, GIT offers a training program that is consistent with the College of Registered Psychotherapists of Ontario's (CRPO) recommendations.
  - Three years after proclamation (of the CRPO), a clinical supervisor is a regulated practitioner in psychotherapy in good standing with his or her College, who has extensive clinical experience, generally five years or more, in the practice of psychotherapy, and who has demonstrated competence in providing clinical supervision.
- Can a GIT Therapist supervise an OT training at GIT?
  - There are discussions at the Transitional Council about practitioners seeking to being supervised by clinical supervisors in other disciplines than their own specialty and there are no guidelines

except the obvious differences between specialties and also colleges. For a member of one to have supervision hours accepted from a supervisor who belongs to another college it will be necessary to ensure no conflict of professional standards.

- Maintaining regular supervision as a psychotherapist is recommended by the CRPO :
  - Clinical supervision means a contractual relationship in which a clinical supervisor engages with the supervisee to promote the professional growth of the supervisee, enhance the supervisee’s safe and effective use of self in the psychotherapeutic relationship, discuss the direction of therapy, and safeguard the welfare of the client.
  - GIT supports supervision during the program and after a student graduates. Graduates may select to work one-to-one with a GIT faculty member, or therapist that meets the guidelines of a supervisor. Clinical group supervision is also available to graduates of GIT.

## Resources (2016)

Resource	Resource Type	Description	Link
Gestalt Therapy: 100 Key Points & Techniques	Print	Mann, D. (2010) Gestalt Therapy: 100 Key Points & Techniques. New York: Routledge Taylor and Francis Group.	N/A
Collaboration in Experiential Therapy	Research Article	Berdondini, L. Elliot, R.& Shearer, J. (2012). Collaboration in Experiential Therapy. <i>Journal of Clinical Psychology: In Session</i> , Vol. 68(2), 159-167 (2012).	N/A
Predictors of differential response to cognitive, experiential and self-directed psychotherapeutic procedures	Research Article	Beutler, L. E., Engle, D., Mohr, D., Daldrup, R. J., Bergan, J., Meredith, K, & Merry, W. (1991). Predictors of differential response to cognitive, experiential and self-directed psychotherapeutic procedures. <i>Journal of Consulting and Clinical Psychology</i> , 59(2), 333-340.	N/A
Humanistic therapies versus other psychological therapies for depression	Research Article	Churchill, R., Davies, P., Caldwell, D., Moore T, M., Jones, H., Lewis, G., & Hunot, V. (2010). Humanistic therapies versus other psychological therapies for depression. <i>Cochrane Database of Systematic Reviews</i> , 9.	N/A

The efficacy of brief dynamic psychotherapy: A meta-analysis	Research Article	Crits-Christoph, P. (1992). The efficacy of brief dynamic psychotherapy: A meta-analysis. <i>The American Journal of Psychiatry</i> , 149(2), 151-158.	N/A
Humanistic therapies versus treatment as usual for depression	Research Article	Davies P, Hunot, V., Moore, T H. M., Caldwell, D., Jones, H., Lewis, G., & Churchill, R. (2010). Humanistic therapies versus treatment as usual for depression. <i>Cochrane Database of Systematic Reviews</i> , 9.	N/A
Gestalt Institute of Toronto	Organization	An organization that promotes the use of Gestalt Therapy in Canada, and offers educational programs to help professionals develop competency as Gestalt Therapists.	<a href="http://www.gestalt.on.ca">www.gestalt.on.ca</a>
Humour in Gestalt Therapy- Curative Force and Catalyst for Change: A Case Study	Research Article	Jacobs, S. Humour in Gestalt Therapy- curative force and catalyst for change: a case study. <i>South African Journal of Psychology</i> , 39(4),498-506.	N/A
Exploring the influence of gestalt therapy training on psychiatric nursing practice: Stories from the field	Research Article	Kelly, T. & Howie, L. (2011). Exploring the influence of gestalt therapy training on psychiatric nursing practice: Stories from the field. <i>International Journal of Mental Health Nursing</i> , 20, 296-304.	N/A
The Gestalt Therapy approach to the treatment of panic attacks and high anxiety: An alternative to cognitive-behavioral approach	Print	Khanna, F & Riker-Kucic, M. (1999). The Gestalt Therapy approach to the treatment of panic attacks and high anxiety: An alternative to cognitive-behavioral approach. The Gestalt Institute of Toronto.	N/A
Gestalt Psychotherapy in the Outpatient Treatment of Borderline Personality Disorder: A Case Report	Research Article	Knez, R, Gudelj. L & Svesko-Visentin, H. (2013). Gestalt Psychotherapy in the outpatient treatment of borderline personality disorder: a case report. <i>African Journal of Psychiatry</i> , January 2013; 16:52-54.	N/A
Gestalt Approach to Group Supervision	Research Article	Melnick, J. & Marijane, F. (2008). A Gestalt Approach to Group supervision. <i>Counselor Education &amp; Supervision</i> , (48): 48-60.	N/A
Psychodynamic Therapies Versus Treatment as Usual for Depression	Research Article	Moore, T, H, M., Hunot, V., Davies, P., Caldwell, D., Jones, H., Lewis, G., & Churchill, R. (2010). Psychodynamic therapies versus treatment as usual for depression. <i>Cochrane Database of Systematic Reviews</i> , 9	N/A

An Interview with John Wymore: Current Practice of Gestalt Therapy	Research Article	Wymore, J. Madewell, J. & Shaughnessy, M. (2009). An interview with John Wymore: Current Practice of Gestalt Therapy. <i>North American Journal of Psychology</i> , 2009, Vol (11), No. 3, 429-436.	N/A
The Therapeutic Process with Children	Research Article	Oaklander, V. (1997). The Therapeutic Process with children. <i>Gestalt Review</i> , 1(4):292-317.	N/A
The Therapy Process with Children and Adolescents	Research Article	Oaklander, V.(1997). The Therapy Process with Children and Adolescents. <i>Gestalt Review</i> , 1, (4).	N/A

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# Psychotherapy Supervision

Supervision of counseling and psychotherapy practice is widely promoted as an essential aspect of ethical and effective therapy and a cornerstone of continuing professional development (Bernard & Goodyear, 2014). Psychotherapy supervision is an expectation in the College of Occupational Therapists of Ontario (COTO) Standards (2010), with recommendations for supervision and training for a minimum of two years. Supervision is a formal process that focuses on theorizing and case conceptualization, skills training, clinical professional and ethical reflection, mentoring, professional development and personal support (Schofield & Grant, 2013). According to the College of Registered Psychotherapists of Ontario (2014), clinical supervision is defined as "a contractual relationship in which a clinical supervisor engages with the supervisee to promote the professional growth of the supervisee, enhance the supervisee's safe and effective use of self in the therapeutic relationship, discuss the direction of therapy, and safeguard the well-being of the client". Psychotherapists often view clinical supervision as a key method for continual improvement of professional competence and many engage in supervision throughout their careers (Schofield & Grant, 2013).

Although supervision is clearly an important aspect of psychotherapy practice, resources to support psychotherapy supervision are not well established within the profession of occupational therapy. A survey of Ontario occupational therapists noted that 54% of the respondents indicated that they never received either formal, or informal psychotherapy supervision and over 65% did not currently have access to supervision (Moll et al., 2013). Although there were therapists who did seek out supervision, it was typically provided by other disciplines, primarily psychologists (43%), psychiatrists (27%) or social workers (19%). Many survey respondents expressed an interest in receiving supervision from other occupational therapists (Moll et al., 2013). There is no formal process, however, for psychotherapy supervision within the profession of OT in Ontario, for either professional development as a supervisor or for finding OTs who are competent to provide supervision. Furthermore, the authors were unable to find any theoretical or research articles regarding psychotherapy supervision in occupational therapy. There is, however, an extensive body of literature on psychotherapy supervision from other professions; this literature was reviewed in terms of how it could inform supervision in occupational therapy practice.

## *Why should therapists obtain supervision?*

Research into psychotherapy supervision supports its value in strengthening the skills of the therapist, and ultimately improving outcomes for clients or patients. Wheeler and Richards (2007) conducted a systematic review of evidence that examined the impact of supervision on therapists, their practice and their clients. Their synthesis of eighteen articles led them to conclude that supervision had a positive impact on: a) self-awareness of therapists, particularly regarding their relationships with clients; b) improved skills in managing different aspects of the psychotherapeutic process; c) increased theoretical congruence; and d) increased therapist self-efficacy. An effective supervision experience can be a positive and enriching learning experience that can lead to many levels of professional development and trainee well-being

(Creaner, 2014). In terms of the impact on client outcomes, studies with novice therapists have shown that well-supervised trainees have fewer premature dropouts from therapy (Okiishi, Lambert, Nielsen & Ogles, 2003), and that the lack of supervision can lead to loss of skill and therapeutic capacity (Leszcz, 2013). Several studies have reported an increased quality of the therapist/client working alliance among therapists who have received structured clinical supervision, compared to those who have not received supervision (Bambling et al., 2006; Hilsenroth et al., 2002). There is also some emerging evidence that supervision can lead to improved client outcomes, including decreased symptoms and increased adherence to therapy (Bambling et al., 2006; Bradshaw, Butterworth & Mairs, 2007). It should be noted, however, that there are many challenges associated with the methodology of supervision research, including weak methodological designs and inconsistent approaches to supervisor training, provision of supervision, and tracking client outcomes (Watkins, 2011).

### *What are the goals of supervision?*

According to the College of Psychotherapists of Ontario (2014), clinical supervision is defined through a contractual relationship in which the supervisor engages with a supervisee to:

- ✓ Promote the professional growth of the supervisee
- ✓ Enhance the supervisee's safe and effective use of self in the therapeutic relationship
- ✓ Discuss the direction of therapy
- ✓ Safeguard the well-being of the client.

Watkins, an established researcher and advocate for psychotherapy supervision, argues that supervision is “an educative process by which supervisors strive to embrace, empower and emancipate the therapeutic potential of supervisees”, and that the objective is “to provide the rich and nourishing soil within which supervisee identity can take form, treatment skills can be developed and independence can be actuated” (Watkins, 2012, p.193). Within this process, the supervisor may take on many roles and tasks, from role model and teacher, to confidante, evaluator and supporter. Supervision is different from mentoring and therapy, however, because it has a required evaluative component, where corrective feedback on the supervisee's performance, teaching and collaborative goal setting are all central elements to the supervision process (Milne, 2009).

A model of the tasks of psychotherapy supervision was created by Inskipp and Proctor (1993). They emphasized three central tasks or functions: normative, formative and restorative. Normative functions focus on administrative tasks such as selection and assessment of clients, quality control issues and record keeping. Formative functions focus on linking theory to practice, thereby ensuring effective and competent intervention. Restorative functions focus on the relationship, such as dealing with counter-transference, therapeutic challenges, and feelings of failure and doubt on the part of the therapist. The therapeutic relationship is central to psychotherapy effectiveness; the parallel process of the supervisory relationship is as important in the process of supervision itself (Klein, Bernard & Schermer, 2011).

## *What does supervision look like?*

There are many different formats that the supervision process may take. Weerasekera (2013) reviews three main approaches:

### *Key Terms*

**Case report** - Many traditional supervision approaches focus on case discussions where supervisees provide a report of their therapy session and the supervisor provides feedback. The feedback is based on the supervisee's account of the session rather than direct observation. It can be helpful for supervisees to reflect upon, and then present a conceptualization of the content and process of the session. It has been noted, however, that supervisees often miss, misinterpret, or inaccurately recall what happens in the therapy session which can limit supervision effectiveness (Bernard & Goodyear, 2014).

**Co-therapy** - The second approach is called "co-therapy" where the supervisor and supervisee conduct the session together and then discuss the process afterwards. There can also be "live supervision" where the supervisor is behind a two-way mirror and providing instructions to the supervisee through an earphone. In this approach, the supervisor acts as a role model, where trainees learn by example. Another advantage of this approach is the opportunity for immediate reflection and feedback which can enhance learning "in the moment" and increase the likelihood of integration of learning (Kivlighan, Angelone & Swafford, 1991).

**Audio or video review** - The final model involves direct supervision with delayed feedback. The supervisor reviews audio or video recordings of the therapy process following the session itself then provides feedback. Weerasekera (2010) argues that this approach adds value because it facilitates self-reflection on the part of the trainee and can also facilitate a process of micro-counselling where moment-to-moment feedback is given to the trainees about their in vivo performance. Advances in technology mean that this can be a cost effective approach to supervision, and can enable supervision from a distance. Webcams can even be used to facilitate live supervision sessions. There are, however, important ethical issues to consider in taping the session and ensuring client consent to share it outside of the confidential client-therapist relationship.

A survey of supervision practices conducted by the American Psychological Association noted the following variation in how often different types of supervision approaches were utilized; case discussion (42%), video recording (12%), live supervision (10%), and audio recording (9%) (Weerasekera, 2013). A document on best practice in supervision recommends that supervisors use a range of methods for direct observation (including live observation as well as recordings), and a range of supervision foci, from case conceptualization to counselling skills and self-reflection (Borders et al., 2014).

Supervision can be provided in a one-to-one, paired, or group format (Ennis, Cameron, Leszcz, Chagoya, 1998). The advantage of individual supervision is that feedback can be in-depth and specific, tailored to the needs of the trainee. For novice (and experienced) therapists, this individualized, focused feedback may be what is most needed. Group supervision, on the other hand, is another option that

may be less expensive. Ellis (2010) explains that group supervision may increase exposure to a wider range of issues and approaches, enabling exploration of a variety of solutions to a clinical problem. Groups can also be a forum for building support and reducing professional isolation. The supervision process, however, needs to integrate theory about group process and dynamics in order to provide an optimal experience (Ellis, 2010).

Peer supervision in a group format is another option that experienced therapists may benefit from as an opportunity for continued sharing of experiences and issues with colleagues, and reducing professional isolation and burnout (Ellis, 2010). It should be noted, however, that unstructured peer supervision in the form of discussion with colleagues is not considered to be an acceptable form of supervision for registration with the College of Psychotherapists of Ontario (CPO, 2014). According to CPO guidelines, at least one of the peers must qualify as a clinical supervisor and the process must be formal and structured.

The recommended duration of supervision varies from one approach to the next. The College of Occupational Therapists of Ontario (2010) recognizes that the need for supervision changes over time, and that therapists may move from supervision to a consultation model for ongoing peer support/review following a period of supervision, feedback, and self-reflection. They do, however, recommend at least two years of formal training that includes structured supervision.

### *Are there different approaches to supervision?*

Supervision may look different depending upon the supervisor, supervisee and the context of the supervision arrangement. Several models of supervision have been proposed to capture different approaches to the teaching-learning process. The focus of the supervisory process may vary depending upon the model that is adopted. Three broad categories of supervision are noted in the literature: developmental, psychotherapy-specific, and integrative (Bernard & Goodyear, 2014).

The first approach to supervision has a developmental focus, where the process varies depending upon the developmental stage of the supervisee. In this approach, it is assumed that the supervisee will progress through a series of distinct stages from beginner to expert, and that a different supervisory approach will be needed at each stage for optimum growth to occur (Bernard & Goodyear, 2014). Stoltenberg (1997), for example, identified three levels of supervisees: beginning, intermediate, and advanced. At the beginning stage, the supervisee might be more rigid or superficial in his/her understanding of the issues therefore the supervisor may need to be more active in providing direction and input. The supervisee may be highly motivated, but also highly anxious, and require supportive feedback. At an intermediate stage, the supervisee might want input with more difficult clients, but resist, or avoid supervision because their self-concept is easily threatened. The supervisor may need to respect the desire for autonomy, but be available to provide input and direction as needed. Over time, the supervisee's competence level increases, and they start to take responsibility for their actions, becoming more self-confident, and self-reliant. According to this model, the supervisor needs to be flexible and respond to the learning needs of the trainee. This involves encouraging the supervisee to build on their prior knowledge and skills as they begin the process



of integrating new knowledge and skills. It is important to note that the stages are not necessarily linear. With a new situation, the supervisee may revert back to a previous level. The process may therefore change and evolve over time.

Another approach to supervision focuses on the framework and techniques of the specific psychotherapy theory or model being practiced by the supervisor and supervisee. Beck, Sarnat and Berenstein (2008) explain that the process of supervision could be a parallel process to therapy, consistent with the principles of the specific approach, whereby the supervisor models the principles in practice. For example, a psychodynamic approach might focus on issues of transference and counter-transference, anxiety and defense mechanisms. The supervisory relationship could be an opportunity for dialogue, self-reflection and personal growth to understand and work through these issues. A cognitive-behavioral (CBT) approach to supervision, on the other hand, might follow a similar structure to a CBT therapy session, beginning with a check-in, moving to problem formulation and problem solving or skill training (eg. role play with feedback) and ending with homework. The supervisor might use CBT techniques such as Socratic questioning or guided discovery to facilitate the learning process. One of the advantages of a modality-specific approach to supervision is the opportunity for immersion in the principles and practices of a particular approach and congruency between the supervisory relationship and clinical practice. The process of socialization and opportunity to learn the nuances of an approach can be helpful, particularly for novice therapists (Beck, Sarnat & Berenstein, 2008). It is important, however, to ensure that there is space for critical reflection on the approach and flexibility in terms of how it might be incorporated into the learning experience. Also, it is important to ensure that the supervision is for the purposes of learning, not therapy (Leszcz, 2011).

The third, more contemporary approach to supervision is classified as “integrative”. These supervision models incorporate more than one theory and technique, and parallel the fact that many psychotherapists adopt an eclectic approach in practice (Haynes, Corey, & Moulton, 2003). Hawkins and Shohet (2012) developed a process model of supervision, which highlights seven different points that supervision may focus on: the client and how he/she is presenting; the intervention techniques; the therapeutic relationship; the reactions of the therapist being supervised; the supervisory relationship; the reactions of the supervisor, and the wider system or organizational context. This model considers relational as well as contextual factors and the tasks of supervision. Watkins & Scaturro (2013) describe another integrative, learning-based model of psychotherapy supervision. They propose a three stage process of supervision: 1) alliance building and maintenance, 2) educational interventions, and 3) learning/re-learning. This model focuses on the foundational process of relationship building, followed by teaching and new learning or re-learning through corrective experiences. In an integrative approach, trainees are exposed to many ways of thinking about a particular case, and are challenged to think synergistically about how different perspectives might inform intervention (Watkins, 2012). Watkins (2012) asserts that psychotherapy supervision in the new millennium will focus on competency-based, evidence-based approaches that



incorporate a range of strategies designed to be individualized to the needs of the trainees and their clients.

As outlined above, there are many different models of supervision with no consensus as to whether one model is better than the other. Instead, it is recommended that the supervisor and supervisee develop an initial contract clearly outlining the expectations and process of the supervision process, with transparency as to the supervision approach that will be adopted (Borders et al., 2014). The model of supervision may vary depend on the learning needs and goals of the supervisee, and the expertise of the supervisor.

### *What should I look for in a supervisor?*

The College of Psychotherapists of Ontario (2014) stipulates that a clinical supervisor is a regulated practitioner in psychotherapy in good standing with his or her College, who has extensive clinical experience, generally five years or more, in the practice of psychotherapy and who is competent in providing clinical supervision.

There is a growing knowledge base regarding supervision competencies and supervisor training (Falender & Shafranske, 2004). The Association for Counsellor Education and Supervision, for example, has developed best practice guidelines for clinical supervision that detail key recommendations generated from an extensive review of the literature, as well as expert consensus, legal precedents, and input from clinical supervisors (Borders et al., 2014). The document outlines twelve areas of best practice, including various stages of the supervision contract (initiating, goal setting, conducting supervision, providing feedback), dynamics of the supervisory relationship (eg. resistance, power dynamics, boundaries), diversity and advocacy, ethical considerations, and documentation. Characteristics, attitudes and behaviors of a competent supervisor are outlined, including recommendations for supervisor preparation and training. Some of the key characteristics of a competent supervisor are as follows:

- ✓ Competent and experienced practitioner who has knowledge of a range of theoretical orientations and techniques and experience with diverse client populations, relevant to their counseling setting;
- ✓ Highly competent, morally sensitive, and ethical in the practices of counseling and supervision;
- ✓ Employs an appropriate ethical decision-making model in responding to ethical challenges and issues and in determining courses of action for themselves and the supervisee;
- ✓ Formal training in clinical supervision with knowledge about strategies to promote self-efficacy, development and competence in supervisees;
- ✓ Competent in multicultural counseling and supervision of diverse trainees
- ✓ Individualizes supervision based on the specific needs of the supervisee (e.g., learning goals, developmental level, learning style);
- ✓ Manages supervisory relationship dynamics competently and appropriately
- ✓ Maintains regular and accurate supervision records;
- ✓ Able to clearly describe the purpose of clinical supervision and distinguishes it from the counselling process as well as from administrative and program supervision and;

- ✓ Engages in self-reflection and other personal professional development as a supervisor.

It is recognized that one of the most important aspects of supervision is the quality of the supervisory relationship (Bernard & Goodyear, 2014; Ellis, 2010; Landy et al., 2013). Supervisors should be supportive, yet appropriately challenge therapists to reflect on and improve their skills (Klein, Bernard & Schermer, 2010). Dansey (2014) suggests that in looking for a supervisor, the initial contact between supervisor and supervisee is critical. He also cautions that supervisors should not supervise people that they have counselled, and that clear contracts should be developed outlining logistics regarding the number and duration of sessions, the supervisor's availability between sessions, and the degree of structure and responsibility of the supervisor (Dansey, 2014; Kilminster & Jolly, 2000). Supervisors must also know how to manage the supervisory relationship including counter-transference and boundary issues.

It is recommended that supervisors receive specific training and ongoing support and feedback in their role (Leszcz, 2011). A study conducted on training for clinical supervisors reported that the training led to improved competence in application of educational principles, adaptation of supervision to different contexts, creation and maintenance of the supervisory alliance, ability to help supervisees to reflect on their work, offer constructive feedback, apply ethical principles, structure supervisory sessions, gauge supervisees level of competence, and act on limitation of supervisee's knowledge and experience (Bagnall, 2011)—all key components of the supervisor's role.

### *Are there any risks, or barriers to supervision?*

It should be noted that there is a cost associated with psychotherapy supervision; it takes both time and money. The cost of supervision may vary depending upon the expertise of the supervisor, the frequency of the sessions and format of the supervision approach. Therapists may need to proactively seek out supervision if it is not already provided in the workplace, and to schedule time for feedback and support. It should also be noted that seeking feedback on performance is not always easy; therapists need to be open to constructive criticism and be willing to make changes to improve their practice. The quality of the supervision may vary depending upon a number of factors related to the supervisor, the supervisee, the relationship, and the practice context, and these forces are not necessarily within your control. As mentioned in the previous section, there are some issues to consider in seeking out supervision. Finally, if you are planning to obtain supervision in your practice, it is important to clearly communicate to your clients and obtain their informed consent to share information, and to create and share video or audiotapes of therapy sessions.

Despite these potential barriers, there are many gains that can be made in terms of developing confidence and competence in working with clients. Psychotherapy is a controlled act due to the potential risk of psychological harm to clients, therefore it is important to practice safely and competently. As such, it should be noted that an essential competency of practicing occupational therapists identified by COTO (2011) is that "occupational therapists use critical reasoning and reflection approaches for

safe, ethical and reflective practice” (COTO, 2011, p. 12). Psychotherapy supervision is an important method to engage in reflection, evaluation and integration of these findings into one’s practice for the betterment of clients. Competency development is a journey. Therefore, supervision may be something that you revisit at various points in your career.

### ***What are the future directions for supervision in occupational therapy?***

In the profession of occupational therapy, the professional culture and infrastructure to support psychotherapy supervision is not well developed. There is little, if any, literature within the profession about psychotherapy, let alone psychotherapy supervision, and many occupational therapists are unable to access psychotherapy supervision as part of their practice. Although there are many potential avenues to access psychotherapy supervision, it does require time to find a suitable supervisor and funding to pay for the supervision. If we are to establish our credibility and competence in psychotherapy, we need to address this significant gap.

#### ***Recommendations for the profession are as follows:***

- ✓ Occupational therapists need to understand the supervision standards associated with the specific psychotherapy approach that they are adopting. Within each chapter of this compendium, there are notes about modality-specific supervision requirements that have been established in the literature.
- ✓ Occupational therapists need to proactively seek out supervision if they are intending to practice psychotherapy, or maintain an established psychotherapy practice. COTO guidelines (2010) outline that the therapist should assume full responsibility to seek out and utilize supervision or consultation, support and resources on an ongoing basis. In this chapter, some guidelines have been provided regarding different models and approaches to supervision, and issues to consider in finding an effective supervisor. There are costs associated with supervision, therefore advocacy may be needed with an employer, and possibly within the larger healthcare system regarding professional competency development.
- ✓ Occupational therapists with expertise in psychotherapy should consider opportunities for additional training to be a supervisor. There is a significant need for OT-specific psychotherapy supervision and this would help to fill a gap within the profession.
- ✓ Opportunities for linking OT supervisees and supervisors need to be developed. This could be facilitated through our professional association, and the OSOT mental health sector team will be exploring options to develop this infrastructure for communication.
- ✓ The good news is that we have clear standards as a profession that emphasize the importance of supervision in establishing and maintaining competency in psychotherapy practice (COTO, 2010). Our professional training is grounded in the importance of reflective practice, and lifelong

learning to maintain professional competence, and we have the foundational skills to provide competent psychotherapy practice. We do, however, need to build a professional culture and resources to support supervision for OTs who are practicing, or who are intending to practice psychotherapy.

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# Appendix A—Key Terms Defined

**ABC Model (CBT):** A model used in CBT to conceptualize the relationship between events, beliefs and consequences of the event. It is an acronym representing ‘activating event,’ ‘beliefs about the event,’ and ‘consequences,’ or the resultant emotions, or behaviours associated with a person’s belief in this event. This term was introduced by Albert Ellis in the development of Rational Emotive Behaviour Therapy (REBT), and refined during the development of CBT by Aaron Beck.

**Acceptance (Mindfulness):** The practice of recognizing the way things truly are in the present moment, free from the ways in which we imagine them to be, or in the context of storytelling.

**Attention (Mindfulness):** The practice of directing our consciousness towards ourselves, or something, or someone in our environment. Mindfulness encourages the practice of sustained attention as a way of developing and cultivating the state of mindfulness.

**Automatic Thoughts (CBT):** Thoughts that appear in a way that seems instantaneous and without conscious control. These thoughts are related to events occurring in a person’s experience. In CBT, these thoughts are seen to be informed by a person’s core belief system, and the ways in which that system forms one’s perspective on the world and themselves. Automatic thoughts are used in CBT to build awareness of core beliefs, and to identify a strategy for managing them.

**Awareness (Gestalt):** Is both a means and an end in Gestalt Therapy (Tonnesvang et al, 2010). Quite simply, awareness can be thought of as bringing attention to what is happening, how it is happening, and when it is happening. As an experiential process oriented therapy, Gestalt employs awareness of how thoughts, sensations, behaviors, etc. occur as a means in therapeutic process, and as an end. Awareness of “the how” in itself can be a result of therapy, support insight, and choice in action.

**Awareness (Mindfulness):** The state of being mindful.

**Behavioural Experiments (CBT):** A strategy used in CBT in which a person agrees to participate in a real-life scenario that will allow him or her to practice new strategies that have been learned in therapy, or to challenge one’s current cognitions. These experiments are conceptualized based on the client and therapist’s formulation of the client’s cognitive structures.

**Change Talk (MI):** In motivational interviewing, a therapist learns to listen for a client’s assertions and statements that indicate an interest and willingness to change. This includes the client’s wish, need, reason, or ability to make changes. This is encouraged in the process of motivational interviewing by the therapist.

**Cognitive Restructuring (CBT):** The act of challenging and addressing distortions with a client in the process of therapy. It also relates to the ways in which a therapist supports a client’s new cognition in the context of therapy and their everyday life.

**Cognitive Distortions (CBT):** Irrational and exaggerated thoughts that form the way a person perceives the world or themselves. An example of a cognitive distortion would be *generalization*, in which a person assumes that *all* persons with a similar quality are entirely similar.

**Contact (Gestalt):** In Gestalt Therapy is used in a specific context and is a multi-dimensional concept and experience. Contact is the "basic unit of relationship involving an experience of the boundary between "me" and "not me"; feeling a connection with the "not -me" while maintaining a separation from it (Yontef & Jacobs, 2010). In this context, contact occurs between self and another person, and between self and environment, when one is engaged. Contact is also an experience within the therapeutic relationship, and the experience of contact fluctuates over time. “What happens in the relationship is crucial...this is more than what the therapist says to the patient, and more than the techniques



used...of most importance is the nonverbal subtext (posture, tone of voice, syntax, interest level) that communicates tremendous information to the patient about how the therapist regards the patient, what is important, and how therapy works” (Yontef & Jacobs, 2010). With the focus of contemporary Gestalt Therapy on the relational aspect between therapist and client, contact is one central component of this.

**Coping Questions (SFBT):** Inquiries posed by therapists in SFBT regarding previous strategies a client has used in the past to manage their problems, or concerns.

**Core Beliefs (CBT):** A long enduring belief that frames the ways in which a person views the world, and their place within it. This helps to inform the ways in which a person behaves in response to their beliefs about the world. An example of this would be that a person believes that he or she is not worthy, and thereby places the needs of others ahead of themselves even when their own needs are not being met. Core beliefs can be positive and adaptive. For example, a person who believes that they are loveable, will act with confidence in social situations due to their assumption that others will like and approve of them.

**Distress Tolerance (DBT):** One’s ability to tolerate a reasonable level of discomfort, and to cope in the context of experiencing it. In DBT, distress tolerance skills are developed in order to increase a person’s resilience in the face of crisis.

**Dialectics (DBT):** An acknowledgement and bringing together what appear to be opposites as a part of the therapeutic process. The notion of integrating *acceptance* and *change* is an example of this and involves both client and therapist arriving at a state of acceptance for the way things currently are, while focusing on change to arrive at the client’s goals.

**Dialogical Contacting (Gestalt):** Refers to the awareness and focused dialogue within the therapeutic encounter. It is entwined with the relational-field that is created by the therapist and client and how they both experience the co-created encounter (Bloom , 2011).

**Emotion Regulation (DBT):** A group of skills used in DBT that help a person to learn to alter their emotions, alter the environment, or think differently about situations in their everyday lives in order to achieve emotional stability.

**Exceptions (SFBT):** Situations or periods of time in which a client did not feel as significantly impacted by their current concerns, and was able to engage in positive successful behaviours and solutions in their life.

**Field Theory (Gestalt):** Refers to the premise that everything is relational and all things are in flux. Holism states that people are essentially self-regulating, focused on growth and that our environment is an integral aspect of who we are. Field theory is based on the idea that our context in life is a core aspect of what we experience (Latner, 1986). Within Gestalt theory there is a discussion as to whether the field is considered - only in terms of the psychological field, or the field as a whole (including psychological and other aspects of the client’s environment and being). Contemporary Gestalt therapy focuses much more on the field as including the client’s environment and the relationship with the therapist. Tonnesvan, Sommer, Hammink, and Sonne (2010) argue that the Gestalt concept of the field include both psychological and non-psychological aspects. They also clarify that limiting the field for the purpose of therapy and research is a process dependent on the psychotherapist’s training, skill, and awareness and that this process is occurring in the moment.

**Gestalt Experiment (Gestalt) and Dialogical Contacting:** Key techniques in Gestalt Therapy. Gestalt Therapy is not about applying techniques in a manualized process. Gestalt therapy focuses on how people can increase their awareness of self/environment and the relationship and/or contact boundary. The awareness of the elements of self, environment and relationship impact the engagement. Having said this, there are some techniques that have historically been integral to GT, and two of them include present-focused experiments and dialogue principles. Holism and creativity are incorporated into the *present-focused experiment* because there are many entry points to the present

moment; art, movement, body awareness exercises, writing, re-enactment of events or dreams, and exploration of metaphor (Zinker 1978). Two-Chair and empty-chair techniques are Gestalt Therapy techniques for which there is a growing body of research (Wagner-Moore, 2004, Shahar et al., 2011, Jones, A., 1992, Clarke & Greenberg, 1986). Again, the focus of the experiment and dialogue is on experiencing in the present moment. In contemporary Gestalt therapy, this experience of the present moment, is always in context with the therapist, and the relationship between client and therapist.

**Guided Visual Imagery (Mindfulness):** A method used in a mindfulness based therapy in which the person's imagination is used to enhance control of one's awareness. The technique typically involves a therapist talking to the client using an imaginative scenario. The client is often prompted to close his or her eyes in order to enhance their visualization of the imagined scenario as framed by the therapist. A number of audio tracks are available for purchase, or for free online to help clients to practice this technique. This technique is practiced in individual and group settings.

**Interpersonal Effectiveness (DBT):** The set of skills that enhance a person's ability to influence others in social relationships in a positive way.

**Life-Threatening Behaviour (DBT):** Self-harm, risk taking, and suicidal behaviour as a way of managing distress when other coping strategies are unavailable.

**Meditation (Mindfulness):** The practice of turning one's attention to a particular focal point for a sustained period of time as a way of developing awareness and understanding. The consistent practice of meditation helps to improve attention and awareness and control of one's thought processes.

**Mindfulness (DBT):** Having awareness or the state of being conscious of one's surroundings and the present moment.

**"Miracle" Question (SFBT):** An interviewing technique used in SFBT in which a therapist asks a client about their ideal outcomes to identify goals. Phrasing can include: "If a miracle occurred, and your main problem/concern disappeared, how would you know the miracle occurred? What would you notice that was different? What would you expect your life to look like?"

**Non-Attachment (Mindfulness):** The ability to avoid focusing on a particular thought at the cost of maintaining one's sense of presence or attention to the present moment.

**Non-Judgement (Mindfulness):** The practice of avoiding making judgements of others, or oneself at the cost of emotional difficulty and challenges with maintaining presence.

**Observation (Mindfulness):** The skill of recognizing one's physical, emotional, and cognitive states with a sense of curiosity and awareness, and without judgement.

**Paradoxical Theory of Change (Gestalt):** Is foundational in Gestalt Therapy. Dr. Arnold Beisser coined the phrase and briefly states: "...change occurs when one becomes what he is, not when he tries to become what he is not." Change does not take place through a coercive attempt by the individual or another person to change him, but it does take place if one takes the time and effort to be what he is – to be fully invested in his current positions". This theory posits that the more a person tries to become someone that they are not, the more they stay the same. In other words, integration of the whole of one's self is best done by not attempting to force change, but rather change happens when we become who we really are (Clegg, 2010). One of the purposes of the Gestalt experiments and dialogic contact is to explore to be aware of these "current positions". Awareness of current positions (values, actions, choices) can impact acceptance and influence change. Given the focus on the present as it is, the paradoxical theory of change shares some commonalities to Eastern philosophies and practices of meditation. Paradoxical theory of change and acknowledging the present moment experience as it is, through experiential experiments can impact self-acceptance; it is this self-acceptance that can support self-transformation (Swales & Heard 2007 pg 187; as cited in Tonnesvang et al., 2010). "That when we have

basically become reconciled to ourselves and to reality as it is, then we have often already changed quite a lot” (Tonnesvang, Sommer, Hammink, & Sonne, 2010, Pg 600).

**Presence (Mindfulness):** The state of maintaining awareness of the present moment without thinking about the past or future.

**Present Moment Experiments (Gestalt):** Present moment experiments and dialogue serve to bring awareness to how the client may be avoiding, or engaging in their own experience. The premise is that the client will increase their awareness and understanding through a process of discovery versus insight or interpretation (Wagner-Moore, 2004). Hence, the primary focus of awareness of the present moment can support understanding of different options and choices. The present moment awareness is not solely a cognitive experience; rather it is an embodied experience that can include emotions, sensations and cognitive insights. Whelton (2011) in a review of evidence of experiential therapies stated that there is growing evidence that “emotion needs to be aroused and felt, and to have its meaning examined and articulated to bring about therapeutic change” (Whelton, 2011 pg 60).

**Progressive Muscle Relaxation (Mindfulness):** A technique aimed at bringing awareness to one’s physical body, and to achieve a state of relaxation. This technique involves a sequential tensing and relaxation of muscle groups in the body.

**Quality of Life Behaviours (DBT):** Behaviours that interfere with a person’s quality of life such as financial, or mental health crises. DBT therapists target behaviours based on a hierarchy of needs. There are four of these including life threatening, therapy interfering, quality of life behaviours, and skill acquisition. Priorities in therapy focus on life threatening behaviours first, followed by the others in order of importance.

**Resistance (MI):** An expected part of the client’s presentation during the motivational interviewing process. Resistance is viewed neutrally in MI such that when a therapist recognizes resistance, a change in direction is needed. Often resistance arises out of a therapist’s misunderstanding of the client’s narrative, and requires further exploration. Resistance is often presented through negating, blaming, minimizing, arguing and challenging as examples.

**Rolling with Resistance (MI):** The response of a therapist trained in MI of adapting to resistance in therapy by engaging in further exploration, reflection, and problem solving with the client in order to achieve clarification. Adapting to resistance through problem-solving and further exploration rather than challenging the client’s resistance can help to maintain therapeutic rapport and safety in the client-therapist relationship.

**Scaling Questions (SFBT):** Inquiries posed by therapists in SFBT to regularly assess as well as increase client awareness of their current progress towards their goals through utilizing their solutions effectively.

**Self-Compassion (Mindfulness):** Bringing awareness to one’s thoughts, feelings, and challenging emotions and evoking positive self-acceptance and understanding towards these feelings as a way of achieving healing, while learning to cope adaptively.

**Skill Acquisition (DBT):** The practice of learning adaptive skills to replace maladaptive skills.

**Socratic Questioning (CBT):** A way of drawing out responses from a client in the context of therapy rather than providing them with answers. It is a form of guided discovery in which the client develops awareness of their thoughts, emotions and behaviour.

**Spirit of MI (MI):** The way that a therapist trained in motivational interviewing approaches the therapeutic encounter when using this approach. The MI process is fundamentally collaborative and recognizes the client’s autonomy in the relationship. The therapist’s role is to evoke a client’s awareness, and a strategy to address the challenges that they face as identified by them.

**Sustain Talk (MI):** The way in which a client identifies the need to maintain their current functioning, no matter how problematic. A therapist trained in MI learns to identify and recognize the statements made by a client that sustain their problematic behaviours.

**Systematic Desensitization (CBT):** A process of gradually exposing a person to an experience that evokes anxiety. By grading their exposure, a person can be supported to develop coping strategies and alter cognitions to mediate the extent to which the experience evokes anxiety. Over time, the person's response to the anxiety provoking experience will decrease with repeat exposure and the simultaneous development of adaptive responses.

**Therapy-Interfering Behaviour (DBT):** In DBT, behaviours demonstrated by persons involved in therapy or therapists that interfere with the therapy process. Examples of such behaviours include venting, criticism, and threatening to quit therapy. These are acknowledged and addressed through the process of therapy.

**Thought Records (CBT):** A tool used in CBT therapy to help bring awareness of a person's pattern of cognitions and behavioural response to these cognitions. A thought record typically includes documenting a situation, a thought that arose in response to the situation, and the person's response to the thought and situation. These documents completed as 'homework' in the context of therapy, and used in therapy sessions to build a cognitive conceptualization of the person's experience. This cognitive conceptualization can help to inform the therapeutic approaches used.

**Wakefulness (Mindfulness):** Sometimes used as a synonym for mindfulness.

**Wise Mind (DBT):** The intersection between *reasonable mind* and *emotion mind* in DBT. This is the place from which a person in DBT comes to know how things 'truly are.' The use of the term *wise mind* highlights the strengths that a person brings to the therapeutic encounter, and by so doing builds one's perception of one's own resilience, which can be advantageous in therapy.



# Appendix B—Selecting E-learning Training Courses

When reviewing training options, these are some of the factors you might want to consider in critically appraising the quality of the course and whether it is the right fit for you.

## Course Development

- Course content & design reviewed by experts
- Biographies: Trainers, developers & reviewers
- Course piloted & learning objectives feasible
- Accreditation with continuing education credits
- Affiliation with Professional organization

## Training Materials

- Current materials
- Ability to tailor for relevancy to setting and client population
- Languages training provided in (specific references)
- Training is respectful and reflective of diversity
- Sample of training objectives and agenda
- References
- Practice Opportunities and Fidelity measures

## Trainer's Background

- Recognized in Field
- Experience working with specific audience
- Experience with clients with same issues
- Training in specific area
- Publications and/or presentations
- Work outside of training (health care setting, research, something else?)

## Training Logistics

- Flexibility of Training schedule
- Options for follow-up after training
- Fees & Expenses
- Opportunities for feedback regarding performance

## Instructional or Learning Strategies

- Enable learners to learn effectively in a variety of ways
- Activities promote practice and transfer of skills
- Strategies promote interactivity. E.g. online discussions, online conferencing, collaborative assignments

## Special Requirements Identified

- Modem speed or internet bandwidth
- Hardware – computing speed and storage capacity
- Software

## Availability of Technological Systems

- Extended hours of help-desk support

# Appendix C—Training Reference Guide

TABLE 1.1 CBT TRAINING OPPORTUNITIES

Organization	Course Name	Description	Cost	Contact
Hincks-Dellcrest Centre – Gail Appel Institute	CBT Foundational Skills	In this two-day workshop, key features of CBT will be explained and demonstrated so that participants gain an excellent foundation in CBT and are able to apply CBT techniques in their clinical work with adults. Participants will learn specific CBT interventions and the application of these in the treatment for various disorders, including depression and anxiety.	\$550 for 2 days	<a href="http://www.hincksdellcrest.org/Home/Training-and-Consultation/About-the-Institute.aspx">www.hincksdellcrest.org/Home/Training-and-Consultation/About-the-Institute.aspx</a>
McMaster University	Post-Professional Program in Clinical Behavioural Sciences	CBT for anxiety and mood disorders: Level 1 (12 weeks), Level 2 (12-16 weeks), Level 3 (20 weeks) and includes application and supervision with 2 cases from your own work.	Varies. Refer to website for further details.	<a href="http://fhs.mcmaster.ca/cbs/">http://fhs.mcmaster.ca/cbs/</a>
Centre for Addiction and Mental Health (CAMH)	Summer Training Institute	Three Day Course/12 Hour Course	\$650-\$750	<a href="http://www.camh.ca/en/education/about/AZCourses/Pages/cbt_si.aspx">http://www.camh.ca/en/education/about/AZCourses/Pages/cbt_si.aspx</a>
University of Toronto (OISE)	Fundamental Skills	“Certificate in Cognitive Behavioral Therapies (CBT): Fundamental Skills” is an 8 week course with three hour sessions.	\$775	<a href="http://conted.oise.utoronto.ca/Certificate_in_Cognitive_Behaviour_Therapy/index.html">http://conted.oise.utoronto.ca/Certificate_in_Cognitive_Behaviour_Therapy/index.html</a>
Beck Institute – Philadelphia, PA	Certificate Programs	Certificate Programs include: CBT for Children & Adolescents, Advanced CBT for Children & Adolescents, CBT for PTSD, CBT for Depression & Suicidality, CBT for Personality Disorders & Challenging Problems. Courses are 3 day intensives held in suburban Philadelphia, PA.	\$1200	<a href="http://www.beckinstitute.org/calendar-of-workshops/">http://www.beckinstitute.org/calendar-of-workshops/</a>
Association for Psychological Therapies introductory online CBT courses	Online	Module based + written projects	\$199-259/course module	<a href="http://www.cbtfromapt.com/ca">www.cbtfromapt.com/ca</a>

SDS Seminars	Online	3 modules (30 training hours) US & UK accredited	\$1100	www.skillsdevelopment.co.uk
CBT Certificate Program- Tape Studies University of Toronto	Online	6 modules to complete certificate with 20 courses to choose from modules primarily 2 days in length & pre-scheduled	Varies— Contact for further information	http://www.tapestudies.com/our-programs/certificate-programs/cognitive-behavioural-therapy
Zur Institute	Online	CBT nuts & bolts online course – reviewing 10 articles	\$39/course	www.zurinstitute.com/cbtcourse.html
Douglas College	Online		\$1500/course	http://www.douglascollage.ca/programs-courses/continuing-education/health/cognitive-behaviour-therapy
National Association of Cog-B'oral Therapists	Online	Home study programs –CBT group therapy, CBT with children (DVD based)	Varies—see Website for details	http://nacbt.amercommerce.com/store/c/4-Home-Study-Trainings-for-Professionals.aspx

TABLE 1.2 DBT TRAINING OPPORTUNITIES

Organization	Course Name	Description	Cost	Contact
Centre for Addiction & Mental Health (CAMH)	DBT Levels A-D	Part A—An Introduction to DBT Part B—An Introduction to DBT Part C—DBT: Practice Based Learning Part D—DBT: Supervised Applications	\$395-795/module	<b>Contact:</b> Janey Haggart, Education Assistant Tel. 416-535-8501 x 6021 janey.haggart@camh.ca <b>Web:</b> <a href="http://www.camh.ca/en/education/about/AZCourses/Pages/dbt_part_a.aspx">http://www.camh.ca/en/education/about/AZCourses/Pages/dbt_part_a.aspx</a>
Behavioural Tech LLC	Various	Online, in-person, consultation and comprehensive training options are offered ranging from days to 2 years. Courses available for newly developing consultation teams, as well as individual therapists	Various— Contact for Pricing	<b>Address:</b> 4746 11 <sup>th</sup> Avenue NE, Suite 102, Seattle, WA 98105 <b>Phone:</b> 206.675.8588



		interested in developing a DBT practice in the absence of a consultation team. Supervision opportunities are available		<b>Email:</b> <a href="mailto:info@behavioraltech.org">info@behavioraltech.org</a> <b>Web:</b> <a href="http://behavioraltech.org/index.cfm">http://behavioraltech.org/index.cfm</a>
Oshawa Psychotherapy Institute	DBT Levels I-III & DBT Skill Training Course	<ul style="list-style-type: none"> <li>○ 4 DBT courses for professionals with varying levels of previous experience.</li> <li>○ DBT Skill Training Course explores DBT skill development instead of learning DBT in its entirety.</li> </ul>	Varies— Contact for Pricing	<b>Address:</b> Oshawa Clinic, 2 <sup>nd</sup> Floor, East Wing 117 King St. E Oshawa, ON  <b>Tel:</b> 905-721-7723 1-866-568-9476  <b>Web:</b> <a href="http://www.oshawapsychotherapytraining.com/home">http://www.oshawapsychotherapytraining.com/home</a>

**TABLE 1.3 MINDFULNESS TRAINING OPPORTUNITIES**

Organization	Course Name	Description	Cost	Contact
University of Toronto— Faculty of Social Work	Applied Mindfulness Meditation— Levels A-D	A progressive certificate program providing a grounding in the historical and theoretical underpinnings of mindfulness, as well as practice in using mindfulness strategies with various practice populations. The program consists of 4 levels of progressive competency development. 5 modules must be completed at each level in order to progress to the next. No prior experience is required to enrol.	\$325 per module	<a href="http://socialwork.utoronto.ca/conted/programs-and-workshops/certificates/mind/">http://socialwork.utoronto.ca/conted/programs-and-workshops/certificates/mind/</a>
UCSD Centre for Mindfulness	Mindfulness Based Professional Training	A variety of professional training opportunities and certification programs to qualify practitioners to gain the competency to teach mindfulness to other professionals. See website for a full description of training opportunities.	Varies. Refer to website for further details.	<a href="http://mbpti.org/">http://mbpti.org/</a>

The Centre for Mindfulness Studies	Introductory and Professional Development Courses	The centre provides a variety of introductory and continuing professional development courses in mindfulness for practicing professionals. These include beginner courses, courses for educators, mindfulness for health care professionals and silent retreats.	Varies. Refer to website for further details.	<a href="http://www.mindfulnessstudies.com/">http://www.mindfulnessstudies.com/</a>
University of Massachusetts Medical School—Centre for Mindfulness in Medicine, Health Care, and Society	Mindfulness Based Stress Reduction (MBSR) Teacher Training	The Center for Mindfulness in Medicine, Health Care, and Society is a visionary force and global leader in mind-body medicine. For thirty years, they have pioneered the integration of mindfulness meditation and other mindfulness-based approaches in mainstream medicine and healthcare through patient care, research, academic medical and professional education, and into the broader society through diverse outreach and public service initiatives. Directed by Saki F. Santorelli, EdD, MA, since 2000 and founded in 1995 by Jon Kabat-Zinn, the Center is an outgrowth of the acclaimed Stress Reduction Clinic – the oldest and largest academic medical center-based stress reduction program in the world.	Contact for further details	<a href="http://www.umassmed.edu/cfm/training/training-pathways/">http://www.umassmed.edu/cfm/training/training-pathways/</a>
Sunnybrook Health Sciences Centre	Sunnybrook Mindfulness	Courses in mindfulness based group practice, which is a six-day interprofessional course for clinicians who wish to lead mindfulness-based groups as well as a supervisory series for mindfulness based group practice for those who have completed the mindfulness based group practice course.	Contact for further details	<a href="Http://sunnybrook.ca/content/?page=mindfulness-meditation-stress-therapy">Http://sunnybrook.ca/content/?page=mindfulness-meditation-stress-therapy</a>  Email: <a href="mailto:mindfulness@sunnybrook.ca">mindfulness@sunnybrook.ca</a>
The NeuroNova Centre for Mindfulness Based Chronic Pain Management (Toronto, ON)	Variety of Courses (see Description)	Mindfulness-Based Chronic Pain Management courses are offered in Toronto at Sunnybrook Health Sciences Centre and St. Michael’s Hospital and via Telemedicine to hospital sites across Ontario. 6 modules have been offered in the	Contact for further details	<a href="http://neuronovacentre.com/courses">http://neuronovacentre.com/courses</a>

		<p>past. These 13 week modules include:</p> <ul style="list-style-type: none"> <li>▪ Mindfulness Based Chronic Pain Management Levels I &amp; II</li> <li>▪ Emotional Skills</li> <li>▪ Mindfulness for Health Care Professionals</li> <li>▪ Mindfulness Maintenance</li> <li>▪ Lumina Spark</li> </ul>		
Mount Sinai Psychotherapy Institute (Toronto, ON)	Mindful Psychotherapy	A series of courses to help clinicians to find ways of incorporating mindful approaches in psychotherapy practice.	\$995 for a full 6 day training course	<a href="http://events.r20.constantcontact.com/register/event?oeidk=a07eawfafow71c8352a&amp;llr=z89hqxgab">http://events.r20.constantcontact.com/register/event?oeidk=a07eawfafow71c8352a&amp;llr=z89hqxgab</a>

**TABLE 1.4 MOTIVATIONAL INTERVIEWING TRAINING OPPORTUNITIES**

Organization	Course Name	Description	Cost	Contact
Centre for Addiction & Mental Health	Motivational Interviewing Courses Level 1-3	<p>This is an on-line course that follows a collaborative clinical education model. The course includes mentoring/coaching of MI to assist with clinical application of MI as well as to give participants evidence of learning of the techniques. Healthcare professionals of diverse backgrounds and practice settings who either provide direct client care or are consulted on behavioural change participate in the course.</p> <p>This course can be taken on it's own. It also qualifies for as an elective of CAMH's Concurrent Disorders Certificate program. The course is accredited by: The College of Family Physicians of Canada; The Royal College of Physicians &amp; Surgeons of Canada and the Canadian Addiction Counsellors Certification Federation (CACCF).</p>	\$250	<a href="http://www.camh.ca/en/education/about/AZCourses/Pages/mi_ol.aspx">http://www.camh.ca/en/education/about/AZCourses/Pages/mi_ol.aspx</a>
University of Toronto (OISE)	Motivational Interviewing Program Spirit to Skills: An Introduction to Motivational Interviewing for	This course is an introductory level course on MI and provides learning on key concepts, skills and techniques and the underlying spirit of MI. It uses mixed methodologies include: didactics, videotaped demonstrations, experiential	\$925	<a href="http://conted.oise.utoronto.ca/Certificate_in_Motivational_Interviewing/index.html">http://conted.oise.utoronto.ca/Certificate_in_Motivational_Interviewing/index.html</a>

	Professional Practice	exercises and practice, with opportunities for reflection and feedback on the use of MI in practice. Registrants have basic clinical and counseling skills and come from various health care professions and/or have a Master's degree in a counseling related field.		
Canadian Training Institute	Motivational Interviewing Courses	<p><b>Motivational Interviewing and Stages of Change</b> (1 day, 2 day) Introductory course for MI principles and practices. Participants will learn key concepts regarding readiness to change; stages of change; spirit of MI and have opportunities to learn and practice key MI skills.</p> <p><b>Advanced Strategies in Motivational Interviewing</b> (1 day) Practical and interactive workshop for individuals with advanced knowledge and experience in motivational interviewing. Participants will learn how to enhance their MI skills and incorporate MI into brief counseling interactions.</p>	Contact for pricing	<a href="http://www.canadiantraininginstitute.com/motivational-interviewing-and-the-stages-of-change">http://www.canadiantraininginstitute.com/motivational-interviewing-and-the-stages-of-change</a>
Humber College	An Introduction to Motivational Interviewing	Two-day (16-hour course) provides an overview of motivational interviewing, core principles and techniques along with practice opportunities.	Contact for pricing	<a href="http://www.humber.ca/continuingeducation/courses/introduction-motivational-interviewing">http://www.humber.ca/continuingeducation/courses/introduction-motivational-interviewing</a>
The Monarch System	Multiple Courses	<p><b>Level 1:</b> Intensive Introduction to Motivational Interviewing (MI) is a two-day session that introduces participants to an overview of MI and MI tools and techniques. It provides opportunity for skill practice and feedback opportunities that support the integration of learning into clinical practice.</p> <p><b>Level 2:</b> Advanced Motivational Interviewing Workshop for Health Practitioners build on the first workshop. Aims to support clinicians with clients that are experiencing difficulties with making health-</p>	Contact for pricing	<a href="http://www.monarchsystem.com/the-monarch-system-workshops/">http://www.monarchsystem.com/the-monarch-system-workshops/</a>

		<p>related behaviour changes. This 2-day training provides additional practice and feedback opportunities.</p> <p>*Both courses are designed for health care professionals from diverse backgrounds and practice settings.</p>		
McMaster University	Motivational Interviewing Level I & II	<p><i>Level I</i> (25hrs) Motivational Interviewing Level I will focus on understanding the theoretical underpinnings and evidence supporting the use of this therapeutic approach for clients who are ambivalent about change. Students will develop and practice beginning and advanced motivational interviewing skills through discussion, case studies and practice in class in pairs and small interprofessional groups.</p> <p><i>Level II</i> (25hrs) This course will focus on the advanced motivational interviewing skills, further exploring ethical use of motivational interviewing, eliciting change talk and developing an action plan with clients who are ambivalent about change. Motivational Interviewing Level 2 will expect that learners understand the theoretical underpinnings and evidence supporting the use of this therapeutic approach for clients who are ambivalent about change. Students will further develop advanced practice and motivational interviewing skills through discussion, case studies and practice in class. Students will participate in pairs and small interprofessional groups to develop and practice advanced motivational interviewing skills.</p>	Contact for pricing	<a href="http://fhs.mcmaster.ca/cbs/motivational_interviewing.html">http://fhs.mcmaster.ca/cbs/motivational_interviewing.html</a>

Kiepek Health Counselling	Motivational Interviewing for Occupational Therapists	2 day workshops specifically designed for occupational therapists, nurses, and other professionals.	Contact for pricing	<a href="http://www.kiepekhealthcounselling.ca/Introduction.html">http://www.kiepekhealthcounselling.ca/Introduction.html</a>
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**TABLE 1.5 SOLUTION-FOCUSED BRIEF THERAPY TRAINING OPPORTUNITIES**

Organization	Course Name	Description	Cost	Contact
University of Toronto— Faculty of Social Work	Solution Focused Counselling	A certificate program aimed at developing specialist level competency in solution focused counselling. This is a 6 module certificate program offered in short intensives over a one year period. Each module represents 14 hours of instruction.	\$325 per module including HST	<a href="http://socialwork.utoronto.ca/conted/programs-and-workshops/certificates/sfc/">http://socialwork.utoronto.ca/conted/programs-and-workshops/certificates/sfc/</a>
University of Wisconsin	Online Training in Solution Focused Brief Therapy	A 16-week online non-credit course offered internationally for practitioners to learn, discuss, and practice strategies used in solution focused brief therapy. Participation requires approximately 3 hours of online participation per week.	\$1295	<a href="http://www4.uwm.edu/sce/course.cfm?id=1361">http://www4.uwm.edu/sce/course.cfm?id=1361</a>

**TABLE 1.6 GESTALT TRAINING OPPORTUNITIES**

Organization	Course Name	Description	Cost	Contact
Gestalt Institute of Toronto		1 year training program for professionals, and 5 year entry level training	\$2,450 per year plus residential fee of \$555 (1 year intensive program for professionals)	<a href="http://gestalt.on.ca/training-programs/five-year-training-program-forprofessionals/">http://gestalt.on.ca/training-programs/five-year-training-program-forprofessionals/</a> Tel: 416-964-9464

