

Work Sample Guide

The final step in the Beck Certification process is completing and submitting a Work Sample. The Work Sample consists of two parts: 1. A Case Write-up of a real client and their conceptualization and treatment (without the client's full name) and 2. An actual recording of a live CBT session with this client (without client's full name). Both parts of the Work Sample (Case Write-up and Recorded Therapy Session) are to be submitted at the same time according to the instructions provided. You may not use a client you submitted for supervision.

Case Write-Up: Summary and Conceptualization

PART ONE: INTAKE INFORMATION

IDENTIFYING INFORMATION AT INTAKE:

Age: Report the client's age at the time the Session Recording was made.

Gender Identity and Sexual Orientation: What was the client's reported identity and sexual orientation at the time of the Recorded Session?

Cultural Heritage: What did the client say their cultural heritage was?

Religious/Spiritual Orientation: What did the client say their orientation was (if any)?

Living Environment: What kind of structure does the client live in (e.g., apartment, single house, homeless, etc.)? In what environment do they live (e.g., inner city, farm, suburb)? Who else lives in their household? What is their relationship to the client?

Employment Status: What kind of work does the client do (e.g., laborer, office worker, manager, professional)? Is this work paid or unpaid? How long has the client worked at this job? Is it full-time or part-time? How satisfied is the client with their work? If relevant, state "takes care of home and family" or, if relevant, "unemployed."

Socioeconomic Status: What is the client's socioeconomic status (SES; as defined by the American Psychological Association: social standing or class measured as a combination of education, income, and occupation), State "high SES," "middle SES" or "low SES."

CHIEF COMPLAINT, MAJOR SYMPTOMS, MENTAL STATUS, AND DIAGNOSIS:

Chief Complaint: Why did the client seek treatment at this time?

Major Symptoms: What symptoms did the client have in these four areas:

Emotional:

Cognitive:

Behavioral:

Physiological:

Mental Status: How did the client appear? What was their mental status, including orientation, memory, and other characteristics that could negatively influence their ability to fully participate in therapy?

Diagnosis (from the Diagnostic and Statistical Manual or International Classification of Disease): What was the name and current Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-5) or International Classification of Diseases (current ICD-10) diagnostic code for the client's disorder(s)? Include relevant descriptors.

CURRENT PSYCHIATRIC MEDICATIONS, ADHERENCE, AND SIDE EFFECTS; CONCURRENT TREATMENT:

Psychiatric Medications: What medications was the client taking at intake or later on? What was the dosage and the condition for which the medication was prescribed?

Adherence to Treatment Recommendations: What was the client's attitude toward taking prescribed medications and following other treatment recommendations made by psychiatrists and other medical treatment providers?

Side Effects: If applicable, what side effects did the client experience?

Concurrent Treatment: If applicable, what other treatment was the client receiving for his psychiatric or psychological condition?

CURRENT SIGNIFICANT RELATIONSHIPS: At intake, what significant relationships did the client have? What were the relationships like?

PART TWO: HISTORICAL INFORMATION

BEST LIFETIME FUNCTIONING (INCLUDING STRENGTHS, ASSETS AND RESOURCES): At what age did the client experience their highest level of functioning and how long did this last? What made this the best period? What strengths did they show? What beliefs did they have about themselves, about others, and about the future? How did others see them?

HISTORY OF PRESENT ILLNESS: When did the client's symptoms first appear, how long have they persisted, and how severe have they been? What has their impact been on the client's functioning?

HISTORY OF PSYCHIATRIC, PSYCHOLOGICAL OR SUBSTANCE USE PROBLEMS AND IMPACT ON FUNCTIONING: What were the client's previous psychiatric diagnoses (if any) and/or substance use conditions (if any)? How old was the client at the time of diagnosis? How severe was the condition(s) and how long did it (they) last? How did the condition(s) impact the client's functioning?

HISTORY OF PSYCHIATRIC, PSYCHOLOGICAL OR SUBSTANCE USE TREATMENT, TYPE, LEVEL OF CARE, AND RESPONSE: What treatments has the client already received for psychiatric and/or substance use? How old was the client when provided with this treatment? What type of treatment was it and how long did it last? What was the client's attitude about treatment? What was their response to treatment?

DEVELOPMENTAL HISTORY (Relevant Learning, Emotional, and Physical Development): What were significant adverse life events from the client's lifetime that have had an impact on the client's functioning (e.g., learning problems, bullying, medical conditions, accidents, and trauma)?

PERSONAL, SOCIAL, EDUCATIONAL, AND VOCATIONAL HISTORY: What were the client's significant positive and negative relationships like with family, friends, teachers, persons in authority, and peers?

MEDICAL HISTORY AND LIMITATIONS: What medical conditions did the client have? How severe were they? What limitations, if any, did they impose on the client's life?

CURRENT NON-PSYCHIATRIC MEDICATIONS, TREATMENT, ADHERENCE, AND SIDE EFFECTS: What non-psychiatric medications (including homeopathic and over-the-counter medication) did the client taking at intake or during treatment? Why did they take the medication? What side effects did the medication have?

PART THREE: THE CASE CONCEPTUALIZATION DIAGRAM (CCD)

COGNITIVE CONCEPTUALIZATION DIAGRAM (CCD): Complete the CCD in its entirety and attach it to this Case Write-Up. Make sure that you choose situations in which the meanings of the automatic thoughts differ from one another, if there are different themes.

PART FOUR: THE CASE CONCEPTUALIZATION SUMMARY

HISTORY OF CURRENT ILLNESS, PRECIPITANTS AND LIFE STRESSORS: What were the internal and external problems the client was dealing with? How did the problems contribute to the onset of symptoms? (Internal stressors could include illnesses, injuries, memories, images or sensations. External stressors might include problems at work/school, relationships, or not meeting performance standards.)

MAINTAINING FACTORS: What helped maintain the client's symptoms? (Maintaining factors could include the continuation of internal or external stressors, the way the client processed information, maladaptive cognitions about and reactions to negative emotion, dysfunctional thought processes, maladaptive behavior, and/or skill deficits.)

VALUES AND ASPIRATIONS (OPTIONAL): What has been most important to your client in life (values)? What does your client want from life or how do they want their life to be (aspirations)?

NARRATIVE SUMMARY, INCORPORATING HISTORICAL INFORMATION, PRECIPITANTS, MAINTAINING FACTORS, AND CASE CONCEPTUALIZATION DIAGRAM INFORMATION: Provide a narrative summary of the completed CCD (starting at the top of the page) to explain why the client's reactions to current problematic situations make sense. Optional: Integrate aspirations and values into your explanation.

PART FIVE: TREATMENT PLAN

OVERALL TREATMENT PLAN: What were your broad therapy goals?

PROBLEM LIST/CLIENT'S GOALS AND EVIDENCE-BASED INTERVENTIONS: Problems are the flip side of goals. What CBT interventions did you use for each problem/goal?

PART SIX: COURSE OF TREATMENT AND OUTCOME

THERAPEUTIC RELATIONSHIP: What was your client’s attitude toward treatment and toward you? What did you do to maintain a positive relationship? If relevant, how did you solve problems in the relationship?

NUMBER AND FREQUENCY OF TREATMENT SESSIONS, LENGTH OF TREATMENT: How often were therapy sessions conducted? Were they standard CBT sessions (if not, how were they different)? How long was the client in treatment?

COURSE OF TREATMENT SUMMARY: How did the treatment process unfold? What was the client’s motivation like? How easy or difficult was it to treat this client and why?

MEASURES OF PROGRESS: What quantitative measures (or assessments of functioning) did you use at intake? How did you monitor progress during treatment?

OUTCOME OF TREATMENT: How much change was there in the client’s symptoms, level of functioning, and/or sense of well-being? What was the clients’ overall level of satisfaction with the treatment provided?

Scoring for Case Write-Up

There are 23 sub-sections on the Case Write-Up. Each of the items will be scored separately.

You are required to complete all items in the Case Write-Up. If you don’t complete a section, you won’t be able to submit your Case-Write Up. The range of possible total scores will be 0- 50. Items in the Cognitive Conceptualization Diagram, Narrative Summary of Conceptualization, and Problems Lists/Goals/EBT’s Sections are weighted more heavily than other sections. These sections require minimum scores of 4 on each item to pass; 12 out of 15 possible points. The remaining sections must total to a minimum score of 28 out of 35 possible points. **A total score of 40 is the minimum passing score.** The scoring grid is as follows:

Case Write-up Scoring Grid

Item	Scoring Range	Your Score
Part One: Intake Information		
Identifying Information (Age, Gender Identity, Cultural Heritage, Religious/Spiritual Orientation, Living		

Environment, Employment Status, Socioeconomic Status)	0-1	
Chief Complaint	0-3	
Current Psychiatric Medications	0-1	
Current Significant Relationships	0-2	
Part Two: Historical Information		
Best Lifetime Functioning	0-2	
History of Present Illness	0-2	
History of Psychiatric, Psychological, or Substance Use Problems	0-2	
Impact on Functioning of Psychiatric, Psychological, or Substance Use Problems	0-2	
History of Psychiatric, Psychological, or Substance Use Treatment, Type, Level of care, and Response	0-2	
Developmental History	0-3	
Personal, Social, Educational, and Vocational History	0-3	
Medical History and Limitations	0-2	
Non-Psychiatric Medications, Treatment, Adherence and Side Effects	0-1	
Part Three: Case Conceptualization Diagram(CCD) ***	0-5	
Part Four: Case Conceptualization Summary		
History of Current Illness	0-2	

Maintaining Factors	0-2	
Values and Aspirations (Optional)	--	--
Narrative Summary, Incorporating Historical Information, Precipitants, Maintaining Factors, and CCD Information***	0-5	
Part Five: Treatment Plan		
Client's Broad Goals, Problem List, Evidenced-Based Interventions Broad Goals***	0-5	
Part Six: Course of Treatment and Outcome		
Therapeutic Relationship	0-1	
Number of and Frequency of Treatment Sessions, Length of Treatment	0-1	
Course of Treatment Summary	0-1	
Measures of Progress	0-1	
Outcome of Treatment	0-1	
Totals for Shaded Items Must Equal at least 12		
Minimum Score of "4" on Each Shaded Item		
Totals for Unshaded Items Must Equal at least 28		
Total Score		
Your Total Score Must Equal at Least 40 (Maximum Score: 50)		



Recording of a Live Session

The second part of the Work Sample is the recording of a live therapy session with the client described in the Case Write-Up. The work sample must be original work completed by the applicant without assistance. The client recorded must not have been discussed during supervision. The recorded therapy session should be a standard Cognitive Behavior Therapy session. It will be rated on the Cognitive Therapy Rating Scale (CTRS). The CTRS has 11 items; each item is scored on a scale of 0-6. **A score of 44 is the minimum passing score.** A copy of the CTRS is included with this Guide.

Cognitive Therapy Rating Scale (CTRS)

Therapist: _____ Client: _____ Date: _____

Tape ID#: _____ Rater: _____ Date: _____

Session#: _____ Videotape Audiotape Transcript Live Observation

DIRECTIONS: For each time, assess the therapist on a scale from 0 to 6, and record the rating on the line next to the item number. Descriptions are provided for even-numbered scale points. If you believe the therapist falls between two of the descriptors, select the intervening odd number (1, 3, 5). For example, if the therapist set a very good agenda but did not establish priorities, assign a rating of a 5 rather than a 4 or 6.

0	1	2	3	4	5	6
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

If the descriptions for a given item occasionally do not seem to apply to the session you are rating, feel free to disregard them and use the more general scale below:

Please do not leave any item blank. For all items, focus on the skill of the therapist, taking into account how difficult the patient seems to be.

Part I. GENERAL THERAPEUTIC SKILLS

1. AGENDA

- 0 Therapist did not set agenda.
- 2 Therapist set agenda that was vague or incomplete.
- 4 Therapist worked with patient to set a mutually satisfactory agenda that included specific target problems (e.g., anxiety at work, dissatisfaction with marriage.)
- 6 Therapist worked with patient to set an appropriate agenda with target problems, suitable for the available time. Established priorities and then followed agenda.

2. **FEEDBACK**

- 0 Therapist did not ask for feedback to determine patient’s understanding of, or response to, the session.
- 2 Therapist elicited some feedback from the patient, but did not ask enough questions to be sure the patient understood the therapist’s line of reasoning during the session or to ascertain whether the patient was satisfied with the session.
- 4 Therapist asked enough questions to be sure that the patient understood the therapist’s line of reasoning throughout the session and to determine the patient’s reactions to the session. The therapist adjusted his/her behavior in response to the feedback, when appropriate.
- 6 Therapist was especially adept at eliciting and responding to verbal and non-verbal feedback throughout the session (e.g., elicited reactions to session, regularly checked for understanding, helped summarize main points at end of session).

3. **UNDERSTANDING**

- 0 Therapist repeatedly failed to understand what the patient explicitly said and thus consistently missed the point. Poor empathic skills.
- 2 Therapist was usually able to reflect or rephrase what the patient explicitly said, but repeatedly failed to respond to more subtle communication. Limited ability to listen and empathize.
- 4 Therapist generally seemed to grasp the patient’s “internal reality” as reflected by both what the patient explicitly said and what the patient communicated in more subtle ways. Good ability to listen and empathize.
- 6 Therapist seemed to understand the patient’s “internal reality” thoroughly and was adept at communicating this understanding through appropriate verbal and non-verbal responses to the patient (e.g., the tone of the therapist’s response conveyed a sympathetic understanding of the client’s “message”). Excellent listening and empathic skills.

___4. INTERPERSONAL EFFECTIVENESS

- 0 Therapist had poor interpersonal skills. Seemed hostile, demeaning, or in some other way destructive to the patient.
- 2 Therapist did not seem destructive, but had significant interpersonal problems. At times, therapist appeared unnecessarily impatient, aloof, insincere or had difficulty conveying confidence and competence.
- 4 Therapist displayed a satisfactory degree of warmth, concern, confidence, genuineness, and professionalism. No significant interpersonal problems.
- 6 Therapist displayed optimal levels of warmth, concern, confidence, genuineness, and professionalism, appropriate for this particular patient in this session.

___5. COLLABORATION

- 0 Therapist did not attempt to set up a collaboration with patient.
- 2 Therapist attempted to collaborate with patient, but had difficulty either defining a problem that the patient considered important or establishing rapport.
- 4 Therapist was able to collaborate with patient, focus on a problem that both patient and therapist considered important, and establish rapport.
- 6 Collaboration seemed excellent; therapist encouraged patient as much as possible to take an active role during the session (e.g., by offering choices) so they could function as a “team”.

___6. PACING AND EFFICIENT USE OF TIME

- 0 Therapist made no attempt to structure therapy time. Session seemed aimless.
- 2 Session had some direction, but the therapist had significant problems with structuring or pacing (e.g., too little structure, inflexible about structure, too slowly paced, too rapidly paced).
- 4 Therapist was reasonably successful at using time efficiently. Therapist maintained appropriate control over flow of discussion and pacing.

- 6 Therapist used time efficiently by tactfully limiting peripheral and unproductive discussion and by pacing the session as rapidly as was appropriate for the patient.

Part II. CONCEPTUALIZATION, STRATEGY, AND TECHNIQUE

7. GUIDED DISCOVERY

- 0 Therapist relied primarily on debate, persuasion, or “lecturing.” Therapist seemed to be “cross-examining” patient, putting the patient on the defensive, or forcing his/her point of view on the patient.
- 2 Therapist relied too heavily on persuasion and debate, rather than guided discovery. However, therapist’s style was supportive enough that patient did not seem to feel attacked or defensive.
- 4 Therapist, for the most part, helped patient see new perspectives through guided discovery (e.g., examining evidence, considering alternatives, weighing advantages and disadvantages) rather than through debate. Used questioning appropriately.
- 6 Therapist was especially adept at using guided discovery during the session to explore problems and help patient draw his/her own conclusions. Achieved an excellent balance between skillful questioning and other modes of intervention.

8. FOCUSING ON KEY COGNITIONS OR BEHAVIORS

- 0 Therapist did not attempt to elicit specific thoughts, assumptions, images, meanings, or behaviors.
- 2 Therapist used appropriate techniques to elicit cognitions or behaviors; however, therapist had difficulty finding a focus or focused on cognitions/behaviors that were irrelevant to the patient’s key problems.
- 4 Therapist focused on specific cognitions or behaviors relevant to the target problem. However, therapist could have focused on more central cognitions or behaviors that offered greater promise for progress.
- 6 Therapist very skillfully focused on key thoughts, assumptions, behaviors, etc. that were most relevant to the problem area and offered considerable promise for progress.

___9. STRATEGY FOR CHANGE

(Note: For this item, focus on the quality of the therapist’s strategy for change, not on how effectively the strategy was implemented or whether change actually occurred.)

- 0 Therapist did not select cognitive-behavioral techniques.
- 2 Therapist selected cognitive-behavioral techniques; however, either the overall strategy for bringing about change seemed vague or did not seem promising in helping the patient
- 4 Therapist seemed to have a generally coherent strategy for change that showed reasonable promise and incorporated cognitive-behavioral techniques.
- 6 Therapist followed a consistent strategy for change that seemed very promising and incorporated the most appropriate cognitive-behavioral techniques.

___10. APPLICATION OF COGNITIVE-BEHAVIORAL TECHNIQUES

(Note: For this item, focus on how skillfully the techniques were applied, not on how appropriate they were for the target problem or whether change actually occurred.)

- 0 Therapist did not apply any cognitive-behavioral techniques.
- 2 Therapist used cognitive-behavioral techniques, but there were significant flaws in the way they were applied.
- 4 Therapist applied cognitive-behavioral techniques with moderate skill.
- 6 Therapist very skillfully and resourcefully employed cognitive-behavioral techniques.

___11. HOMEWORK

- 0 Therapist did not attempt to incorporate homework relevant to cognitive therapy.
- 2 Therapist had significant difficulties incorporating homework (e.g., did not review previous homework, did not explain homework in sufficient detail, assigned inappropriate homework).
- 4 Therapist reviewed previous homework and assigned “standard” cognitive therapy homework generally relevant to issues dealt with in session. Homework was explained in sufficient detail.

- 6 Therapist reviewed previous homework and carefully assigned homework drawn from cognitive therapy for the coming week. Assignment seemed “custom tailored” to help patient incorporate new perspectives, test hypotheses, experiment with new behaviors discussed during session, etc.



CTRS Detailed Score Report

Tape ID# or Therapist: _____ Date of Rating: _____

Total Score: _____

Part I. GENERAL THERAPEUTIC SKILLS

- _____ 1. Agenda
- _____ 2. Feedback
- _____ 3. Understanding
- _____ 4. Interpersonal Effectiveness
- _____ 5. Collaboration
- _____ 6. Pacing and Efficient Use of Time

Part II. CONCEPTUALIZATION, STRATEGY, AND TECHNIQUE

- _____ 7. Guided Discovery
- _____ 8. Focusing on Key Cognitions or Behaviors
- _____ 9. Strategy for Change
- _____ 10. Application of Cognitive-Behavioral Techniques
- _____ 11. Homework

_____ **TOTAL SCORE**