



## **Application Guide: Part II**

Updated July 2014

## ACT Part II Application Checklist

---

Optional: Fill out the ACT mentor program form to indicate whether you would like ACT to connect you with a mentor for help with completing Part II (see Mentor Program FAQs p3). *If you are interested in being connected with an ACT Mentor, please complete and return this form to the ACT office as soon as possible.*

Compile and submit together:

- Audio Sample.
- Case Write Up.
- Statement of Verification and Payment.

Mark the Audio Sample and Case Write Up with your initials only. Do not include your name, your client's names, or any other personal identifiers.

### Steps to compile an audio sample

---

Determine method for recording and submitting sample (see Audio Recording FAQs p4).

Choose and obtain consent from patient (see Sample Consent Form p6).

Record a session with your patient.

Recordings must be:

- Unrehearsed, unscripted, & unedited, from a therapy case that you conducted;
- Between 45 and 55 minutes long (after 55 minutes, reviewers will stop listening);
- From sessions 3 to 12 (recordings should not be from an intake, session one or termination session);
- Labeled with the session number, DSM IV or V diagnosis(es) and **your own** initials.

Other requirements:

- The client must be at least 16 years of age;
- The audio recording may be from the same or a different case than the Case Write-Up;
- If your session is not in English, Spanish, Portuguese, Turkish, Mandarin, Russian, Cantonese, Japanese, or Arabic we will need you to submit (2) copies of the original recording along with (2) copies of an English transcription of the recording. Upload recorded sessions on the computer and/or burn on to a CD (see FAQs below).

### Steps to compile a case write up

---

Write a case write-up (see Appendix A and B for detailed directions and sample).

Include sections to address case history (750 words), case formulation (500 words), treatment plan and course of treatment (750 words).

**Submit two (2) copies of your case write up to ACT, with your audio sample and payment.**

### Submission of Statement of Verification and Payment, Audio Sample, and Case Write Up

---

ACT recommends that you send Part II materials via digital upload, as ACT cannot be held responsible for lost packages. If necessary, please send a completed payment form and two (2) copies of your audio sample and case write up to:

**Academy of Cognitive Therapy  
245 N. 15th Street, MS 403  
#17302 New College Bldg.  
Philadelphia, PA 19102 USA**

## **Application Guide: Part II Next Steps**

When ACT receives your Part II materials, the office will send you a notice of receipt. The review process for written and audio-recorded materials is approximately 6-8 weeks. After materials have been reviewed, the ACT office will notify applicants in writing of the determination.

The audio and written materials you submitted will not be returned to you, but will remain the property of ACT and stored securely until a decision has been made about your application, after which these materials may be utilized anonymously by ACT for psychometric purposes unless permission to do so is expressly denied.

### ***If your application is accepted:***

You will be asked to submit an information request and specialty checklist form. These forms are required to:

- Provide up-to-date and accurate information for your listing on ACT's online database of certified therapists;
- Inform consumers about your specialization areas;
- Ensure the appropriate name format and credentials on your certificate;
- Ensure that registration with ACT's listserv uses your correct email address.

Following receipt of the information request and specialty checklist forms, ACT will post your information online and register you on the ACT listserv.

Certificates take one (1) to two (2) months to be completed, as they are drafted by a local calligraphy artist.

### ***If your application is rejected:***

You may submit different materials for a second rating, within two years of the initial determination, or you may appeal the determination.

A detailed description of the appeals process can be found on page 6 of the Candidate Handbook. The right of appeal is granted to anyone who is denied certification in ACT. More information on the appeal process will be provided in the event (re)certification is rejected.

*ACT continues to seek ways to improve its application process. Your feedback is important to us. All applicants, regardless of determination, will be asked to complete a one page evaluation form that ACT will use to ensure the most effective and user-friendly application process.*

## **Frequently Asked Questions about the ACT Mentor Program**

### **What is the purpose of the ACT Mentor Program?**

The Part II application may feel like a daunting process when you first begin. ACT would like to make this process as easy and straightforward as possible. In order to do so, we have asked Certified Members who recently applied to become mentors to our applicants. We feel as though current members are best suited to help guide applicants throughout specific sections and address any questions or concerns they have.

### **Do I need a mentor throughout this process?**

You do not need a mentor. However, you may find having one or more phone meetings with a mentor who has recently gone through this process to be extremely helpful as you complete Part II.

### **How will my mentor be able to help me?**

- Your mentor can go over the logistics of filling out the application and advise you in submitting accompanying materials
- Your mentor can discuss with you each step of the process, including:
  - How to record a patient;
  - How to obtain consent (what is the best way to approach a patient?);
  - Different components of the cognitive therapy rating scale (CTS).
- Applicants may experience some natural anxiety about being recorded and evaluated. It may be useful to hear more about the experiences of other applicants and how they overcame any challenges they experienced.
- You may also check in periodically with your mentor with ongoing questions, concerns and clarifications on submitting materials.

### **How can I find a mentor?**

Please fill out the ACT mentor program form to indicate that you would like a mentor. ***Please return this form as soon as possible to the ACT office.*** ACT Staff will place you with a mentor nearest you. Please contact Troy Thompson, Membership Coordinator, at [tthompson@academyofct.org](mailto:tthompson@academyofct.org) or 215.831.7838 for more information.

## **Frequently Asked Questions about Audio Recording**

### **What format should I use to record an audio sample of a cognitive therapy session?**

ACT strongly recommends that you use a digital audio sample for the following reasons:

- Audio quality is at least 10x better on digital CDs (as compared to cassette tapes)

- Tape cassettes can sometimes delay the certification process as some of our raters are not equipped with cassette players
- Digitally recorded sessions can be uploaded using iTunes or media player, or can be sent via Citrix ShareFiles so the ACT rater can listen to them on a computer.
- ACT will have the ability to:
  - Play back at faster or slower speeds or instantly 'queue' the recording to any point in the session
  - Refer to particular sections (i.e. please listen to part of session that starts at elapsed time 10 minutes, 30 seconds)

### **What audio recorder should I buy?**

Many members use Olympus brand recorder Model # DS30 or the Sony ICD-P520 but any make/model that records in MP3 or WMA or WAV format will work as well. There are MP3 player/recorders in Kmart for as little as \$20. Make sure whatever recorder you use has a 'voice recorder' feature and is downloadable to a computer. Most of the new ones can directly plug into your computer using a USB port.

### **Where should I place the audio recorder in the session?**

Patients tend to talk softer than therapists so please place the audio recorder closer to your patient. We highly encourage all applicants to do a test recording to make sure your voice is heard.

### **What comes next after I finish recording the session?**

Plug it into the USB port of your computer and upload it onto your computer using iTunes or Windows Media Player.

### **How do I submit the audio sample?**

After you make a recording and download the sound file to your computer, you can log onto your internet connection and go to the following website, [www.academyofct.org/upload](http://www.academyofct.org/upload) so that you can securely send the file to ACT.

### **How do I know it will work?**

We encourage all applicants to listen to their own audio sample prior to sending it. If you choose to email it, please send a 'test' recording to yourself. Once you receive this test email please make sure you are able to download and play the recordings.

## **Sample Audio Recording Consent / Authorization Form**

I agree to be recorded and authorize the Academy of Cognitive Therapy to use audio recordings (or transcripts of recordings) of this cognitive therapy session for certification and standardization purposes. This audio sample may be sent via email or through the mail for this purpose. My name and other identifiers will not be used to identify me in the recording.

I agree to be recorded but do not authorize the use of this recording for any purposes other than certification with the Academy.

---

Patient Name

---

Patient Signature

## Case History, Formulation, and Treatment Plan

### I. Case History (Suggested # of words: 750)

**General Instructions:** The case history should briefly summarize the most important background information that you collected in evaluating this patient for treatment. Be succinct in describing the case history.

#### A. Identifying Information

Provide a fictitious name to protect the confidentiality of patient. Use this fictitious name throughout the Case History and Formulation. Describe patient's age, gender, ethnicity, marital status, living situation, and occupation.

#### Chief Complaint

Note chief complaint in patient's own words.

#### History of Present Illness

Describe present illness, including emotional, cognitive, behavioral, and physiological symptoms. Note environmental stresses. Briefly review treatments (if any) that have been tried for the present illness.

#### B. Past Psychiatric History

Briefly summarize past psychiatric history including substance abuse.

#### Personal and Social History

Briefly summarize most salient features of personal and social history. Include observations on formative experiences, traumas (if any), support structure, interests, and use of substances.

#### Medical History

Note any medical problems (eg., endocrine disturbances, heart disease, cancer, chronic medical illnesses, chronic pain) that may influence psychological functioning or the treatment process.

#### Mental Status Observations

List 3-5 of the most salient features of the mental status exam at the time treatment began. Include observations on general appearance and mood. Do not describe the entire mental status examination.

#### DSM IV or V Diagnoses

Provide five Axis DSM IV or DSM V diagnoses.

### Case Formulation (Suggested # of words: 500)

**General Instructions:** Describe the primary features of your case formulation using the following outline.

#### A. Precipitants:

*Precipitants* are large scale events that may play a significant role in precipitating an episode of illness. A typical example is a depressive episode precipitated by

multiple events, including failure to be promoted at work, death of a close friend, and marital strain. In some cases (eg., bipolar disorder, recurrent depression with strong biological features) there may be no clear psychosocial precipitant. If no psychosocial precipitants can be identified, note any other features of the patient's history that may help explain the onset of illness.

The term *activating situations*, used in the next part of the Case Formulation, refers to smaller scale events and situations that stimulate negative moods or maladaptive bursts of cognitions and behaviors. For example, the patient who is depressed following the precipitating events described above may experience worsening of her depressed mood when she's at work, or when she's with her husband, or when she attends a class she used to attend with her friend who died.

Which *precipitants* do you hypothesize played a significant role in the development of the patient's symptoms and problems.

**B. Cross-sectional view of current cognitions and behaviors:**

The *cross-sectional* view of the case formulation includes observations of the predominant cognitions, emotions, behaviors (and physiological reactions if relevant) that the patient demonstrates in the "here and now" (or demonstrated prior to making substantive gains in therapy). Typically the cross-sectional view focuses more on the surface cognitions (ie., automatic thoughts) that are identified earlier in therapy than underlying schemas, core beliefs, or assumptions that are the centerpiece of the *longitudinal* view described below.

The *cross-sectional* view should give your conceptualization of how the cognitive model applied to this patient early in treatment. List up to three current activating situations or memories of activating situations. Describe the patient's typical automatic thoughts, emotions, and behaviors (and physiological reactions if relevant) in these situations.

**C. Longitudinal view of cognitions and behaviors:**

This portion of the case conceptualization focuses on a *longitudinal* perspective of the patient's cognitive and behavioral functioning. The *longitudinal view* is developed fully as therapy proceeds and the therapist uncovers underlying schemas (core beliefs, rules, assumptions) and enduring patterns of behavior (compensatory strategies).

What are the patient's key schemas (core beliefs, rules, or assumptions) and compensatory behavioral strategies? For patients whose pre-morbid history was not significant (eg., a bipolar patient with no history of developmental issues that played a role in generation of maladaptive assumptions or schemas) indicate the major belief(s) and dysfunctional behavioral patterns present only during the current episode. Report developmental antecedents relevant to the origin or maintenance of the patient's schemas and behavioral strategies, or offer support for your hypothesis that the patient's developmental history is not relevant to the current disorder.

**D. Strengths and assets**

Describe in a few words the patient's strengths and assets (eg., physical health, intelligence, social skills, support network, work history, etc.).

**E. Working hypothesis (summary of conceptualization)**

Briefly summarize the principal features of the working hypothesis that directed your treatment interventions. Link your working hypothesis with the cognitive model for the patient's disorder(s).

## **Treatment Plan (Suggested # of words: 250)**

*General Instructions:* Describe the primary features of your treatment plan using the following outline.

**A. Problem list**

List any significant problems that you and the patient have identified. Usually problems are identified in several domains (eg., psychological/psychiatric symptoms, interpersonal, occupational, medical, financial, housing, legal, and leisure). Problem Lists generally have 2 to 6 items, sometimes as many as 8 or 9 items. Briefly describe problems in a few words, or, if previously described in detail in the HPI, just name the problem here.

**B. Treatment goals**

Indicate the goals for treatment that have been developed collaboratively with the patient.

**C. Plan for treatment**

Weaving together these goals, the case history, and your working hypothesis, briefly state your treatment plan for this patient.

## **Course of Treatment (Suggested # of words: 500)**

*General Instructions:* Describe the primary features of the course of treatment using the following outline.

**A. Therapeutic Relationship**

Detail the nature and quality of the therapeutic relationship, any problems you encountered, how you conceptualized these problems, and how you resolved them.

**B. Interventions/Procedures**

Describe three major cognitive therapy interventions you used, providing a rationale that links these interventions with the patient's treatment goals and your working hypothesis.

**C. Obstacles**

Present one example of how you resolved an obstacle to therapy. Describe your conceptualization of why the obstacle arose and note what you did about it. If you did not encounter any significant obstacles in this therapy, describe one example of how you were able to capitalize on the patient's strengths in the treatment process.

**D. Outcome**

Briefly report on the outcome of therapy. If the treatment has not been completed, describe progress to date.

**CASE WRITEUP EXAMPLE**  
**December 2, 1998**

**I. CASE HISTORY [actual word count: 774] (suggested # of words: 750)**

**A. Identifying Information:** Ann is a 44-year-old, twice-divorced, Caucasian woman who has no children, lives alone, and has been working full-time as a Spanish teacher for the past 22 years.

**B. Chief Complaint:** Ann sought treatment due to an escalation in her depression which started in October, 1996. She reported that she was also binge eating and overusing and abusing laxatives at least once a week, though she was much more concerned by the depression than the eating/laxative problem.

**C. History of Present Illness:** In October, 1996, Ann divorced her second husband and began to develop depressive symptoms (sadness, crying, social withdrawal, severe self-criticism). The depression worsened until it reached the severe level in March, 1997. At intake (May, 1997), her symptoms included the following:

Emotional symptoms: sadness, anxiety, lack of interest in almost all activities

Cognitive symptoms: difficulty concentrating, believing she was worthless and unloveable

Behavioral symptoms: crying, social isolation

Physiological symptoms: difficulty falling asleep, tiredness

She developed subclinical symptoms of bulimia nervosa in April, 1997. At intake, she reported that she binged, felt out of control of this behavior, and overused laxatives about once a week; she was (and is) intermittently preoccupied with a misperception that she is fat and is highly self-critical.

The major stressors in Ann's life are social ones. Since her divorce she has withdrawn from friends, family, and co-workers. She has dated several times since her divorce but each date has been a "one-night stand," which leaves her feeling rejected and defective. She used to derive significant satisfaction from relationships but has isolated herself and now feels sad, lonely, and rejected by others. While she finds it more difficult to do her job, work does not appear to be a significant stressor.

Ann restarted Prozac about 2 weeks ago (prescribed by her family physician) but thus far sees no change in her depressive symptoms.

**D. Psychiatric History:** Ann's first episode of major depression occurred in 1977 when her first husband divorced her. She was hospitalized for three weeks and was given Elavil. She discontinued the medication (against medical advice) at discharge but initiated psychological treatment (cognitive therapy) for the first time. Her depression remitted after four months of this outpatient psychotherapy, though she remained in therapy on a biweekly basis for another year, working on Axis II issues.

In 1989, Ann and her second husband received about six sessions of (predominantly psychodynamic) marital counseling which she found "mildly helpful."

In October, 1996, Ann's family physician prescribed Prozac which initially helped reduce her depressive symptoms. The depression worsened in December, 1997, and she discontinued the medication on her own.

- E. Personal and Social History:** Ann grew up the middle child of three. Her parents were Italian immigrants and her mother did not speak English. Ann considered herself the “ugly duckling” of the family. Her older sister was considered thin and pretty while Ann was called “chubette” and “big nose.” She felt as if she were an extra burden to her family since they strongly wanted a boy when she was born. Her younger brother was born 18 months later and received nearly all the family's attention. She describes her father as having been strict, controlling, demanding, and very concerned about what others thought of him. She describes her mother as quiet, unhappy, not affectionate, and old-fashioned. Ann felt unloved and unable to measure up to her siblings.

Ann attended Catholic school where she reports being trained to be “the perfect soldier.” She married for the first time at age 18. She reports that she was abused and controlled by her first husband who was violent at times. She believed she deserved the abuse and submitted to his wrath. When she finally got the courage to leave the marriage, she did not have her family's approval and to this day resents their lack of support.

Ann remarried in 1989. Her second husband reportedly spent a lot of time with young men and Ann suspects he was bisexual. He ceased having any sexual relations with her about three years after their marriage. Though they tried marriage counseling briefly, her husband was unwilling to work on modifying the situation and they divorced in October of 1996.

- F. Medical History:** Ann did not have any medical problems which influenced her psychological functioning or the treatment process.

- G. Mental Status Check:** Patient is fully oriented, with depressed mood.

- H. DSM IV Diagnoses:**

Axis I: Major Depressive Episode, Recurrent, Severe

Rule out Bulimia Nervosa

Axis II: Avoidant Personality Disorder

Axis III: None

Axis IV: Divorce, Multiple Relationship Failures

Axis V: GAF Current—68. Best in Past Year—80.

- II. CASE FORMULATION: [actual word count: 403] (suggested # of words: 500)**

- A. Precipitants:** Ann's second divorce probably precipitated a recurrence of depression. Although it was she who initiated the divorce, she nevertheless felt rejected, believing that if she were more loveable, her husband would have fought to save the relationship. Feeling not only unloved by and unloveable to her husband but also unloveable in general, she began to isolate herself. She was no longer getting much positive input from her friends, family, and co-workers because of her lack of contact with them—but, like the divorce, she perceived this self-initiated reduction of contact as their rejecting her, instead of her withdrawing from them. She became increasingly sad and lonely and other depressive symptoms began to develop.

**B. Cross-Sectional View of Current Cognitions and Behaviors:**

A typical current problematic situation is that Ann has just had sex on the first date with a man. Lying in bed with him she has the automatic thoughts, "I'm so ugly, what does he see in me, he'll never call, I might as well get up and leave now." Emotionally she feels sad and her behavior is to leave abruptly (probably appearing unfriendly, at best, to her date). A second typical situation is that she's reflecting on how a man has not called her back after a date. Her automatic thoughts are, "I'm too fat. No one wants me." She then feels sad, binges, and takes laxatives. A third situation is attending a family dinner where she perceives her father as being critical about her and her mother as lacking affection. She thinks, "No one cares about me; there's something wrong with me, I'm unimportant." She feels sad and becomes monosyllabic, speaking only when spoken to.

**C. Longitudinal View of Cognitions and Behaviors:**

Ann grew up with non-English speaking Italian immigrant parents: a father who was demanding and critical and a mother who was emotionally distant. Early on she developed the belief that she was defective and unloveable, beliefs that were strengthened by the attention heaped upon her younger brother, by increasing academic expectations of her father, by the criticisms of her teachers, and by her self-comparisons to her more attractive older sister. She developed the following key assumption: "If I'm perfect, don't cause trouble, and try always to please others, they'll like me. If I don't, they'll find me unloveable." Her compensatory behavioral strategies included being overly compliant, submissive, "perfectly" behaved, and avoidant of conflict.

**D. Strengths and Assets**

Ann has had many years of success in her professional life. In her role as teacher, she is extremely well-liked by her students, and given high praise from her peers.

**E. Working Hypothesis (summary of Conceptualization)**

It is understandable that Ann came to view herself as unlovable and defective as a result of the circumstances of her childhood. Being the daughter of highly demanding, critical European parents, her strict parochial education, and her abusive marriages, laid the foundation and then reinforced her negative view of herself. This negative self view is typically activated in interpersonal situations where she perceives rejection.

In order to function in the world, she has established rigid assumptions for herself: i.e., "I must be perfect or people will reject me," "I must please others, or they will dislike me."

To operationalize her assumptions, she has developed the following behavioral compensatory strategies: submission, avoidance, and acquiescence.

**III. TREATMENT PLAN: [actual word count: 195] (suggested # of words: 250)**

**A. Problem List:**

1. "Ann bashing"--hating self (ugly and unlovable)
2. Depression; especially loneliness, sadness, crying
3. Avoidance and isolation: wanting to be loved but fearing rejection
4. Anxiety: fearing serious consequence of unrelenting depression
5. Binge eating and abuse of laxatives
6. Resentment towards parents for lack of affection and love

**B. Treatment Goals:**

1. Reduce dysfunctional behaviors: Verbally berating herself  
Bingeing and purging

## Isolation

2. Reduce negative distorted thinking.
3. Increase self worth, self-value and self-image. (Modify unloveability and not-good-enough (defective) schemas).
4. Find healthier ways to have fun.
5. Gain confidence to go out alone and take risks in pursuing intimacy again.
6. Build assertiveness skills and reduce subjugation.

### C. **Plan for Treatment:**

The treatment plan was to reduce Ann's depression through helping her respond to her automatic thoughts (especially those connected with unloveability) and activity scheduling (especially to increase socializing). We also worked on alternative behaviors to bingeing when she was upset. Next, we tested her assumptions about being rejected if she displeased people and then worked on assertiveness skills. We are currently working at the belief level, modifying her view of herself as unloveable and defective.

## IV. **COURSE OF TREATMENT [actual word count: 300] (suggested # of words: 500)**

**A. Therapeutic Relationship:** Treatment was facilitated by Ann's eagerness to please ("If I please others, they'll like me") but the counterpoint to this assumption ("If I disagree with people, they won't [like me]") did interfere slightly. Ann was too eager to please in therapy; she quickly agreed with me, sometimes without really stopping to reflect on the hypotheses or alternative perspectives I presented to her. I was able to elicit from her another belief ("If I tell someone I disagree, they'll take it as criticism"), helped her test these beliefs with me, correct her thinking, and then she became more willing to tell me when she didn't fully understand or agree with what I had said.

### B. **Interventions/Procedures:**

1. Taught patient standard cognitive tools of examining and responding to her automatic thoughts (which allowed the patient to see her dysfunctional distorted logic and thus significantly reduced depressive and anxious symptoms.)
2. Had Ann conduct behavioral experiments to test her assumptions (e.g., If I say no to a man about having sex on a first date, he'll get mad and never call me again.). This resulted in reduced avoidance and increased assertiveness.
3. Had Ann keep an ongoing log of evidence that she was a loveable person, which helped her modify a key core belief.

**C. Obstacles:** When Ann had a bad week, she became hopeless about therapy. We reframed her setback as a reactivation of her schema due to an unfortunate incident with a date and as an opportunity to practice responding to negative automatic thoughts and solidifying a new, healthier belief.

**D. Outcome:** Ann's depression gradually reduced over a four month period after we started therapy, until she was in full remission. She remains in therapy to work on lingering problems with male relationships and her self-image.