The Academy of Cognitive Therapy: Purpose, History, and Future Prospects

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The Academy of Cognitive Therapy (ACT) was developed as a means to identify and credential mental health professionals who demonstrate competence in cognitive therapy. Its missions include certifying clinicians from all disciplines as competent cognitive therapists and educating the public about this empirically supported treatment. This article reviews the history of ACT, its current activities, and future prospects. It is argued that ACT fulfills several important roles and is a valuable resource for mental health professionals and consumers.

The Academy of Cognitive Therapy (ACT) was created in 1996 as an organization to benefit both mental health professionals and the public. The principal function of ACT is to assess the competency of clinicians in cognitive therapy and to certify them in this type of psychotherapy. Since its inception, however, other aspects in its evolution have occurred, and several more are planned. In this article, we describe the purpose and short history of ACT. We then present the credentialing process that has been adopted by ACT and end with future prospects for the Academy.

Purpose and History

As is well known to readers of this journal, one of the most important developments in the field of psychotherapy in the latter part of the 20th century was that of the cognitive-behavioral therapies (cf. Dobson, 2001). Among the various approaches to cognitive-behavioral therapy (CBT), cognitive therapy has had a specific role. Originated by Aaron T. Beck, M.D., cognitive therapy was one of the first CBT approaches to develop a manualized treatment (Beck, Rush, Shaw, & Emery, 1979). Cognitive therapy has adopted a consistent view of the nature of psychopathology, and has developed a series of treatment techniques that have been shown over time to have efficacy in the treatment of a number of disorders (cf. Butler & Beck, 2001).

Given the conceptual clarity and integrative ability of cognitive therapy (Alford & Beck, 1997), coupled with the increasing empirical support for the treatment approach, it is not surprising that cognitive therapy has been given prominence in graduate programs (Crits-Cristoph et al., 1995). The emergence of training institutes, internship programs, and workshops in the field have also contributed significantly to the broad dissemination of cognitive therapy to various mental health professionals. In like fashion, books in the popular press (Burns, 1980; Greenberger & Padesky, 1995; Young & Klosko, 1993) have advocated the approach to consumers of mental health services, increasing the public demand for trained cognitive therapists.

By the middle of the last decade the growth and popularity of cognitive therapy had increased to the point where important professional and consumer issues began to emerge. As a result of these pressures, 36 directors of cognitive therapy programs met in Philadelphia in October 1996 to discuss the merits of creating an organization to educate the public about cognitive therapy and to certify qualified mental health professionals in cognitive therapy. The program directors at the initial conference decided that it was important to certify individuals as cognitive therapists for several reasons:

- Cognitive therapy is a distinct empirically supported psychotherapy, which must maintain its own identity. One way to create a community of like-minded therapists is to create an organization uniquely situated to recognize qualified colleagues.
- There has been confusion in the field, particularly in the distinction between cognitive-behavioral therapies in general (as well as some therapies that selectively employ cognitive techniques) and cognitive therapy in particular.
- Many therapists had begun to identify themselves as cognitive therapists, when their overall practice does not reflect such an orientation. Consumers, agencies, insurance companies, and researchers may be misled by erroneous self-labeling.

Given the above concerns, the Academy was established as a way to address these issues. ACT was established as a

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nonprofit organization, which has two major missions: to benefit consumers through education, and to identify health professionals who have been awarded ACT credentialing in recognition of their demonstration of a sound knowledge of the theory of cognitive therapy and competence in its practice. From the outset, ACT has been multidisciplinary and international. Founding fellows, who consisted of an original group of identified experts, include internationally recognized leaders in the field.

As described on the ACT Web site (www.academyofct.org), ACT certification provides the following advantages and benefits:

- inclusion on the ACT list of certified cognitive therapists;
- documentation of competence in cognitive therapy for employment, promotion, or tenure purposes;
- description of members' practices, publications, and presentations on the ACT Web site;
- promotion of the effectiveness of cognitive therapy to consumers, insurers, managed care companies, and behavioral health-care institutions;
- referrals of patients seeking cognitive therapy through an international referral database;
- favorable consideration by insurers and managed care panels;
- opportunities to guide the development of cognitive therapy by serving on the governing board and committees of the Academy;
- participation in continuing education programs sponsored by ACT.

Another excellent benefit of belonging to ACT is the opportunity to participate in the organization's Web-based listserve, as the listserve is used to discuss a variety of clinical, educational, theoretical, and research issues. The questions are responded to by both experts in these areas and by the general membership. Membership in ACT allows access to the prominent leaders in the field.

ACT is not a membership organization, in that it is not open to anyone with an interest in cognitive therapy. Nor is credentialing by ACT available to students in mental health disciplines. Individuals who apply for certification must document the completion of their postgraduate education and professional licensing, as well as specific training in cognitive therapy. They are required to submit a written case summary with a cognitive conceptualization and an audiotape of actual treatment, which are evaluated by the Credentialing Committee.

Although ACT has existed for a relatively brief time, it has already undertaken a number of developmental steps. A Board of Directors has been established. Official incorporation as a nonprofit organization, based in the State of Pennsylvania, has been completed. The criteria and procedures for certification have been established and enacted. As of January 2005, there were over 500 fellows and certified members. New applications are received and processed weekly. In addition to the credentialing process, the ACT board is moving to ensure consumer education and advocacy related to cognitive therapy and that its mandate as a not-for-profit organization is fulfilled. These issues are discussed more fully below. However, as credentialing is another purpose of ACT, to ensure the public has access to well-trained, experienced cognitive therapy practitioners, that process is described first.

The Credentialing Process

Membership in ACT is based on demonstrated knowledge of and competence in the practice of cognitive therapy. Typically, applicants first begin the process by completing Part I of the application, described on the ACT Web site.[1] Part I involves providing demographic information, training/degree, practice, and health information, and payment of an application fee. Applicants must hold an advanced professional degree in any mental health profession (e.g., psychiatry, psychology, social work, nursing) and a current license for their profession (if available in their locale) in order to apply for certification. Applicants must also attest that they are not the subject of an ethics complaint or disciplinary process, or legal action, and that they possess malpractice insurance as necessary in their profession and geographical region to practice as a qualified mental health professional. Two letters of reference from professionals who can attest to their work in cognitive therapy are also required.

The information provided in Part I is evaluated by the Credentials Committee. Once the Credentials Committee has approved the first part of the application, the applicant is invited to complete and submit the second part of the application, which is related to the demonstration of clinical competence in cognitive therapy. In order to conduct this review, a description of training in cognitive therapy, a case write-up, an audiotape of an actual cognitive therapy session, and an application fee are required.

The required training can take place in a number of forms (e.g., formal graduate program, postgraduate course, workshop, and training, or formal internship or externship program). Whatever form it takes, though, certain experiences are required. For example, there are a series of publications in the field that are considered core to a cognitive therapist's training. These are listed on the ACT Web site (these references are reproduced here in the Reference list, with an asterisk to denote them; other references that are recommended can also be found on

[1] Applicants also can obtain information through e-mail at info@academyofct.org or by calling the ACT membership office at (610) 664-1273.

the ACT Web site), and applicants must attest that they have read at least five books in the area, and a minimum of three of the required books. Further, the applicant must have completed the treatment of at least 10 patients using cognitive therapy, for a minimum total of 40 hours of clinical training (and a minimum of 10 hours of supervision). Information about the nature of the patients is required in the application process.

The case history that is part of the application process must be written using a particular format, which fits the cognitive case conceptualization that is expected to be part of all cognitive therapy (J. Beck, 1995). The case description begins with a general history and description, which is to include such elements as identifying information, chief complaint, history of present illness, psychiatric history, personal and social history, medical history, mental status observations, and applicable *DSM-IV* diagnoses.

A case formulation follows the case history. This section includes such issues as precipitants of the current disorder, a cross-sectional view of current cognitions and behaviors, a longitudinal view of cognitions and behaviors (i.e., core beliefs, rules, or assumptions), strengths and assets, and a working hypothesis that is directed toward treatment interventions. The treatment plan follows, including a problem list, treatment goals, and plan for treatment.

The final section of the case write-up is a description of the course of treatment. The applicant is expected to address a number of key features of cognitive therapy in this section, including the nature and quality of the therapeutic relationship, any relationship issues that were encountered, the major cognitive therapy interventions that were used (including a rationale that links these interventions with the patient's treatment goals and the working hypothesis), treatment obstacles, and treatment outcome. Applicants are also encouraged to explain any unusual aspects of the case that warrant consideration.

In addition to the written case, applicants must provide an audiotape of an actual therapy session (or, if the applicant is not English-speaking, a certified transcript of an actual therapy session). The taped session may be from the written case, but this is not a requirement of the application process. It should also be noted that there is considerable latitude in the type of case that the applicant presents for evaluation. Age, gender, culture, presenting problems, and primary intervention methods can all vary, as is true in normal clinical practice. Indeed, one of the implicit aspects of the evaluation process used by ACT is to make it as naturalistic as possible.

Evaluation criteria and procedures have been adopted for both the case write-up and audiotape. Materials are evaluated by members of the Credential Committee. For the written case, the required elements are judged as *absent*, *present but deficient*, or *satisfactory*. Each element is assigned a score, and a criterion has been developed for the applicant to be considered to have passed. In like measure, the audiotape is rated using the Cognitive Therapy Scale (CTS; Young & Beck, 1980). A cutoff score has been established as the minimum expected level of cognitive therapy competence. The CTS was selected as the primary measure of competence, as it has been used in other research projects and has been shown to possess adequate reliability and validity for the current purpose (Dobson, Shaw, & Vallis, 1985; Vallis, Shaw, & Dobson, 1986).

As the above description reveals, the evaluation process for ACT is comprehensive. Its focus on general professional credentialing, specific cognitive therapy training, and the ability of the applicant to conceptualize and work with actual cognitive therapy cases is seen as a challenging yet appropriate process to credential mental health professionals in cognitive therapy. It is also noted that although there are several aspects to the ACT credentialing process, none by itself is daunting. It is rather in the integration of the characteristics that a specialist in cognitive therapy can be recognized.

Accomplishments and Future Prospects

Despite the brief history of ACT, it has accomplished a great deal. The Web site, www.academyofct.org, offers a wealth of information to consumers and mental health professionals. ACT members have undertaken a number of projects for consumers, from volunteering to do free screening for psychiatric disorders as part of designated programs to offering low-cost or pro bono treatment to insolvent patients. A number of ACT members are involved in psychiatric residency programs and have exchanged course syllabi and training strategies to make their cognitive therapy programs more effective. ACT members travel nationally and internationally to offer training to mental health professionals in cognitive therapy and consult with organizations worldwide to help them develop their own training programs. ACT has sponsored symposia about various aspects of cognitive therapy at the annual conference of the Association for Advancement of Behavior Therapy (AABT; now known as the Association for Behavioral and Cognitive Therapies). At its annual information meeting at AABT, ACT has sponsored presentations of innovative cognitive therapy topics by Aaron T. Beck, M.D., and has established an annual award to honor those leaders in cognitive therapy who have made a substantial and significant impact on the field.

ACT will continue its several missions. It will continue to evaluate applicants for certification though its credentialing system. It will continue to promote cognitive therapy through sponsoring training initiatives and

conferences, through bringing together cognitive therapy educators, and through encouraging the growth of research in cognitive therapy. Education of both consumers and interested mental health professionals, through the sharing of clinical, research, and educative expertise via the Internet, will persist as an important service.

What other actions might be in the future of the Academy? For one, the issue of credentialing in mental health has increased in profile in recent years. With the development of empirically supported treatments and the increased recognition of the need for training in these areas in professional accreditation and training standards, it is highly likely that this role will continue to be of central importance. In particular, standards such as those set by ACT, which operate within a particular model of therapy but across different professional groups, will serve as an important antidote to potential profession-specific claims to special expertise. Promotion of enhanced training standards, and public awareness of these standards, will be central to ACT's future. Communication among, and support for, ACT's members will persist. While it is unlikely that ACT will directly become involved in lobbying for the funding of the service provided by its members, it is likely that such lobbying will take place. If so, ACT will work to ensure that its credentialing process is accurately presented and used. Efforts that have already been made to ensure that ACT's credentialing process is open to international applicants also makes it likely that increased globalization efforts will be needed. Finally, the enhancement of public awareness of empirically supported treatments in general and cognitive therapy in particular will likely occupy an increasing role for ACT. In short, there is much to do. As cognitive therapy continues to occupy a central place in the array of psychotherapies in the early 21st century, and as its future only seems brighter (Norcross, Hedges, & Prochaska, 2002), it is likely that ACT will become an increasingly significant organization in the years to come.

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