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A SURVEY OF PSYCHIATRISTS COMPLETING A COGNITIVE BEHAVIOURAL PSYCHOTHERAPY DIPLOMA COURSE

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Abstract. There is widespread support for training in Cognitive Behavioural Psychotherapy (CBP) amongst psychiatrists and from the Royal College of Psychiatrists. One possible way to gain such training is to undertake a diploma or certificate course, a growing number of which exist in the United Kingdom. We report on a postal questionnaire survey of psychiatrists who have completed a CBP diploma course. Psychiatrists described the course as altering their clinical practice and found the skills learned, the format of multidisciplinary learning and of supervision all useful and helpful. However, individuals who undertook a CBP diploma were concerned about their ability to apply these skills and undergo further training, given the time constraints within busy consultant jobs.

Keywords: Cognitive behavioural psychotherapy, psychiatry, training, survey, CBT, psychotherapy.

Introduction

Whilst clinical psychologists remain the main providers of Cognitive Behavioural Psychotherapy (CBP) within the National Health Service other mental health groups are now training in CBP, for example nurses, occupational therapists and psychiatrists. Together with the increasing evidence-base for CBP (Roth & Fonagy, 1996), and its increased application to major psychiatric disorders, has come a drive to provide better training opportunities for psychiatrists. A recent revision of the requirements for psychotherapy training for basic grade trainee psychiatrists (i.e., Senior House Officers) have been set out by the Royal College of Psychiatrists (Bateman & Holmes, 2001). These include the development of general skills alongside training in and experience of specific psychotherapies, with CBP being defined as one of the three main psychotherapy models alongside ''transference-based therapies'' and ''integrative therapies''.

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In the past, however, reports have shown that few training schemes have consistently managed to meet the previous and less demanding standards (Hamilton & Tracey, 1996) and that access to CBP training was limited in those schemes that had no consultant trained in CBP. The limited availability of psychiatrists with appropriate training has led to psychiatrists accessing training and supervision either through a certificate or postgraduate course in CBP or through other mental health professionals such as psychologists or cognitive behavioural therapists. This preliminary study aimed to identify the benefits (or otherwise) of psychiatrists undertaking a CBP diploma course and their views on the impact of the training upon their clinical work. A further aim was to examine views on ongoing professional development and supervision.

The study

In May 2000, a questionnaire was sent to all psychiatrists who had completed the University of Dundee Diploma course. The questionnaire was prepared on the basis of an extensive literature review, consultation with mental health colleagues, and the researchers' previous experience of a survey of supervision in psychiatry. A comparison group was not selected as the characteristics of psychiatrists attending diploma courses need to be addressed whether or not they are at variance with all attendees or all psychiatrists.

This initial study was a retrospective survey conducted by means of an anonymous questionnaire[1] with an accompanying explanatory letter. Doctors who failed to return the questionnaire within 4 weeks were sent a further copy. The short questionnaire collected data on the following items: demographic and employment data; experience of CBP before the course; experience on the course and the use of CBP and further training in CBP after completion of the diploma course. Throughout the questionnaire there were free text sections. Detailed analyses were not performed on the data as the numbers in each group were too small.

Results

Demographics

Of the 16 psychiatrists who completed the diploma course, one was excluded as author of this paper; of the 15 remaining, 11 (75%) returned their questionnaires. The median length of time since completing the diploma was 9 months (range 0–3 years). Eight respondents (73%) started the course as a specialist registrar and 2 (27%) as a consultant. One individual became a consultant during the course. Eighty-two per cent (9) were either training, or fully trained, in general adult psychiatry, often alongside another speciality or subspeciality. The remaining 2 respondents were from forensic and child and adolescent psychiatry respectively.

Experience of CBP before the course

Only 3 respondents (27%) had no prior experience of CBP, though for many experience was limited to single cases (4; 50%), or to one therapeutic strategy (2; 25%). Supervision

[1] A copy of the survey instrument is available from the first author on request.

was provided by consultant psychiatrists trained in CBP (4; 50%), clinical psychologists (2; 25%), cognitive-behavioural nurse therapist (1; 13%), with one respondent not specifying their supervisor's background. Supervision by non-psychiatrists was viewed as at least helpful by all respondents but one respondent (13%) supervised by a consultant described it as very unhelpful and inadequate. One respondent commented that local CBP practitioners had been too busy to be able to train and supervise. All candidates stated that they believed they needed supervision of clinical cases, though for 25% (2) it had not been available prior to the course.

Experience on the course

Table 1 shows the number of respondents endorsing each statement regarding their experience on the CBP course. A number of candidates had more than one supervisor. Only one candidate (9%) had a consultant psychiatrist as supervisor, with 8 candidates (73%) supervised by cognitive behavioural nurse therapists and 4 (36%) having experience of supervision from a clinical psychologist. All supervision was viewed as at least helpful. Supervision was weekly for 3 (27%), fornightly for 7 (64%) and monthly for one (9%). The one individual who had supervision less frequently than fortnightly described it as allowing more discussion of treatment approaches but less direct supervision of individual cases. (The individual was undertaking the course over 2 years.) Supervision was viewed as the most useful component of the course by 4 candidates (36%).

Every candidate saw patients with anxiety and depressive disorders with the majority of patients having multiple problems and comorbidity. The numbers of candidates seeing other problems and conditions varied, the most common being: 8 (73%) personality difficulties, 4 (36%) post-traumatic stress disorder, 3 (27%) adjustment problems, and 3 (27%) with hallucinations and delusions. Two or less saw patients with bereavement, low self-esteem, anger problems, eating disorders, obsessional symptoms, somatoform disorder and body dysmorphic disorder.

Table 1. Respondents agreeing with statements regarding the CBP diploma course

	Number (%)		
	Agree/ strongly agree	Not sure	Disagee/ strongly disagree
The course was helpful to my everyday clinical practice	11 (100%)	0	0
The course altered my clinical practice	11 (100%)	0	0
The course was helpful to my psychotherapy practice	11 (100%)	0	0
The course was challenging for me academically	10 (91%)	0	1 (9%)
It was helpful to complete a research proposal	7 (64%)	1 (9%)	3 (27%)
The workshop format was helpful	10 (91%)	1 (9%)	0
Group supervision was useful	11 (100%)	0	0
Individual supervision was useful	11 (100%)	0	0
CBP supervision has provided a useful format for ongoing supervision	10 (91%)	1 (9%)	0
It was helpful to do a multidisciplinary course	9 (82%)	0	2 (18%)

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Ongoing training and use of CBP

Of the 7 candidates who completed this section all stated they continued to employ the CBP paradigm, but 5 (71%) did not intend pursuing supervision and 3 (43%) had difficulty setting up supervision. Five (71%) respondents stated that they had no time to see CBT cases and 6 (82%) thought they would have insufficient time in the future. All candidates thought it was important to continue training in CBP and intended to attend British Association for Behavioural and Cognitive Psychotherapies (BABCP) conferences. The majority (5; 71%) of candidates viewed participation in a special interest group as of great benefit.

Of the 11 respondents who completed this section 4 (36%) were members of the BABCP. Only one of the remainder did not anticipate joining, with time limitations given as the reason. Two (18%) of the candidates were accredited by the BABCP with 3 candidates (27%) who stated they would not seek accreditation sharing the view that their core qualification was enough. No differences were found between individuals with or without prior CBP experience in relation to whether they believed their clinical practice was altered, whether they anticipated continuing to use CBP, and whether they intended to pursue supervision or accreditation.

Discussion

This initial survey suggests that there are a number of benefits for psychiatrists undertaking a course on CBP. Whilst many of the respondents had concerns about having time as consultants to see CBP patients, all had either continued to employ the CBP paradigm, or intended to, and stated the course had altered not just their ''psychotherapy'' but their routine clinical practice. Whilst not all respondents agreed that a multidisciplinary course was very helpful, it is interesting that many did (9; 82%). This experience may assist with multidisciplinary team working as a result of a better understanding of other team members' clinical practice and conceptualization of illness.

Specific features of the CBP course were valued by psychiatrists. For example, supervision outside one's own professional group is unusual but psychiatrists in this survey found it helpful. In addition, whilst individual supervision is the commonest style for psychiatrists (Bradbury, O'Brien, & Gospert, 1996) group supervision was found helpful. In addition, respondents commented upon their wish to apply the supervision model they experienced in other settings. Psychotherapy-based supervision models take precedence over supervision-specific models in psychiatry, with supervisory style commonly mirroring clinical style. Psychiatrists have tended to have more exposure to psychodynamic psychotherapy and this style may therefore be adopted in supervision. Greater exposure to other psychotherapy models and supervision styles will help integrate different approaches into style of supervision of trainees, medical students and other team members. The varied helpfulness of supervision by senior psychiatric colleagues described in this survey may, in part, reflect consultants' attempts to be helpful where no other supervision was available.

The limitations of this study are that: (i) it is a small sample on only one course; (ii) the questionnaire was not validated elsewhere; and (iii) the sample are self-selected as interested in CBP. These limitations are compensated for by: (i) the use of both Likert and open text sections to allow elaboration of opinions; and (ii) the inclusion of all psychiatrists (other than the author). The response rate of 73% is acceptable for this type of study though non-responders may have held less positive attitudes toward their experience.

At the time of writing few psychiatrists are members of the BABCP (n = 294; 6% of all members) and still fewer are accredited by the BABCP as Behavioural/Cognitive Psychotherapists (n = 40; 14% of all psychiatric members). This survey sheds little light upon the low rates of membership as the candidates can be viewed as an atypical sample with a special interest in the area. As discussed by others (Ashworth, Williams, & Blackburn, 1999), and suggested here, the majority of psychiatrists with training and interest in CBP may not seek accreditation as the core professional qualification is seen as enough. The respondents, though keen to employ CBP, had concerns about the potential for employing, refreshing and improving these skills. Efforts are needed to allow individuals to incorporate this commitment into job descriptions and career development through protected time or via designation of special interest posts.

The public and other professionals working within mental health expect psychiatrists to have a basic understanding of psychological therapies, to have knowledge and skills to employ appropriate psychotherapies, and to liaise with other professionals with regard to specialist treatment. The Royal College of Psychiatrists' new guidelines (Bateman & Holmes, 2001) will play a part in producing such psychiatrists but ultimately effective methods need to be found to allow individuals time to incorporate these newly acquired skills in their own clinical practice, continue to develop these skills, and assist in the training of others.

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