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WHAT BECOMES OF COGNITIVE THERAPY TRAINEES? A SURVEY OF TRAINEES' OPINIONS AND CURRENT CLINICAL PRACTICE AFTER POSTGRADUATE COGNITIVE THERAPY TRAINING

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Abstract. Training in cognitive therapy includes a grounding in relevant empirical research, and the development of a range of clinical skills. It is recognized that this training will need to be continually updated in line with new developments. Several postgraduate training courses in cognitive therapy or cognitive behaviour therapy exist in the United Kingdom. Such courses are expensive in terms of both direct and indirect costs. A postal survey was employed to investigate the effects of the one-year post-qualification course in cognitive therapy at the Newcastle Cognitive Therapy Centre on trainees who had attended the course. The questionnaire examined trainees' views about the course, of their current clinical skills in cognitive therapy and their use of cognitive therapy since leaving the course. Finally, continuing professional development, on-going supervision and further training in cognitive therapy were examined.

Keywords: Cognitive therapy, psychotherapy, training, follow-up, survey.

Introduction

As the efficacy of cognitive therapy (CT) interventions becomes increasingly established, the use of CT is becoming widespread. This is likely to increase the demand for training in CT for health professionals (Enright, 1997). Traditionally, developments

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within CT have arisen through innovation alongside empirical evaluation of interventions. The efficacy of training in psychotherapy has already been widely studied (Stein & Lambert, 1995). As CT specialists devote an increasing proportion of their time to the training and supervision of other therapists, it is natural that these interventions should also become the object of evaluation.

Specialist training is often provided by professionals working within cognitive therapy centres of excellence. At the Newcastle Cognitive Therapy Centre a range of training opportunities are available. The CT Forum provides a regular lunchtime special interest group meeting, aimed at experienced clinicians, usually including a talk given by a local or visiting speaker, and runs other training workshops provided by leading national and international cognitive therapists. Members of the CT Training Clinic see patients and receive supervision and meet as a group for clinical discussion. An intensive one-year postgraduate course is also offered. This combines supervised clinical practice, workshop style training and personal academic study. Such training courses are expensive in terms of fees (over £2,000) and time away from work (one day a week for the course plus personal study time).

CT training aims to equip the trainee with an understanding of cognitive theory and mastery of a range of clinical skills that are applied in a structured fashion. It is recognized that even after training there is a continuing need to update this knowledge and clinical skill in line with new developments in CT (Padesky, 1996). However, there is a paucity of information about the skills gained through CT training, and of the continued development of knowledge and skills after the course.

Previous studies have examined the outcome of training courses in behaviour and cognitive-behavioural therapies both in the U.S. and the U.K. Various methodologies have been used. O'Farrell, Sewitch and Cutter (1980) reported the results of a survey at the end of, and two years after, an intensive month-long training course in behaviour therapy. Respondents reported that they had greater knowledge of behaviour therapy theory and techniques in comparison with their retrospective ratings of pre-training. These improved ratings were maintained at two-year follow-up. Reported use and teaching of behaviour therapy increased. This study is compromised by the use of self-ratings of knowledge and the retrospective nature of pre-course ratings. Freiheit and Overholser (1997) surveyed clinical psychology graduate students before and after a nine-month CBT course using the Behaviour Therapy Scale. This measure assesses knowledge and attitudes to CBT, and gathers information about recent use of cognitive and behavioural interventions. The test of knowledge showed improvement and attitudes towards CBT became more positive. Ratings of recent use of cognitive and behavioural techniques indicated increased use after the course. The methodology of this study is strengthened by the collection of data before and after training, and less reliance on self-assessment.

Two further studies examined training effects using direct assessment of therapist skill rather than relying on self-report data. Both used the Cognitive Therapy Scale (CTS: Young & Beck, 1980), an 11-item rating scale devised to assess therapist competency in applying CT through expert ratings of recordings of whole CT sessions. It includes items scoring both general therapeutic and CT specific skills. Shaw and Wilson-Smith (1988) describe the use of the CTS as a tool for monitoring the skills development of trainees undertaking CT training in order to take part as therapists in

the NIMH trial of CBT for depression (Elkin, Parloff, Hadley, & Autry, 1985). The trainees were highly selected and already experienced therapists. The CTS ratings showed a significant training effect for most, although not all, trainees. However, because the training was carried out with the aim of bringing all therapists up to a predetermined competence level, there was variation in the level of intervention for each trainee. The study does not therefore measure the outcome of a standardized training intervention.

A pilot study reported the use of CTS ratings of sessions conducted by trainees of a British CBT course (Williams, Moorey, & Cobb, 1991). Tapes of sessions carried out early, and at the end of the year-long course were compared. The response rate was low resulting in a small sample ($n = 11$) and the majority of the rated therapists were experienced psychologists and therefore not representative of the trainee group as a whole. Overall, the group did not show significant improvement in CTS ratings after training, althouth 8 of the 11 subjects did show improvement. The small numbers make conclusions difficult to draw.

The studies described above reported outcomes of different training interventions and trainee groups comprising individuals of different professions and previous levels of experience. Survey data showed that trainees rated their knowledge as improved and reported greater use of therapeutic interventions. Studies using CTS ratings showed that most trainees improve following training.

The impact of any staff training is limited by the extent to which trained staff use the skills that they have acquired (Corrigan & McCracken, 1997) and a wide variety of factors have been found to influence the implementation of new skills following training (Burdett & Milne, 1985). However, no studies have reported the impact of CT training on the work practices of individuals trained in the U.K. A similar study of nurses trained in behaviour therapy (Barker, 1980) suggested that there was some variation in the extent to which nurses were able to employ behavioural techniques, depending on the role to which they returned after training. Individuals attending CT training come from a range of health care professions, not just nursing. It is likely that these professionals have different levels of experience prior to the course, different views of training, and would apply CT in different ways.

The aim of the study was to report descriptive data on the professionals who attended the year-long CT training course provided at the Newcastle Cognitive Therapy Training Centre, their views of the impact of the course on their clinical work, and their ongoing continual professional development and access to clinical supervision. Differences between the professional groups were also examined.

Method

The Newcastle course has run since 1990 on a yearly basis (with the exception of 1991–92). Fourteen trainees completed the course in its initial year (1990–91); 17 in 1992–93; 16 in 1993–94 and 18 in 1994–95 (total 65).

A questionnaire and a stamped addressed envelope were sent out to all past trainees for whom an address was available. As past trainees of the course, two of the authors (PA and CW) completed questionnaires. The questionnaire could be filled in anonymously, and it was explained that the aim was to examine "how useful (or not!) the

course has been to you, and also to find out how the training course may have affected your clinical practice''. The reliability of the questionniare was not tested.

The four page questionnaire was made up of six sections:

1. General information (sex, age, year of course attendance).

2. Cognitive therapy training and experience before attending the course
Information about the respondents' experience of reading, attending CT workshops or supervision, attendance at the Newcastle Cognitive Therapy Centre's other regular training events, and membership of relevant organizations prior to the course was gathered using closed questions with Yes/No responses.

3. Experience on the course
Respondents were asked to rate their experience of the course using 7-point Likert scales. Ratings of the quality of supervision and the teaching received were gathered using a scale anchored 1 (very poor) to 7 (excellent). Respondents were also asked to rate the importance of various course elements in improving their knowledge and skills (1, not at all important to 7, very important). Further questions rated the extent to which respondents' general clinical skills and CT skills had been enhanced by the course (1, not at all, to 7, very much), and comparing current skills with skills at the end of the course (1, a lot worse, to 7, a lot better).

4. Current job situation
Respondents were asked to record their profession and whether CT was the main focus of their current post. They were asked if they had changed job since the course, and asked whether they thought the course had altered their job prospects using fixed response questions.

5. Use of cognitive therapy since the course
Respondents were asked to state their predominant therapeutic approach and report on their current use of CT.

6. Continuing professional development
Respondents were asked to report on their attendance on further CT training, and access to CT supervision. They were also asked about their current and past membership of relevant organizations (e.g., British Association of Behavioural and Cognitive Psychotherapy BABCP) and registration with the United Kingdom Council for Psychotherapy (UKCP).

The results were analysed for the sample as a whole, and additional selected analyses were carried out to compare responses based upon the year of the course attended, the professional group (clinical psychology, medical, nursing, or other), and by two factors presumed to indicate greater prior experience of cognitive therapy training (whether they had attended cognitive therapy training workshops or received clinical supervision before the course). These sub-groups were compared using independent groups *t*-tests and pre-selected one-way analyses of variance (ANOVA).

We hypothesized that those trainees with higher previous knowledge and experience of cognitive therapy would be most likely to continue to be active in their practice of CT after the course.

Table 1. Profession of trainees 1990–1995

Profession	*n*	%
Clinical psychology	13	25
Psychiatry	12	23
General Practice	4	8
Other medical	1	2
Community psychiatric nursing	7	14
Behaviour nurse therapy	3	6
Other nursing	4	8
Social work	4	8
Other	4	8
Total	52	

Results

Fifty-two of the 65 (80%) questionnaires were returned after two mailings of the questionnaires in April and August 1996 (i.e. at least 10 months since completing the course for the latest training cohort). In order to summarize data effectively, the number of missing cases is only specified if it is greater than 5 (10% of the sample) and unless otherwise specified, percentages are calculated from the total of $N = 52$.

The mean age of respondents was 37 years (*SD* 7 years), the median current age was 37 years with a range of 26–56. Twenty-five of the respondents were male (48%) and 27 female (52%). The professions of the respondents are summarized in Table 1.

Those grouped as ''other'' specified themselves as an occupational therapist, an occupational psychologist, an academic and a counsellor. In order to allow an analysis of the responses by profession, all professions were combined to form sub-groupings of clinical pyschology (13; 25%), medicine (17; 33%), nursing (14; 27%) and other (8; 17%). There was a trend towards increasing numbers of nurses and clinical psychologists in later years. At the time of the survey three of those who returned completed questionnaires were off work sick, two were on maternity leave, and one was not employed in a clinical job.

Cognitive therapy training and experience before attending the course

Before attending the course, almost all (51; 98%) had read books on CT; 38 (73%) had attended training days or workshops; 29 (56%) had received CT supervision; 8 (15%) had attended the Newcastle CT Training Clinic and 8 (15%) had joined the Newcastle CT Forum. This suggests that the group was knowledgeable and experienced in cognitive therapy prior to attending the course.

Experience of the course

1. Ratings of quality of supervision and teaching. Average ratings of the quality of supervision and teaching were high. There were no significant differences in the ratings

Table 2. Ratings of quality of teaching and supervision

	Median and range: 1 (very poor) to 7 (excellent).	% rating high score (6–7)	% rating low score (1–2)
Quality of supervision	6 (2–7)	75	4
Quality of teaching	5 (4–7)	50	0

of supervision and teaching quality by different professional groups. The responses are summarized in Table 2.

2. Perceived importance of course elements in improving knowledge and skills. All course elements were perceived as making important contributions to knowledge and skills. The responses are summarized in Table 3. When asked which single element was the *most* important, 30 (57%) reported supervision as the single most important element. There were no significant differences in professional groups' ratings of the importance of course elements.

Table 3. Perceived importance of course elements in improving clinical knowledge and skills

	Median and range: 1 (not at all important) to 7 (very important)	% rating high score (6–7)	% rating low score (1–2)
Supervision	7 (1–7)	87	4
Class teaching	6 (3–7)	75	0
Reading	5 (3–7)	46	0
Essays	5 (2–7)	44	2
Case reports	5 (2–7)	42	2
Learning from peers	5 (2–7)	33	4

3. Perceived impact of course on clinical skills. All respondents rated their cognitive therapy skills as enhanced, and almost all subjects rated their general clinical skills as enhanced by the course. On the scale of 1 (not at all) to 7 (very much), 42 (81%) rated the enhancement of their general therapy skills as between 5 and 7, and 50 (96%) rated the enhancement of their cognitive therapy skills as between 5 and 7 (Table 4). Doctors and trainees in the "other" professions group (i.e., not doctors, clinical psychologists

Table 4. Perceived improvement in general clinical skills and cognitive therapy skills

	Mean Improvement Ratings					
	Whole group ($N = 52$)	Clinical psychologists ($N = 13$)	Doctors ($N = 17$)	Nursing staff ($N = 14$)	Other professions ($N = 8$)	
General therapy skills	5.42	4.92	6.06	4.86	5.88	$p < .05$
Cognitive therapy skills	6.17	5.77	6.41	5.93	6.75	$p < .01$

or nurses) rated their general therapy skills as more enhanced by the course than did clinical psychologists or nurses. There was a significant difference between groups ($F(3, 48) = 2.94$, $p < .05$). Similarly, doctors and other professions rated their cognitive therapy skills as more enhanced than either clinical psychologists and nurses. There was a significant difference between groups ($F(3, 48) = 4.24$, $p < .01$).

Ratings of how *current* skills in cognitive therapy compared to skills at the end of the course on the scale of 1 (a lot worse) to 7 (a lot better), the mean response was 5. No subjects rated their skills as "a lot worse"; 11 (21%) rated themselves as being "a lot better". There were no differences between professional groups' ratings of their skills.

The impact of previous CT experience on the course experience

Some clear differences were found when those who had more previous experience of cognitive therapy were compared with those with less previous experience. Those who had previously attended workshops or training days found the class teachings useful, but significantly less so than those who had no previous workshop experience (mean 5.78 vs. 6.43, $t(49) = 2.55$, $p < .02$). Similarly they rated learning from peers as less important (mean 4.68 vs. 5.54, $t(48) = 2.08$, $p < .05$). Those who had received supervision prior to course attendance rated the quality of supervision more highly than those without such previous experience (mean 6.17 vs. 5.43, ($t(50) = 2.34$, $p < .03$). Those with previous experience of supervision rated learning from peers as less important than those without such experience (mean 4.55 vs. 5.38, ($t(48) = 2.27$, $p < .03$).

Current job situation

The majority (46; 88%) believed that attending the course had *improved* their job prospects. No-one believed that their job prospects had been worsened by attending the course. Most (37; 71%) had altered their job or applied elsewhere since attending the course.

Of those curently working in a clinical setting ($n = 46$), only 11 (24%) reported that they were specifically employed to deliver cognitive therapy. Of these 11, only 4 reported that CT had been the main focus prior to their attendance at the course. However, as can be seen in the next section, cognitive therapy methods were widely used by most trainees in their various jobs.

Use of cognitive therapy since the course

Almost all respondents (50; 96%) reported continuing to use cognitive or cognitive-behavioural treatments with patients in either *some* or *most* of their caseload. Most (46; 90%) stated that their predominant therapeutic approach was now either cognitive or cognitive-behavioural. Others described their predominant therapeutic approach as psychodynamic (1), eclectic (1), cognitive analytic (1) and medical (2).

Current work patterns showed a wide variation. The number of different clients seen in the last month ranged from 0 to 80 (median 15). Cognitive therapy was used as the main focus of treatment with a median of 6–10 patients over the previous month and

most respondents (43; 83%) reported using some cognitive therapy techniques with additional clients. The majority (37; 71%) reported carrying out a cognitive formulation with at least half of their clients. Although most (29; 56%) respondents had seen more than five patients in the last month where cognitive therapy was the main focus of treatment, 16 (31%) had seen two or less clients. Nine subjects (17%) had not seen any clients; this was due to maternity or sickness (3), individual therapy not applicable to current job (2), or worked as a psychiatrist or GP with no therapy patients (4).

When those respondents who were not engaged in clinical jobs ($n = 6$) were excluded from the analysis, some differences in the work patterns of the different professional groups were found. Doctors stated that they had seen only a mean of 4.33 patients were cognitive therapy was the main focus of treatment in the previous month. This contrasted with a mean of 7.82 for nurses, 8.50 for clinical psychologists, and 6.63 for other professions (missing cases 8, $F(3, 43) = 3.65$, $p < .02$). Likewise, doctors only carried out a cognitive formulation on a mean of 37% of their total caseload. This contrasted with 79% for clinical psychologists, 71% for nurses and other professionals, (missing cases 7, $F(3, 45) = 7.96$, $p < .001$). This suggests that the different professional groups apply their cognitive therapy skills in different ways.

Current supervision and ongoing training

The majority of the respondents in clinical posts ($n = 46$) reported receiving CT supervision (36; 78%). Of these 36, 33 (92%) reported that their supervisors had received formal training. Of those receiving supervision, most received supervision from peers (22), with others supervised by colleagues (15) and Newcastle Centre Staff (12) (some respondents were receiving supervision from more than one source).

Almost all respondents reported continuing to read about CT (50; 96%). However, in the last year, few respondents had attended many formal training days or workshops in cognitive therapy, with a median of only one day attended; 19 (36%) had not attended any further training days in the last year. Almost all respondents (49; 94%) stated that they would be interested in further cognitive therapy training. The majority of subjects had a local interest group available (45; 87%), but only half of them ($n =$ 24, 46%) attended any meetings, and few attended frequently, the mean attendance being 3.3 meetings per year.

Membership of organizations

Nearly two-thirds of subjects (32; 62%) reported being a current member of the BABCP. A total of 13 (25%) trainees had joined UKCP since completing the course. No-one had been a member of this organization prior to this.

Discussion

This survey of past trainees of a cognitive therapy course found that they were drawn from a range of professional backgrounds and, as a group, were already knowledgeable about CT before the course. All course elements were felt to be important in the development of knowledge and skill, although supervision was particularly highly valued.

Respondents reported that in their own assessment their skills had improved as a result of the course, and they believed their skills had continued to improve after the end of the course.

The survey suggests that past trainees of the course continue to use their CT skills, although there was variation in the manner in which these were employed by different professional groups. Nurses and clinical psychologists reported seeing larger numbers of clients for therapy using CT as the main focus of treatment as compared to doctors and others. However, this does not necessarily indicate that doctors use their CT skills less than other professional groups. Given the increasing diversity in modes of delivery of CT (Padesky & Greenberger, 1995), the restriction of the questionnaire to direct clinical intervention may have revealed differences in the *way* in which different professionals used their CT skills rather than indicating that some professional groups use their CT skills more than others. Furthermore, it may be that graduates of the course utilize their training and CT skills in ways not indicated by data about direct clinical intervention. Future studies might focus on the ways in which CT skills are employed through supervision of other staff, teaching and training, identification and referral of suitable candidates for CT, service development, research and other activities.

It was clear that few respondents were employed in jobs with the provision of CT as the main focus, although most had changed job, or applied for new jobs since the course. It is important and disappointing that so few trained staff are able to exercise their CT skills on a full-time basis. This is in contrast with the findings of Barker (1980) who reported that the majority of nurses had been moved into specialized roles following their training in behaviour therapy. Given that the current sample was multi-disciplinary, it is possible that this difference reflects less scope, or desire, for some professions, particularly perhaps the medical staff, to take specialist CT jobs. The survey did not ask about the nature of the job changes made by respondents but it is reassuring that at follow-up only one respondent was no longer employed in a clinical job. However, it is of concern that staff may only have opportunities for promotion into roles that involve less therapeutic contact, and thus valuable skills may be underutilized. Further data about the availability of specialist CT jobs, and factors influencing the opportunity for the use of therapeutic skills in jobs not identified as "specialist" would shed further light on this important issue.

Although few reported being employed in specialist CT jobs, the respondents reported good access to continuing professional development (CPD). The majority of respondents working in clinical jobs reported receiving supervision, mainly from supervisors who had themselves had specialist training. Although most wanted further specialist training and had access to a local interest group, few had attended either frequently. Despite this, it is encouraging that respondents viewed their skills as continuing to improve after the end of the course. This could be due to continued learning from reading and supervision, which was a highly valued element of the course particularly for the more experienced. Alternatively, this may be a reflection of the automatization of aspects of the skills with further practice, allowing the therapist to attend more to other aspects of the therapeutic interaction.

It is intriguing that respondents reported that their general therapeutic skills were enhanced as a result of training, as well as their CT skills, and this was particularly the case for doctors. Comparisons between sub-groups of respondents revealed that those

with more previous experience found the workshops less useful, and the supervision more useful, than those with less experience. This may reflect the ability of the supervisor to match the level of supervision to the experience and skills of the trainee, whereas the workshops are aimed to provide a thorough grounding and cannot be adapted so effectively to individual needs.

There are a number of methodological issues that limit the conclusions that may be drawn from survey studies. The response rate for this survey was good (81%) and an effort was made to obtain a high response rate by sending out two mailings. However, the questionnaire used was generated on an ad hoc basis for this study, and its reliability has not been tested. Most importantly, it is not possible to conclude that respondents' reports regarding changes in skill level as a result of the course are a true reflection of actual improvement. The validity of self-rated change could be investigated through comparison with change in expert ratings of CT skill, for example using the Cognitive Therapy Scale (Young & Beck, 1980), before and after the course and at follow-up.

This study reveals that CT trainees rated their training highly, and had continued to use their CT skills. Further research would be required to validate the respondents' reports that their skills improved as a result of training. At follow-up some differences were found when professional groups were compared, particularly that doctors reported seeing fewer patients for CT than other professional groups. Only a minority of respondents reported being employed in specialist posts. Future studies should focus on how trained staff use their CT skills in ways other than for direct clinical interventions. This study also indicates a need to investigate the factors that influence the ability of the individual to implement their new skills if training is to have maximum impact.

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