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Editorial
Skills-based training in cognitive–behavioural therapy

Steve Moorhead

Cognitive–behavioural therapy (CBT) is an effective treatment for a wide (and widening) range of psychiatric conditions, severe and enduring as well as common. The Royal College of Psychiatrists considers it an essential component of basic specialist training. A recent survey has highlighted how strongly psychiatric consultants view the importance of CBT training (Le Fevre & Goldbeck, 2001). Ninety-five per cent agreed that CBT was a valuable treatment option, 87% agreed that CBT training should be available to all trainee psychiatrists and 65% reported integrating CBT techniques into their practice. Yet only 48% of those appointed in the past 5 years had received the level of supervised training recommended by the College and only 29% of the sample had received any supervised training at all. In practice, only 15% were able to offer formal CBT to their patients and 38% would have liked to have been able to offer more CBT.

The scope of the problem in obtaining skills in CBT is emphasised by the fact that there are currently only around 40 psychiatrists of all grades who are accredited by the lead organisation for CBT in the UK, the British Association for Behavioural and Cognitive Psychotherapies (BABCP – http://www.babcp.com). Among these are the handful of psychiatrists accredited as CBT psychotherapists within the College. Many more psychiatrists have at least some training in CBT, however it is difficult for this training to be recognised within the College at present.

Accessibility of CBT training experience to psychiatrists is limited. This is partly a consequence of a limited availability of trainers and partly a consequence of an apparent reluctance of trusts to invest in such training. It is important for psychiatrists to understand more about CBT for a variety of reasons. Stern (1993) expressed concern about psychiatrists' future abilities to lead multi-disciplinary teams without the knowledge and skills of CBT. At the most basic level, if they are making referrals to colleagues who are more specialised in CBT, it is helpful for them to understand the nature of the intervention for which they are considering their patients. At a more sophisticated level, the focus on problem identification within a CBT formulation is helpful in the multi-disciplinary team to facilitate understanding and communication, and guide intervention.

The highlighted difficulties in practising formal CBT in busy clinical settings mean that, when available, training needs to be focused on the components of CBT that are most helpful for individuals to learn. Traditional models of training are taught as if trainees were embarking on a process of becoming specialist therapists, yet able to stop at any point. They could then take whatever new knowledge, attitudes and skills they had gained with them and find their own way to adapt them to their everyday practice. The Le Fevre & Goldbeck (2001) survey supports the idea that this process occurs, although it would be interesting to gain some objective assessment of how effective such adapted interventions are and how they are experienced by patients.

Williams & Garland (2002) begin a series of five articles, presenting a model that can help with some

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of these difficulties. This makes up part of the SPIRIT (Structured Psychosocial InteRventions In Teams) programme, which has been developed for use by secondary and primary care practitioners who wish to offer CBT assessment and focused CBT interventions in busy clinical settings. A training programme is being offered city-wide to psychiatric teams within Glasgow and pilot data have confirmed clinically significant improvements in knowledge and skills. This programme has pioneered the dissemination of a CBT skills-based training model among multi-disciplinary teams throughout a trust. It was developed as a jargon-free approach that could be accessible to a wider range of professionals and patients and refined through feedback during its implementation. In addition to facilitating a diagnostic assessment, the model encourages clinicians to go beyond this to assess the range of current problems and monitor their outcome. These articles summarise some of the content of this training programme and focus sequentially on:

(a) assessment;
(b) how to implement the model;
(c) approaches to unhelpful thinking;
(d) approaches to overcoming unhelpful behaviour;
(e) the evidence base for CBT.

Although the written articles alone are not a substitute for supervised practice among individuals who wish to develop their skills (an integral part of the whole SPIRIT course of 10 sessions lasting 2–3 hours), it is an important step forward in focusing on components of CBT that are adapted to be transferable to daily clinical practice. The articles are true to the model of CBT in that they encourage people to identify learning goals, go out and use the model and then review its utility.

This model may provide an important focus for the training in CBT among psychiatrists and other practitioner groups. It may also be a more helpful approach than creating therapists and assuming that they will be able to transfer these skills to clinical practice. The model used is the five areas assessment model, first developed as part of an NHS commission to develop an accessible CBT model that is acceptable across a range of practitioner groups (Williams, 2001). The model may be used in clinical teams as a focus for assessment and management, which is completely compatible with current diagnostic and problem-focused assessments, and integrates a number of interventions, including the effective use of medication. It may facilitate more wide exposure to CBT training and thus be more attainable given the current limitations of resources. The dissemination of CBT knowledge and skills will facilitate communication among teams and also with more skilled CBT therapists. The latter will be enabled by this process to provide consultation and supervision to a wider group of clinicians. With these issues in mind, the publication of this series should be welcomed and many will be encouraged to develop their understanding and practice of CBT as a result.

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