specialist in-patient units for the treatment of severe obsessive compulsive and phobic patients. At present there are only three such specialist in-patient units including the Bethlem and St George's Hospitals, which are stretched to receive patients from all over the country.

The second option is for more consultants to be appointed at a district level. These appointments should be prioritised to those areas where the provision of behavioural psychotherapy is at present poor. Funding for such regional or district posts will have to compete with all the other demands for new consultant posts in other specialities. The posts envisaged could be modified from general adult psychiatry posts to include a special interest in behavioural psychotherapy. Alternatively some consultant posts in dynamic psychotherapy could be converted to posts in behavioural psychotherapy following the retirement or resignation of some of their incumbents.

No doubt these proposals will be fiercely resisted by some vested interests. I believe that the College should lead the way by redrafting its requirements for specialist training in psychotherapy and that more psychiatric services should consider whether they should appoint more consultants in behavioural psychotherapy in future. How many more successful clinical trials have to be done before there is a greater provision of services and teaching of behavioural psychotherapy by consultant teams?

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*A full list of references and information on training in behavioural psychotherapy for psychiatrists is obtainable from the author.*

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# The Institute of Psychiatry cognitive behaviour therapy course

STIRLING MOOREY, Cancer Research Campaign Psychological Medicine Group, Royal Marsden Hospital, Fulham Road, London SW3 6JJ; RUTH WILLIAMS, Institute of Psychiatry, De Crespigny Park, London SE5 8AF; and JOHN COBB, Priory Hospital, Roehampton, London SW15 5JJ

Cognitive behaviour therapy is now widely accepted clinically as a treatment for depression and anxiety, and there is increasing research evidence to confirm its efficacy (Rush *et al*, 1977; Blackburn *et al*, 1981; Murphy *et al*, 1984; Butler *et al*, 1987; Beck, 1988). Of the various short term psychotherapies currently available, it is probably the most widely known and best researched. Despite this, and the recommendation of the Royal College of Psychiatrists (1986) that trainees receive training in cognitive therapy, there is little opportunity to gain a formal training in this psychotherapy. Short workshops are often available through the British Association for Behavioural Psychotherapy and from other sources, and *ad hoc* supervision from interested psychologists and psychiatrists may be available in some centres. Scott *et al* (1985) described a workshop and peer supervision training scheme in Newcastle. Macaskill (1986) reported a course for psychiatrists in training in Sheffield which extended over 20 weeks and combined Beck's cognitive therapy and Ellis' Rational Emotive Therapy.

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In 1987 an interdisciplinary course was set up at the Institute of Psychiatry. Participants include psychiatrists, psychologists and other mental health professionals. Two of the course leaders (SM and RW) had received training at the Center for Cognitive Therapy in Philadelphia and the third (JC) was an experienced behaviour therapist who had been practising cognitive therapy for some years. The aim of the course has been to provide clinicians with an introductory training in cognitive behaviour therapy with a major emphasis on Beck's cognitive therapy. The assumption has been that while many clinicians have received some training in this method few have received it in a structured way, or received intensive supervision on a case.

## Course participants

Although there are no formal criteria for acceptance, apart from possession of the relevant qualifications to allow clinical practice in the discipline to which the trainee belongs, we have tended to take clinicians who already have a reasonable degree of experience and patient contact. In practice this has meant post-membership psychiatrists and psychologists of senior grade or above. Course members have been selected to produce a balance of 50% psychiatrists and psychologists. A senior nurse specialist has also completed the course. Most of the participants have come from the South East of England, although two travelled regularly from Leicester and one consultant psychiatrist attended as an observer from Singapore while on sabbatical in the UK. The number of trainees each year has varied between 10 an 15. The course has been oversubscribed by 100% each year and interest seems to be increasing.

## Content and structure of the course

The course consists of a two day introductory workshop followed by 18 half day sessions extending over six months. Each session is divided into a $1\frac{1}{2}$ hour supervision group followed by $1\frac{1}{2}$ hours of large group teaching.

### Introductory workshop

This aims to introduce the cognitive model of emotional disorders and demonstrate how it forms the basis for defining problems and designing interventions in cognitive therapy. Cognitive-behavioural interventions are illustrated through role play and video. Issues of assessment and patient selection are also covered.

### Supervision groups

Each leader takes a group of four to five trainees. Cognitive therapy with one or two patients is supervised in depth over the six months of the course. Because cognitive therapy skills are somewhat different from the techniques participants have been used to employing, it is helpful if these skills are learned in therapy with relatively straightforward cases. Once these skills have been learned it is then possible to move on to dealing with more difficult cases. During supervision trainees are taught how to conceptualise cases in cognitive therapy terms, how to decide strategy and the choice of appropriate cognitive behavioural techniques. Participants are encouraged to bring audiotapes of therapy sessions. This allows discussion of finer points of technique than would be available from a verbal report of the session.

### Large group teaching

In the first half of the course the basic principles of cognitive therapy are taught. This begins with assessment and patient selection. The way in which problems are defined and the rationale for cognitive therapy explained is covered next. Behavioural and cognitive techniques are presented and trainees are given the opportunity to practise these techniques in role plays. Eliciting and challenging the underlying assumptions which predispose to emotional distress forms the final part of this section. In the second half of the course other aspects of cognitive therapy are covered such as homework and compliance, difficult patients, termination and relapse prevention. During this section expert guest speakers give presentations of their current research and clinical work.

## Feedback and evaluation of course

Feedback from course participants has been very favourable. Many welcome the opportunity to have supervision through a whole course of therapy, and to be able to share this with other experienced clinicians. The practical, skills-based teaching is particularly appreciated, leading to consistent requests for more role-play and more videotapes of cognitive therapists in action. On the other hand, the guest lectures, which cover theoretical and research issues, are also received with enthusiasm. This is perhaps a reflection of the inevitable tension between the clinical and academic components of the course. The mixture of psychologists and psychiatrists has proved a successful experiment. Both disciplines bring their own perspective to discussions of patients. The common role of cognitive therapist seems to dispel any interdisciplinary rivalry, and there is not a tendency for the two groups to split off into their own subgroups. The level of expertise among the participants is such that they are often already very competent therapists, though not always in the cognitive therapy mode. The course helps to sharpen their thinking about cognitive

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therapy and to give them the opportunity to practise it in a structured form with feedback from peers and teachers. One of the problems of choosing experienced clinicians is that occasionally there are difficulties in adopting the role of student; for instance when revealing clinical technique in the form of an audiotape. Although this problem has sometimes occurred, the majority of trainees, some of whom have been practising for many years, are prepared to take the risks necessary to learn. Experience of a different therapeutic model does, however, often make it more difficult to switch to the cognitive approach. It is our impression that those who already have some experience of behaviour therapy learn cognitive therapy more quickly than those coming from a psychodynamic perspective.

Over the three courses we have been exploring ways of evaluating the efficacy of the training. In a pilot study, trainees recorded tapes of therapy sessions immediately after the two day workshop and then at the end of the course. The course leaders (blind to the time at which the tapes were recorded) rated tapes for competence in cognitive therapy, using the Cognitive Therapy Scale (Young & Beck, 1980). The majority of participants showed an improvement in competence as measured by this scale (Williams *et al*, 1989). This is encouraging since the course is short in comparison with the training course at the Center for Cognitive Therapy which encompasses a year of full time training with supervision of many cases. Plans are being made to evaluate the course more systematically using independent raters.

## Comments

Our experience suggests that it is possible to give basic training in cognitive therapy in a course of 18 weekly half day sessions, and that the content and format of the course is acceptable to participants. In the light of feedback from the three courses so far run, we intend to extend the next course by a further six sessions to allow for a longer period of supervision and more time for skills-based learning. We have found that the mixture of disciplines on this course enhances rather than detracts from its value and we would recommend the concept of multidisciplinary training to others who might consider setting up similar courses in their own areas.

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