

Training and Clinical Impact of Cognitive Behaviour Therapy Workshops in a Teaching Hospital in North India

Arun Kumar Gupta^{1,2}, Eesha Sharma³, Sujita Kumar Kar⁴, Adarsh Tripathi⁴, Thomas Reeves⁵, Renuka Arjundas⁶, Pronob Kumar Dalal⁴

ABSTRACT

Background: Cognitive behaviour therapy (CBT) is an empirically supported psychotherapy with applications across psychiatric disorders. The demand for nonpharmacological interventions is increasing in the developing world. Unfortunately, existing resources are unable to cater to treatment and training needs. **Methods:** The aim of the current paper is to provide a description of the format of a series of CBT training workshops and their clinical impact in a psychiatric tertiary care center in north India. Over a period of nine years, nine training workshops were conducted. CBT concepts and skills sets were inculcated in faculty and student participants, using teaching strategies based on adult learning techniques. **Results:** The workshops resulted in a tremendous increase in the number of patients taken up for CBT. While therapeutic and training outcomes were not systematically assessed, the naturalistic outcomes (60 out of 85 patients completed therapy; improvement reported by >90% of the completers) are encouraging and showcase capacity building by means of CBT training in these workshops. **Conclusions:** CBT training workshops are an effective way to impart CBT skills and, therefore, to build CBT expertise in a resource-poor setting.

Key words: Adult learning theory, cognitive behaviour therapy, outcome, training, workshop

Key message: Short-duration, recurrent CBT training workshops are an effective way of imparting CBT skills to practicing and trainee mental health professionals.


CBT has a definitive role in the treatment of several psychiatric disorders.^[1-3] In comparison to other forms of psychotherapy, CBT has certain conceptual and practical advantages. It is time-bound, is structured,

and can be manualized.^[4] Epidemiological studies from India suggest that more than 20% of the

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¹Sunderland South CTT and Adults ADHD Service, ⁵Psychological Services Sunderland and ⁶Centre for Specialist Psychological Therapies, Northumberland Tyne and Wear NHS Foundation Trust, ²Newcastle Medical School, University of Newcastle Upon Tyne, UK, ³Department of Child and Adolescent Psychiatry, National Institute of Mental Health and Neurosciences, Bengaluru, Karnataka, ⁴Department of Psychiatry, King George's Medical University, Lucknow, Uttar Pradesh, India

Address for correspondence: Dr. Eesha Sharma

Department of Child and Adolescent Psychiatry, National Institute of Mental Health and Neurosciences, Bengaluru, Karnataka, India.
E-mail: eesha.250@gmail.com

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adult population in the community is afflicted with psychiatric disorders.^[5] Increasing awareness about mental illnesses has led to an increased demand for nonpharmacological interventions such as CBT. Unfortunately, there is a shortage of therapists. There are less than 700 Clinical Psychologists registered with the Rehabilitation Council of India (http://rciregistration.nic.in/rehabcouncil/Report_StCat_Jdbc.jsp). Other mental health professionals, i.e., Psychiatrists and Psychiatric Social workers, have only limited exposure to CBT during training. Shortage of skilled human resources is considered a critical barrier in improving access to evidence-based psychological interventions in low resource settings.^[6] A large number of patients who could benefit from the incorporation of CBT in their treatment continue to suffer disabling symptoms; this also results in over-reliance on polypharmacy, with its inherent limitations and adverse effects. There is, thus, an immense need for scaling up services for psychological interventions.

CBT has specific, delineable technical components that can be taught.^[7] There is only one institute in India that runs a formal CBT training program. In this program, training in cognitive and behavioral therapies is offered through a 3-month clinical posting. Training programs, ranging in duration from a single day workshop to a 12-week systematic training, for mental health and non-mental health professionals, have been examined.^[8-10] These highlight the feasibility and effectiveness of CBT training outside of academic curricula. There is room for methodological improvement and demonstration of cross-cultural applicability and utility. Beck *et al.*^[7] proposed a two-stage CBT training model—a smaller group of master trainers/supervisors/researchers and a larger group of practitioners, ensuring the continuation of CBT provision and monitoring beyond the training period. Their model also stresses on the need for cultural adaptation of CBT and the use of Kolb's model of experiential learning.^[11] Simplification in language, use of pictorial materials, use of local metaphors and phrases, in addition to drawing analogs from mythological/folk tales could be useful in cultural adaptation.^[6] Experiential learning^[12] is related to adult learning theory^[13] which states that adults learn when the teaching program appreciates their existing knowledge and experiences and when their experiences are linked to the learning process. Active learning methods, including techniques such as brainstorming, demonstrations, role-playing, games, and case studies, are generally more useful than passive learning.

We organized a series of CBT training workshops in the Department of Psychiatry at a tertiary care hospital in north India. Even though a tertiary care hospital, there were no established services for CBT. The aim of the

current paper is to provide a description of the format of the workshops and their clinical impact. The proposal for this paper was approved by the Institutional Ethics Committee.

METHODS

The workshops and training method

Frequency, duration, and spacing

Between 2007 and 2015, nine workshops were organized, i.e., one per year, each lasting two to three days, three hours in the afternoon on each day.

The trainer

A CBT practitioner (lead author) has been the expert trainer in these workshops. He received peer supervision from two CBT practitioners certified in the UK.

The trainees

Faculty members (Psychiatrists and Clinical Psychologists) along with postgraduate students in Psychiatry and Clinical Psychology attended these workshops. Participation in the workshops was voluntary. For all the participants, knowledge and exposure to CBT before the workshops were mainly from didactic lectures from their masters' coursework and from self-reading.

The training method

The instruction method adopted was a combination of didactic presentations alongside experiential learning. During a 2-day "pre-workshop," faculty members with some prior exposure to CBT conducted introductory sessions informed by theoretical principles described in reference books,^[14,15] with lectures on topics such as the cognitive behavioral conceptualization of disorders and the evidence base for CBT. The workshops followed these introductory sessions. They were conducted in a teaching hall with the trainer and trainees seated in a circle. The format of the 3-day workshops is depicted in Table 1.

RESULTS

Each of the nine workshops was attended by 25–30 participants. Typically, 80% of the participants were postgraduate MD and MPhil students, and 20% were faculty members. While faculty members were able to attend multiple workshops over the course of nine years, postgraduate students attended on average 2-3 workshops, due to the tenure of their postgraduate program.

The workshops, drawing on principles of adult learning, used a variety of case-based discussions and demonstrations. Open group discussions, brainstorming, and role plays were often employed, whereas didactic

Table 1: Format of the 3-day CBT training workshops

Day	Agenda	Time	Technique
1	Familiarization with ongoing CBT work in the department	30 minutes	Open session with the faculty participants
	Ice-breaking with the group/introductions	15 minutes	A short game followed by trainees introducing themselves
	Assessment of prior learning and experience in CBT	30 minutes	Individual inputs from all trainees
	Learning targets for current workshop	45 minutes+	Individual inputs from all trainees; working in groups; role play
	Role-play/demonstration/practice of CBT skills	45 minutes	
	Homework assignment for trainees for next day		
2	Inculcate skills related to practice and supervision of CBT in the select group	45 minutes	A separate session with faculty participants Case studies, Demonstrations, Brainstorming
	Feedback on the previous day	15 minutes	Individual inputs from all trainees
	Introduction/enhancement of CBT skills	45 minutes+	Case presentations, Demonstrations by trainer, Roleplays
		45 minutes	
	Take home messages from the day and any additional inputs for the next day; agreeing on homework for the next day	15 minutes	Individual inputs (on a semi-structured proforma) from all trainees
3	Inculcate skills related to practice and supervision of CBT in a select group	45 minutes	A separate session with faculty participants Case studies, Demonstrations, Brainstorming
	Feedback on the previous day	15 minutes	Individual inputs from all trainees
	Introduction/enhancement of CBT skills	45 minutes+	Case presentations
		45 minutes	Demonstrations by trainer Role plays
	Take home messages and learning from the workshop	15 minutes	Individual inputs (on a semi-structured proforma) from all trainees

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sessions and PowerPoint presentations were seldom used. On each of days 2 and 3 of the workshop, clinical cases were presented by pre-identified participants and discussed. On day 2, the trainer led group sessions—either small groups working on different aspects of the case or a larger group discussion. For each identified problem in the case, the trainer invited responses from the group. Each of the responses was then discussed, and the trainer provided constructive feedback. On day 3, the trainer supervised faculty participants in leading the group sessions. Discussions during the workshops were utilized to demonstrate communication skills and techniques. As an example, when a maladaptive thinking pattern was identified in a case, the trainer employed Socratic dialogue and guided discovery to help participants reach the most apt method to use for cognitive restructuring. The workshops provided opportunities for case-based learning and for developing a capacity for further self-learning.

CBT skills discussed

CBT skills were covered in the context of case studies on depression, generalized anxiety disorder, obsessive compulsive disorder, phobia, and panic disorder. General psychotherapeutic skills included patient selection and planning of therapy, collaborative agenda setting, handling dependency on the therapist, and termination and relapse prevention. Specific CBT skills included—5-area model, cognitive behavioral formulation, Socratic dialogue, guided discovery, thought record, correction of negative automatic thoughts, cognitive restructuring, exposure and response prevention, homework, and behavioral experiments.

Peer-supervision

The CBT workshops encouraged peer-feedback and supervision. Consequently, an additional key skill developed in the group was ‘peer-supervision.’ Peer supervision can provide an emotionally safe environment for therapists to identify and discuss shortcomings in their role and thereby improve patient care.^[16] From the 5th annual workshop, a group of five faculty members in the department started weekly peer group meetings that lasted a couple of hours. Before each meeting, all members read up on a specific aspect of CBT and discussed it in the first half hour. This helped enhance theoretical knowledge. Therapy cases were presented and discussed, with one member by turn leading the discussion. Role plays were often used to troubleshoot. The peer-supervisory groups were a much-needed space for the beginner therapists to constructively handle their own stress arising from the multi-faceted challenges of the new arena they were stepping into.

Status of CBT practice in the department

The state of CBT practice saw a dramatic change since the first CBT workshop in 2007. The number of cases taken up for CBT went up from only six cases in 2008, to 85 cases in 2015. The majority of these cases were of obsessive compulsive disorder (36.5%), followed by depression (34.1%) and anxiety disorders (17.6%). All these patients were taken up for CBT following inadequate/no response to pharmacotherapy. Of the 60 patients (70.5%) who completed therapy sessions, a massive majority (91.7%) reported a good outcome (Clinical Global Impression-Improvement scale^[17] rating 1 or 2) at the end of therapy. Pharmacotherapy was continued alongside CBT.

DISCUSSION

We have reported in this paper the training and clinical impact of a series of CBT training workshops conducted in a tertiary-care hospital in India. The key outcomes of these workshops were an increase in the number of people with exposure to CBT training, increase in the number of patients taken up for CBT, the development of a peer-supervisory group, and continued collaboration with the trainer to take this program further. In the absence of a formal academic curriculum for CBT training in our institution, it is heartening to note that a workshop model has been able to generate sufficient interest among the trainees and has led to the beginnings of clinical services for CBT in the department. CBT training or formal training in any form of psychological therapy is not yet mandatory for psychiatry training in India. In the workshops described herein, the trainees sought the training voluntarily and offered it to clients over and above their regular work, often working more than contracted hours.

The training program has addressed some of the limitations of the previous work in this area. Continuous supervision has been identified as a key factor in positive training outcomes. Research has shown that distant supervision via technological means and peer-supervision are helpful where on-site expert supervision is not readily available.^[6,7] Our training program has laid special emphasis on the development of a peer-supervisory group among faculty members, who can, in turn, provide individual supervision to students.

Earlier papers have reported the outcome of training only from the perspective of the trainees. However, as pointed out by Maunder *et al.*^[8] trainees could be biased towards reporting positive outcomes for social-desirability or motivational reasons alone. In this paper, we have chosen to report the clinical impact of the training program in terms of the increase in the number of patients being offered CBT and the treatment outcomes. Over the nine years of this program, there was a 10-fold increase in patients taken up for CBT. The increase in the number of patients taken up for CBT is a reflection of the participants' interest in and theoretical understanding of CBT that was honed by the workshops. Our findings suggest that the CBT training program described in this paper was effective and that it is feasible to develop CBT skills in mental health professionals in similar resource-poor settings.

We are aware of the limitations of this paper. The CBT skills of the trainees have not been assessed formally by use of established rating scales such as Cognitive Therapy Scale-Revised (CTS-R).^[18] The outcome of CBT

in patients, assessed prospectively, is partly evidence of the efficacy of training in the practical sense. Moreover, all the patients taken up for CBT had not adequately responded to pharmacotherapeutic treatment alone. In this context the improvement at the end of therapy could be attributable to the introduction of CBT. We thought it important to report this work at this stage to share our experience and encourage similar training programs in other parts of the country. When compared to academic programs for CBT training in India, there obviously appears to be much lacking in terms of the hours and rigor of training. Further long-term evaluation and more formal outcome assessments of our training program can inform us about the shortcomings that need to be addressed. Audio- and video-recorded sessions are often recommended for monitoring and supervision of psychotherapy, and the absence of these in our work is a limitation. However, the development of a peer supervisory group would have partly addressed this limitation.

An earlier publication,^[19,20] also based on these workshops, reported the feasibility of training mental health professionals, from a non-English speaking background, in CBT. We demonstrate how, even in a resource-poor setting, in terms of regular availability of trained CBT practitioner, CBT skills can be inculcated in faculty and students by means of yearly workshops, of short duration and utilizing adult learning models. The feedback from faculty participants and students has been encouraging, as has been the changing scenario of CBT practice in the department. Interestingly, the acceptability of the CBT model was good, considering that we used the same techniques used internationally. Thus, there were no apparent cultural barriers to the practice of CBT. Teaching methods in a diverse and growing field like psychotherapy need as much stringent attention and research as is being paid to pharmacotherapy and other treatment methods like brain stimulation. The evaluation of psychotherapy training programs has often been limited by small sample sizes, lack of external validity, and the use of pre-post designs without adequate control.^[9] This has to change.

CONCLUSION

Capacity building is the need of the hour in mental health. Task-shifting approaches to service delivery, with supervisory arrangements, have been stressed as a key intervention to improve the state of service availability.^[6] However, before we can task-shift, we need to have enough training capacity. Following Beck's two-stage training model, and in light of the positive impact of CBT training workshops, the stage is set for further systematic evaluation of these workshops by carefully designed clinical trials.

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Conflicts of interest

There are no conflicts of interest.

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