

# Making it Stick: Factors that Help and Hinder Ongoing Practice after Cognitive Therapy Training

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While there is evidence that graduates gain competence in the practice of Cognitive Behaviour Therapy (CBT) as a result of training, the clinical environment to which the graduate returns can impact on the ongoing use of CBT skills. Twenty seven New Zealand mental health services professionals were surveyed about the impact CBT training had on their therapeutic skills, confidence with complex cases, ability to conceptualise, interdisciplinary communication and treatment planning. They were also asked about the extent of current CBT use. Clinical supervisors were also surveyed about their views of the impact of CBT training on the graduates' clinical practice. The results suggest training had a positive impact on graduates' clinical practice, with the frequent use of CBT-specific skills across a range of disorders being reported. Some barriers to the use of CBT within mental health services were identified and ideas for overcoming these are discussed.

In response to government mental health workforce development initiatives some university departments in New Zealand have developed specific Cognitive Behaviour Therapy (CBT) training courses. There is evidence that graduates gain competency in the practice of CBT as a result of training (Milne, Baker, Blackburn, James & Reichelt, 1999; James, Blackburn, Milne & Reichelt, 2001, Barnfield, Mathieson & Beaumont, 2007), but it has been argued that the extent of skill transfer following CBT training also needs to be assessed (Milne et al, 1999). There is no guarantee that graduates will actually apply skills in the work setting. For example Kavanagh, Piatkowska, Clark & O'Halloran (1993) assessed the implementation of training in CBT family interventions for schizophrenia and found only 18% of therapists had applied their learned skills.

This study investigates the extent of self-reported implementation of CBT skills, supervision availability and ongoing training following an intensive

CBT training course.

There are a small number of studies in the area of skill transfer into clinical practice following CBT training. Based on graduate self report three months after completing training, Myles & Milne (2004) found there was a significant increase in self reported CBT skill use in the workplace. A postal survey of graduates of a year long CBT course in the United Kingdom was conducted by Ashworth, Williams & Blackburn (1999). Most of the graduates reported continuing to read books on CBT, completing a Cognitive Therapy formulation for at least half of their clients and receiving supervision. The graduates rated the receipt of ongoing supervision as the most important factor in improving knowledge and skills. A quarter of the graduates reported they were specifically employed to deliver CBT, but almost all reported continuing to use CBT with some or most of their caseload. Although most reported they were interested in additional training, they reported little participation in

further training or workshops. This study, however, was limited by not investigating factors that influenced the ability of the graduates to use their new skills in the workplace.

The use of new skills in the workplace by graduates is influenced by a variety of organisational factors. Those that facilitate ongoing use of skills include support from supervisors and colleagues (Corrigan & McCracken, 1997, Heaven, Clegg & McGuire, 2006; Kennedy-Merrick, Haarhoff, Stenhouse, Merrick & Kazantzis, 2008), having ongoing contact with those from the same training course (Milne, Keegan, Westerman and Dudley, 2000) and regular opportunities to use the skills (Goldstein & Ford, 2002). There are also a number of organisational factors that have been shown to hinder the ongoing use of skills following training. These include constraints on time (Fadden, 1997; Hull & Swan, 2003; Le Fevre & Goldbeck, 2001) shortages of staff and resources, increased demands for documentation and difficulties in integrating casework with other work requirements (Corrigan & McCracken, 1997).

There are several studies that specifically investigate barriers to the transfer of CBT skills following training. In a survey of UK psychiatrists trained in CBT, Whitfield, Connolly, Davidson, & Williams (2006) found that 84% engaged in some therapeutic CBT activity after training, but only 49% received CBT supervision. Reasons given for not engaging in CBT included inadequate 'protected time' and that

CBT had not been included in 'job plans'. The researchers concluded that supervision requirements were not being adequately met. A recent New Zealand study (Kennedy-Merrick et al, 2008) found that graduates of an intensive CBT training programme perceived the way that client care is organised was a barrier to skill transfer.

In New Zealand, case management forms a large part of some disciplines' functions. It may be that these disciplines find it difficult to 'ring-fence' time for CBT within their other roles. Psychiatrists, for instance, carry a large caseload and have numerous short appointments, making it difficult to adhere to the structured and relatively time consuming role of CBT therapist. There is some evidence this is the case in other countries (Le Fevre & Goldbeck, 2001; Swift, Durkin and Beuster, 2004; Whitfield et al., 2006).

The present study examined factors that both facilitate and hinder the use of CBT skills in the workplace after the completion of an intensive training course. It builds on the Kennedy-Merrick et al. (2008) study in that it examines the views of workplace supervisors as well as those of graduates.

**Method**

*Participants*

Twenty-seven graduates who had completed a halftime year-long postgraduate level CBT course in the past five years were sent an optional self report postal survey. Nineteen graduates returned their postal surveys. The graduates were non-psychologists, who were registered mental health professionals (social workers, occupational therapists, nurses and psychiatric registrars), all working in mental health settings.

Eleven workplace supervisors were asked to complete questionnaires about graduates' use of CBT. Supervisors were registered clinical psychologists experienced in CBT who had supervised at least one student over the past five years. The supervisors attended five two-hour training sessions on the CBT course material, supervision of students from a different discipline and CBT supervision practice.

The graduates were not asked to

disclose their identity when completing the surveys. A self addressed envelope with postage was provided but no further incentives were given.

**Measures**

*Graduate Survey*

The survey asked graduates to rate on a seven point Likert scale (anchored between zero to six with higher scores reflecting more positive responses) how much they believed the course affected their general therapeutic skills, confidence to work with complex cases, enhanced their ability to conceptualise, improved interdisciplinary communication, enhanced treatment plans and resulted in shorter treatments for clients. They were provided with a list of CBT techniques and asked which they used with clients. The survey also asked graduates to specify their current theoretical approach, estimate how much opportunity they had to use CBT in their current roles, estimate the percentage of clients they use CBT models and treatment with, the percentage of clinical time they spent with CBT clients and which DSM-IV disorders they had applied CBT treatments to. The graduates were also asked how much supervision and ongoing training in CBT they had received. Finally, they were provided with a list of factors that may get in the way of them implementing CBT and asked to indicate the extent each factor affected their practice.

The full survey can be obtained by contacting the authors.

*Supervisor Survey*

Supervisors were registered clinical psychologists, experienced

in CBT and based in the student's workplace. The supervisors were asked how many students they had supervised and their views on whether, as a result of training, the students had gained enhanced knowledge about CBT, enhanced skill levels, improved conceptualisations, enhanced treatment plans and improved interdisciplinary communication. Supervisor ratings were based on supervision that occurred prior to graduation from the training programme. All 11 supervisors returned their questionnaires.

**Procedure**

*CBT Training Course*

The CBT training consisted of a half-time postgraduate level course of 30 week duration. It was designed to provide training in CBT for experienced mental health professionals working in a public mental health setting. Students were selected for the course based on referee endorsement, interview, curriculum vitae and a minimum of two years of mental health experience. The course consisted of two components, a 300-hour academic component consisting of lectures, practical exercises, demonstrations, tutorials, and assignments, and a 300-hour practicum completed in the student's regular workplace. In order to graduate from the course, students were required to complete three in-course written case histories and recordings of client sessions, assessed with the Cognitive Therapy Scale-Revised (Blackburn, James, Milne, Baker, Standart, Garland & Reichelt, 2001). They were also required to satisfactorily complete the 300 hour supervised practicum, and achieve a passing grade on the final assessment which included the submission of

Table 1. Graduates mean rating of the impact of training on workplace practice

Skills	M	SD
General Therapeutic skills	4.7	1.0
Confidence to work with more difficult/ complex cases	4.3	1.4
Enhanced ability to conceptualise	5.1	0.8
Improved interdisciplinary communication	3.6	1.4
Enhanced treatment plans	4.4	0.6
Shorter treatments	3.2	1.2

Note: Higher scores reflect more positive responses

Table 2. Graduates mean frequency of use of CBT techniques with clients

Techniques	M	SD
Thought records	3.9	1.8
Behavioural experiments	3.4	1.4
Social skills training	3.1	1.4
Assertiveness training	3.3	1.3
Socratic questioning	4.7	1.0
Problem solving	5.1	0.8
Downward arrows	3.8	1.5
Agenda setting	3.9	1.3
Setting homework	4.9	1.4
Panic inductions	0.8	0.8
Responsibility pies	2.4	1.6
Continuums	3.5	1.7
In vivo exposure	1.8	1.7
Activity scheduling	4.3	1.3
Relaxation training	3.8	1.7

Note. Higher scores reflect more positive responses

written work, a recording of a therapy session and an oral exam. The approach taken to assess competence is described by Barnfield, et al. (2007).

## Results

### Graduate Survey

Seven of the 19 graduates were male and 12 female. Four reported working in a mental health specialty team, eight reported being currently employed by a community mental health team, and seven reported working in a government funded mental health service. Two reported being employed outside government funded services. Six reported holding social work qualifications, seven were psychiatric nurses, five were qualified occupational therapists, and one identified as holding another form of mental health qualification. The range in ages was from 26 to 59 years. Due to the small sample size, responses were not compared across the different professional groups.

Table 1 indicates that the participants thought that training in CBT had the greatest impact on their ability to conceptualise and general therapeutic skills while it had the least impact on the length of treatment they provided.

The information in Table 2 shows that Socratic questioning; problem-solving, setting homework and activity

scheduling were frequently used by the graduates. The least used techniques were responsibility pies, in vivo exposure and panic inductions.

Table 3 shows that graduates received low levels of CBT based supervision, had had limited further CBT training, but had higher levels of reading CBT related material. Although these levels of reading were higher than the levels for CBT supervision and further training they were still occurring at a low frequency.

The mean ratings that graduates gave to factors that interfered with the use of CBT in the workplace were calculated. The main factors that they identified as interfering were: the case management role ( $M = 4.1, SD = 2.0$ ), high patient acuity ( $M = 3.3, SD = 2.0$ ) and high caseloads ( $M = 3.2, SD = 2.0$ ).

Graduates also rated the frequency of the disorders that they used CBT with. The most common disorder

was depression ( $M = 4.6, SD = 1.2$ ). This was followed by social phobia ( $M = 2.8, SD = 1.9$ ), panic disorder/agoraphobia ( $M = 2.6, SD = 1.9$ ), generalised anxiety disorder ( $M = 2.3, SD = 1.9$ ) and psychosis ( $M = 2.2, SD = 1.8$ ). Substance abuse ( $M = 1.9, SD = 1.7$ ) was the disorder to which CBT was applied least often.

### Supervisors Survey

The supervisors reported they had provided varied levels of CBT supervision over the past five years. One had supervised six graduates, two had supervised four, three had supervised three, four had supervised two and one had supervised one graduate.

Using a Likert scale of zero to six with zero being not at all and six being a great deal, the supervisors reported that in their view graduates had gained the following benefits from CBT training: enhanced knowledge ( $M = 5.0, SD = 0.6$ ), improved interdisciplinary communication ( $M = 4.8, SD = 1.0$ ), improved ability to conceptualise client problems ( $M = 4.8, SD = 1.1$ ), enhanced skill level ( $M = 4.0, SD = 1.4$ ), and enhanced treatment plans ( $M = 3.9, SD = 1.2$ ).

## Discussion

The present study examined factors that facilitate and also hinder the use of CBT skills following the completion of a year long post graduate CBT training course.

Graduates were non psychologist mental health professionals. From their perspective, training appeared to have a positive impact on their overall clinical practice, particularly on their general therapeutic skills and conceptualisation ability. They reported regularly using CBT skills across a range of disorders. This suggests that graduates did retain their skills over time and did not entirely revert to their previous way of

Table 3. Graduates mean frequency of ongoing professional development activities

Professional Development	M	SD
CBT-based supervision	1.4	1.7
Reading material	2.5	1.4
Further CBT training	1.8	0.4

Note. Higher scores reflect more positive responses

working. This finding was consistent with the results of Ashworth et al. (1999), who found that most graduates continued to use CBT with some or most of their caseload. Supervisors also rated the impact of training positively, particularly in terms of enhanced knowledge, conceptualisation skills, interdisciplinary communication, increased skill levels and treatment planning.

The results regarding frequency with which different CBT techniques were used suggest that core techniques, such as Socratic questioning and structured techniques such as activity scheduling and homework setting, were most frequently used. Some specific techniques such as panic inductions and in vivo exposure were less frequently used. This may be a result of the higher frequency of clients with depression and the lower frequency of clients with panic disorder. It is also possible that it is a function of the ubiquitousness of other CBT skills such as agenda and homework-setting. Responsibility pies were also used infrequently, consistent with Kennedy-Merrick et al. (2008) and again this may be a function of the type of disorders that are most commonly seen by graduates.

The results also suggest that for many graduates there is limited workplace support for ongoing skill development, in terms of access to supervision, further training and reading materials. High caseloads, high acuity of cases and having a case management role, in particular, appeared to be barriers to CBT use. This finding is of concern, given that in the Ashworth et al. (1999) United Kingdom study, and the Kennedy-Merrick et al. (2008) New Zealand study, graduates rated ongoing supervision as being the most important factor in improving knowledge and skills. In addition, a number of studies examining the transfer of training highlight the importance of supervision in both maintaining and developing skills once training is complete (Franklin, Abramowitz, Furr, Kalsy & Riggs, 2003; Mannix, Blackburn, Garland, Gracie, Standart & Scott, 2006; Rakovshik & McManus, 2010). It is unclear why supervision availability in New Zealand appears to differ from the United Kingdom. It may be that

there is less emphasis on supervision within mental health service generally in comparison to the United Kingdom. It may also reflect a greater emphasis on the importance of CBT in the United Kingdom, since psychological therapies became an integral component of the United Kingdom government mental health strategy, with CBT cited as the preferred treatment for a wide range of mental health problems (Department of Health, 2001). Recent moves by the mental health workforce development agency in New Zealand (Te Pou, 2009) may lead to a greater emphasis on psychological therapies in New Zealand.

This study has a number of limitations: the sample was small, which means only cautious conclusions can be drawn; a comparison between the different professional groups was not possible, due to small numbers and there was no attempt to measure the impact of training on patient outcome. It may be that graduates used skills in ways that were not included in the survey, such as supervising others, delivering training, research, service development or triaging referrals.

Despite these limitations, these results do suggest that there is a need for increased support of graduates in the workplace following CBT training so that they are able to continue to use and develop their skills. In particular, these results support the need for provision of supervision and ongoing professional development and training in CBT.

Early experiences in the workplace when attempting to use new skills determine whether a person maintains or abandons those skills (Heaven et al, 2006). Strategies aimed at ameliorating negative influences such as relapse prevention (Milne et al, 2002), continuing education, refresher training, goal-setting, feedback and reward systems to assist motivation may be helpful.

The results of this study suggest that workplaces not only need to support the initial training but to work together with training institutions to assist students' ongoing learning and skills transfer to the workplace following training. This can occur through providing a supportive climate with positive reinforcement, administrative and

supervisory support, user-friendly interventions and opportunities for professional development (Kennedy-Merrick et al. 2008). If this does not occur graduates are likely to get a double message: 'We support your training, but do not support ongoing practice'.

Further research is needed into ways to ensure the ongoing use and development of CBT skills and knowledge following training, ways to remove barriers to utilisation and to assist organisational development in this area.

## References

- Ashworth, P., Williams, C., & Blackburn, I. M. (1999). What becomes of cognitive therapy trainees? A survey of trainees' opinions and current clinical practice after postgraduate cognitive therapy training. *Behavioural & Cognitive Psychotherapy*, 27(3), 267-277.
- Barnfield, T.V., Beaumont, G.R., & Mathieson, F. M. (2007). Assessing the development of competency during post-graduate cognitive-behavioural therapy training. *Journal of Cognitive Psychotherapy: An International Quarterly*, 21(2), 140-147.
- Blackburn, I-M, James, I.A., Milne, D.L., Baker, C., Standart, S., Garland, A. & Reichelt, F.K. (2001). *Behavioural and Cognitive Psychotherapy*, 29(4), 431-446.
- Corrigan, P.W., & McCracken, S.G. (1997). *Interactive staff training*. New York: Plenum Press.
- Department of Health (2001). *Treatment choice in psychological therapies and counseling*. London: The Stationery Office.
- Fadden, G. (1997). Implementation of family interventions in routine clinical practice following staff training programmes: A major cause for concern. *Journal of Mental Health*, 6, 599-612.
- Franklin, M.E., Abramowitz, J.S., Furr, J.M., Kalsy, S., & Riggs, D.S. (2003). A naturalistic examination of therapist experience and outcome of exposure and ritual prevention for OCD. *Psychotherapy Research*, 13(2), 153.
- Goldstein, I.L., & Ford, J.K. (2002). *Training in organisations: Needs assessment, development & evaluation* (4th ed.). Canada: Wadsworth group.
- Heaven, C., Clegg, J., & McGuire, P. (2006). Transfer of communication skills training from workshop to workplace: The impact of clinical supervision. *Patient Education*

- and Counseling, 60, 313-325.
- Hull, A.M., & Swan, J.A. (2003). Survey of psychiatrists completing a cognitive behavioural psychotherapy diploma course. *Behavioural and Cognitive Psychotherapy, 31*, 467-471.
- James, I. A., Blackburn, I. M., Milne, D. L., & Reichelt, F. K. (2001). Moderators of trainee therapists' competence in cognitive therapy. *British Journal of Clinical Psychology, 40*(2), 131-140.
- Kavanagh, D. J., Piatkowska, O., Clark, D., & O'Halloran, P., (1993). Application of cognitive-behavioural family intervention for schizophrenia in multidisciplinary teams: What can the matter be? *Australian Psychologist, 28*(3), 181-188.
- Kennedy-Merrick, S.J., Haarhoff, B.A., Stenhouse, L.M, Merrick, P.L & Kazantzis, N. (2008). Training cognitive behavioural therapy practitioners in New Zealand: From university to clinical practice. *New Zealand Journal of Psychology, 37* (2), 8-18.
- Le Fevre, P. D., & Goldbeck, R. (2001). Cognitive-behavioural therapy: A survey of the training, practice and views of Scottish consultant psychiatrists. *Psychiatric Bulletin, 25*(11), 425-428.
- Mannix, K.A., Blackburn, I.M., Garland, A., Gracie, J., Moorey, S., Reid, B., Standart, S. & Scott, J. (2006). Effectiveness of brief training in cognitive behaviour therapy techniques for palliative care practitioners. *Palliative Medicine, 20*, 579-584.
- Milne, D. L., Baker, C., Blackburn, I.-M., James, I., & Reichelt, K. (1999). Effectiveness of cognitive therapy training. *Journal of Behavior Therapy & Experimental Psychiatry, 30*(2), 81-92.
- Milne, D., Keegan, D., Westerman, C., & Dudley, M. (2000). Systematic process and outcome evaluation of brief staff training in psychosocial interventions for severe mental illness. *Journal of Behavior Therapy and Experimental Psychiatry, 31*, 87-101.
- Myles, P.J., & Milne, D.L. (2004). Outcome evaluation of a brief shared learning programme in cognitive behavioural therapy. *Behavioural and Cognitive Psychotherapy, 32*, 177-188.
- Rakovshik, S.G., & McManus, F. (2010). Establishing evidence-based training in cognitive behaviour therapy: A review of current empirical findings and theoretical guidance. *Clinical Psychology Review, 30*, 496-516.
- Swift, G., Durkin, I., & Beuster, C. (2004). Cognitive therapy training for psychiatrists: impact on individual clinical practice. *Psychiatric Bulletin, 28*, 117-119.
- Te Pou (2009). *Action Plan for we need to act talking therapies 2008-2011: processes to increase quality, sustainability and spread of talking therapies for users of mental health and addiction services in New Zealand*. Te Pou o Te Whakaaro Nui: The National Centre of Mental Health Workforce Development.
- Whitfield, G., Connolly, M., Davidson, A., & Williams, C. (2006). Use of cognitive-behavioural skills among trained psychiatrists. *The Psychiatrist, 30*, 58-60.

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