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Transporting Cognitive Behavioral Therapy (CBT) and the Improving Access to Psychological Therapies (IAPT) Project to Japan: Preliminary observations and service evaluation in Chiba

Osamu Kobori[1)], Michiko Nakazato[2)], Tetsuya Shiraishi[3)], Kouta Takaoka[2)], Akiko Nakagawa[2)], Masaomi Iyo[3)], Eiji Shimizu[2)]

1) Centre for Forensic Mental Health, Chiba University
2) Research Center for Child Mental Development, Chiba University Graduate School of Medicine
3) Department of Psychiatry, Chiba University Graduate School of Medicine

RUNNING HEAD: Transporting CBT/IAPT to Japan

Abstract

Purpose: This paper discusses the implementation and evaluation of a cognitive behavioral therapy (CBT) training course for clinicians in Chiba, the sixth-largest province in Japan.

Design/methodology/approach: Individual CBT for obsessive-compulsive disorder, bulimia nervosa, or social anxiety disorder was delivered by trainees of the Chiba CBT training course in a single study design.

Findings: The results demonstrated that individual CBT delivered by trainees led to statistically significant reductions in symptom severity for all three disorders. Feedback from the trainees indicated that the training course achieved its aims.

Implications: Barriers to the dissemination of CBT in Japan such as opportunities for training and possible solutions are discussed.

Originality: This paper evaluates the Chiba CBT training course, which is a Japanese adaptation of the UK Improving Access to Psychological Therapies Project and the first post-qualification CBT training course in Japan.

Keywords: anxiety, cognitive behavior therapy, eating disorders, psychotherapist training, psychotherapist supervision, psychologist development, outcome research

Introduction

Barriers to the dissemination of CBT

Among evidence-based treatments, forms of cognitive behavior therapy (CBT) have been consistently shown to be effective across a wide range of disorders. While some studies have demonstrated the clinical effectiveness of cognitive behavior therapy for adults in routine clinical practice (e.g., Westbrook & Hill, 1998; Westbrook & Kirk, 2005), several authors have noted that evidence of the effectiveness of empirically supported treatments in routine practice is rarely available, and often, the evidence may be delivered suboptimally (e.g. Andrews & Titov, 2009; Gunter & Whittal, 2010; Shafran et al., 2009).

Shafran et al. (2009) identified two barriers to the dissemination of CBT. First, commonly held beliefs, such as 'Research trials have limited applicability to clinical practice' and 'Non-specific therapist effects are more important than specific interventions', hamper the availability of CBT. Second, gaps in the current knowledge about training, measuring competence, key factors in the etiology or maintenance of the treated disorder, and the minimum dose required for treatment, limit the widespread adoption of the protocols to clinical settings (Shafran et al., 2009). Gunter and Whittal (2010) also identified various barriers to the wide-scale dissemination of CBT for anxiety disorders, including those that are applicable to empirically supported treatments in general (e.g. lack of training opportunities, failure to address practitioner concerns), as well as those that may be specific to CBT for anxiety disorders (e.g. practitioner concerns about using exposure interventions). To overcome these barriers, Gunter and Whittal (2010) advise continuing the accumulation of research-based data, advocating and appealing for the required funding and organisational support, and training practitioners to deliver CBT treatments. Advocates of CBT for anxiety disorders will also need to demonstrate that these treatments are cost effective if wide-scale dissemination is to occur.

In order to address the severe under-provision of treatments and the dissemination of

CBT, the UK government has instigated a highly ambitious program, Improving Access to Psychological Therapies (IAPT), by funding the implementation of NICE guidelines for people suffering from depression and anxiety disorders in England. The IAPT program aims to address the under-provision of these treatments by training 3600 new psychological therapists between 2008–2011, which will provide 900,000 people access to treatment, with half of those engaging in treatment moving to recovery, and 25,000 fewer sick pay and medical benefit expenditures by 2010/11. Initial evaluation of two UK demonstration sites, Doncaster and Newham (Clark et al., 2009) has been published, and a two-year prospective cohort study was carried out to assess the impact of implementing empirically supported stepwise psychotherapy programs in routine practice in northern England (Richards & Borglin, 2011).

Status of mental healthcare and CBT in Japan

Awareness of the effectiveness of CBT has spread in Japan, not only among professionals and academics but also to the public through media (e.g., books, newspapers, TV). In April 2010, the inclusion of CBT for mood disorders in the national health insurance scheme marked a milestone for psychiatric care in Japan, where pharmacotherapy has historically been much more common. The inclusion of CBT in Japan's insurance program is boosting CBT research through randomized controlled trials and facilitating training and practice in this field. However, many obstacles must still be overcome. For example, CBT for mood disorders is covered by national health insurance only if it is provided by medical doctors. Thus, patients bear all costs when other mental health professionals (e.g., clinical psychologists) conduct CBT. In addition, CBT for other mental health problems—such as anxiety disorders—are not yet covered by national health insurance. Most importantly, there are few competent CBT therapists in Japan, mainly because the opportunities for training are extremely limited compared to the UK supervision structure in the IAPT services. There are

workshops during annual conferences, and several institutions, such as the Tokyo CBT Academy and the National Centre for Cognitive Behavior Therapy and Research, regularly provide a series of workshops. However, only a limited number of clinicians can attend such training because it is primarily in Tokyo. Moreover, the total training time is relatively short (2–50 hours), and supervision is not provided (even when available, it is not provided on a regular basis).

Chiba University training course

Chiba University was founded in 1949 by uniting several regional national colleges and schools, including the Chiba Medical College. The university is located in Chiba province, which has a population of approximately six million—the sixth largest among the 47 provinces in Japan. In 2010, the Graduate School of Medicine at Chiba University set up a CBT training course, the first post-qualification course for CBT in Japan. Trainees who enroll in the course are required to attend a series of workshops held over two years. The training day typically consists of a 3-hour workshop in the morning, and a 90-minute clinical case conference, and 60-minute group supervision in the afternoon. In addition, trainees receive 30-minute individual supervision. The full course of training includes more than 400 hours. This training course started in April 2010 with three supervisors (two psychiatrists and one psychologist) and 18 trainees; however, the numbers of supervisors and trainees are increasing. Most trainees work in Chiba province and are psychiatrists, psychologists, psychiatric social workers, nurses, and pharmacologists.

Our training course was inspired and influenced by the IAPT Project in the UK; our project aims to disseminate CBT in Chiba province and to increase the number of CBT therapists equivalent to the “high-intensity practitioners” in the UK. Similar to the accreditation for high-intensity practitioners, our trainees are required to complete 200 hours of clinical practice, receive 70 hours of supervision, and complete written reports for a

minimum of eight cases. Along with the written reports, trainees are required to submit audio or a video record of the sessions, and their competence in each session is assessed by supervisors using the Revised Cognitive Therapy Scale (CTS-R: Blackburn et al., 2000). The major differences between the UK IAPT and our course are the frequency that trainees come to the university for the course and how this training is funded. Because the trainees do not receive government funding, they attend the course only once per week for two years, and their training is funded by their employers. For those with limited opportunity to conduct individual psychotherapy at their own workplaces, the course also provides placement at Chiba University Hospital, where trainees see patients with anxiety disorders or bulimia nervosa (BN). Furthermore, our course, unlike the UK IAPT, offers follow-up supervision sessions, in which trainees received 30-minute individual supervision once a month for one year after the completion of the course. Moreover, some trainees go on to a PhD course and continue to attend the program.

Purpose of the present study

The purpose of this study is to report the preliminary outcomes of individual CBT for obsessive–compulsive disorder (OCD), BN, and social anxiety disorder (SAD) delivered by the trainees at Chiba University Hospital. To reflect routine clinical practice, we included patients with comorbid mood disorders if OCD, SAD, or BN was the principal diagnosis. The outcomes of trainee-delivered CBT are used to measure the effectiveness of our training course. We predicted that CBT would be associated with decreased symptom severity. Additionally, a post-hoc survey was conducted to receive feedback from the trainees who completed the course.

Methods

Design

Between April 2010 and December 2011, patients were recruited by clinical referrals from both Chiba University Hospital and other local psychiatric hospitals and clinics; these patients were assessed by the supervisors at Chiba University Hospital using the Structured Clinical Interview for Axis I Disorders (SCID-I; First & Gibbon, 1997). Written informed consent was obtained from all participants. The criteria for inclusion in this study included a primary diagnosis of OCD, BN, or SAD according to the DSM-IV and 18–65 years of age. The exclusion criteria were psychosis, mental retardation, current high risk of suicide, substance abuse or dependence in the past six months, antisocial personality disorder, unstable medical condition, pregnancy, or lactation.

After enrolling in the study, the patients were placed on a waiting list. The waiting period was not controlled because it was based on the availability of therapy rooms; the wait averaged 140.90 days (SD = 62.18) for OCD, 89.6 days (SD = 84.5) for BN, and 13.26 days (SD = 3.21) for SAD. After the waiting period, the participants received a 50-minute individual CBT intervention for 12 weeks. Extra sessions were flexibly added, and termination of treatment was determined jointly by the participants and therapists in consultation with the supervisor. The average number of sessions per participant was 16.25 (SD = 3.77) for OCD, 13.75 (SD = 2.87) for BN, and 13.89 (SD = 1.24) for SAD. Concominant medications were permitted if the dose remained stable throughout the study. Participants were assessed using the outcome measures at pre- (first session) and post-CBT (final session).

This study was conducted at an outpatient clinic at Chiba University Hospital, which is used by trainees who have limited opportunities to conduct individual psychotherapy at their own workplaces.

Outcome measures

The primary outcome measures were self-reported obsessive–compulsive symptoms, as measured by the Obsessive Compulsive Inventory distress scale (OCI; Foa et al., 1998); self-reported bulimic symptoms, as measured by the Severity Scale of the Bulimic Investigatory Test, Edinburgh (BITE-SS; Henderson et al., 1987); and self-reported symptoms of social anxiety, as measured by the Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987).

General severity of mood and anxiety were measured by the standard measures used in the UK IAPT: the 9-item version of the Patient Health Questionnaire (PHQ-9; Kessler et al., 2002), which has scores ranging from 0 to 27 and a recommended cut-off of ≥10 for distinguishing between clinical and non-clinical populations; and the 7-item version of the Generalized Anxiety Disorder scale (GAD-7; Löwe et al., 2008), which was originally developed to screen for GAD, but also has satisfactory sensitivity and specificity for the detection of other anxiety disorders. These scales are outcome measures commonly used in the UK.

Therapists

CBT was delivered by the trainees in the CBT training program. As a course requirement, they attended 30-minute individual supervision sessions once every two weeks and 60-minute weekly group supervision sessions, allowing both supervisors and other trainees to give support and assistance in planning future sessions.

Twenty-two therapists participated in the present study (16 women and six men) with a mean age of 42.13 years (SD = 10.99). In this study, the trainees treated an average of 1.86 patients; most therapiss were allocated 1 or 2 patients. In terms of clinical licenses, there were 13 clinical psychologists, three psychiatrists, one general physician, two psychosocial workers, and three nurses. The average number of years in practice as a clinician was 7.00 years (SD = 6.95), and the average number of days of CBT workshop they had attended before enrolling in our course was 7.47 days (SD = 9.61). The clinical or therapeutic orientation they had used

most in their practice included psychodynamic (*n* = 1), CBT (*n* = 3), psychiatric (*n* = 3), counseling/client-centered (*n* = 6), integrated/eclectic (*n* = 7), or a combination of these orientations/other (*n* = 7).

Interventions

The main steps in the CBT treatment for OCD were:

- Provision of psycho-education about the cognitive-behavioral model of OCD
- Goal setting
- Tailored case formulation
- Exposure and response prevention
- Homework
- Relapse prevention

Therapists were also permitted to use other intervention strategies as needed (e.g., Hougton et al., 2010), including behavioral experiments to test the validity of erroneous beliefs, opinion surveys, and ratings of mastery and pleasure.

Our CBT program for BN was based on Maudsley's model, "Getting Better Bite by Bite" (Schmidt & Treasure, 1993). Getting Better Bite by Bite is the only self-help program that has been evaluated in a randomized controlled trial and provides detailed, step-by-step advice for dealing with BN. The main steps in treatment were:

- Guidelines for behavior change
- Discussion of the pros and cons of maladaptive eating behaviors
- Core values and goal setting
- Psycho-education regarding nutrition, food, and weight
- Self-monitoring using a food diary and provision of a structure for eating
- Action plans on how to stop bingeing and purging behaviors
- Identification of automatic thoughts and modification of maladaptive assumptions and

core beliefs

- Behavioral experiments to challenge maladaptive beliefs
- Progressive actions
- Discussion of remaining challenges
- Dealing with interpersonal difficulties
- Relapse prevention.
- Homework assigned after every session

Our CBT program for SAD was based on the model of Clark and Wells (1995). The main steps in treatment were:

- Developing an individualized version of the cognitive behavioral model of SAD
- Conducting role-play–based behavioral experiments with and without safety behaviors
- Restructuring distorted self-imagery using videotape feedback
- Practicing external focus and shifting attention
- Conducting behavioral experiments to test negative beliefs
- Modifying problematic pre- and post-event processing
- Discussing the difference between self-beliefs and other people's beliefs (reflected in survey results)
- Dealing with remaining assumptions (schema work)
- Rescripting early memories linked to negative images in social situations
- Preventing relapse
- Homework assigned after every session

Statistical analysis

The outcomes of the CBT treatment were examined by the comparison of pre- and post-CBT scores of each scale (OCI, BITE-SS, LSAS, PHQ-9, and GAD-7) using within-group *t*-

tests. Effect sizes were determined ($[M_{pre\text{-}CBT} - M_{post\text{-}CBT}]/SD_{re\text{-}baseline}$). According to Cohen (1988), the effect sizes were categorized as follows: small (0.20–0.49), medium (0.50–0.79), and large (0.80 and above).

Feedback from trainees

A post-hoc survey via email was conducted with the trainees who took part in this study to obtain their feedback on the training course. They were asked to rate the following questions on a seven-point scale (ranging from very satisfied [7], satisfied [6], slightly satisfied [5], neutral [4], slightly dissatisfied [3], dissatisfied [2] to very dissatisfied [1]):

1. How satisfied were you with the length (i.e., one day a week for two years) of the training course?
2. How satisfied were you with the content and the delivery of the workshops?
3. How satisfied were you with the frequency and the duration of the supervision?

Additionally, they were asked to note the distinctive aspects of our training course compared to the CBT training they had previously and note any difficulties faced during the training.

Results

Results of patients with OCD

Of the 21 patients screened, three were excluded because OCD was not their primary diagnosis (one OCPD, one adjustment disorder, and one hypochondriasis). Eighteen participants satisfied the study criteria and were referred to the study. During the waiting period, four patients declined the treatment without disclosing their reasons. Once the treatment started, the remaining 14 patients completed the study.

Table 1 shows the baseline demographic and clinical variables of the 14 participants (Table 1). Eleven were women (79%), and the participants' mean age was 36.79 years. Five

participants (36%) were unemployed, and six (43%) were single. All participants met the principal DSM-IV diagnostic criteria for OCD (mean duration: 5.21 years). Six participants (57%) also met the criteria for major depressive disorder as an additional Axis I diagnosis. Other clinical variables and participants' demographics are shown in Table 1.

Table 1 about here

The primary outcome measure was the severity score of the OCI. The mean OCI score decreased from 64.43 (SD = 3.39) to 32.54 (SD = 17.49) over the course of treatment. The PHQ-9 and GAD-7 scores reduced from 8.57 (SD = 4.09) to 5.07 (SD = 4.29) and from 8.14 (SD = 5.63) to 4.07 (SD = 2.84), respectively. A within-group *t*-test revealed significantly different scores between the pre- and post-CBT scores on the assessed scales: $t(1, 13) = 5.153$, $p < .001$ for the OCI; $t(1, 13) = 2.775$, $p = .015$ for the PHQ-9; and $t(1, 13) = 3.277$, $p = .006$ for the GAD-7. The effect sizes between the pre- and post-CBT were 1.05 (large), .86 (large), and .72 (medium) for the OCI, PHQ-9, and GAD-7, respectively.

Results for patients with BN

Of the 11 subjects screened, one was excluded from the study because her primary diagnosis was not BN (anorexia nervosa binge-eating/purging type). After enrolling in the study, no patients dropped out, but assessment data were not obtained from two patients. As a result, the data of eight patients were subject to analysis.

Table 2 shows the baseline demographic information and clinical variables of the eight patients whose data were analyzed. All of the participants were female, and their mean age was 31.3 years. One patient was employed, three were students, and four were single. Four patients had comorbid psychiatric disorders: two had additional Axis I diagnoses of major depressive disorder, one had bipolar disorder, and one had SAD. Other clinical variables and participants' demographics are shown in Table 2.

Table 2 about here

The primary outcome measure was the severity score on the BITE-SS. The average BITE-SS score decreased from 9.75 (SD = 4.28) to 4.00 (SD = 4.34) over the course of the study. The PHQ-9 and GAD-7 scores reduced from 12.12 (SD = 7.70) to 8.13 (SD = 7.42) and from 9.38 (SD = 6.12) to 6.25 (SD = 6.67), respectively. A within-group *t*-test revealed significant differences between pre- and post-CBT in BITE-SS, $t(1, 7) = 2.803$, $p = .026$, and GAD-7 scores, $t(1, 7) = 2.739$, $p = .028$. However, there was no significant difference in the PHQ-9 scores over the course of the study, $t(1, 7) = 1.782$, $p = .117$. The effect sizes between pre- and post-CBT were 1.348 (large), .516 (medium), and .508 (medium) for the BITE-SS, PHQ-9, and GAD-7, respectively.

Results for patients with SAD

Of the 23 subjects screened, four were excluded: two had high risk of suicide, and the primary diagnoses of the other two were not SAD (autism spectrum disorders). As a result, 19 patients met the enrolment criteria and were referred to the study. All patients completed the study.

Table 3 shows the baseline clinical variables and demographics of the 19 patients who enrolled in this study (Table 3). Fourteen of the participants were women (74%), and the patients' mean age was 32.3 years. Four patients (21%) were unemployed and 12 (63%) were single. All participants met the principal DSM-IV diagnostic criteria for SAD (mean duration: 14.3 years). Patients with additional Axis I diagnoses included five (26%) who met the criteria for major depressive disorder, two (13%) for bipolar disorder type II, and one (5%) for panic disorder with agoraphobia.

Table 3 about here

The primary outcome measure was the severity score of the LSAS. The average LSAS score decreased from 87.05 (SD = 29.40) to 54.00 (SD = 29.99) over the course of the study. The PHQ-9 and GAD-7 scores reduced from 11.11 (SD = 6.88) to 6.84 (SD = 5.07) and 9.32 (SD

= 5.86) to 5.74 (SD = 4.74), respectively. A within-group *t*-test revealed significantly different scores between the pre- and post-CBT scores on the assessed scales: $t(1, 18) = 5.627$, $p < .001$, for the LSAS; $t(1, 18) = 3.338$, $p = .003$ for the PHQ-9; and $t(1, 18) = 2.486$, $p = .002$ for the GAD-7. The effect sizes between pre- and post-CBT were 1.124 (large), .620 (medium), and 0.611 (medium) for the LSAS, PHQ-9, and GAD-7, respectively.

Result of feedback from trainees

Ten trainees took part in the post-hoc survey about the training course. Regarding satisfaction with the length (i.e., one day a week for two years) of the training course, eight selected "satisfied," and two selected "very satisfied." As for the workshops, six selected "satisfied," three selected "very satisfied," and one selected "slightly satisfied." With respect to the frequency and the duration of the supervision, five selected "satisfied," three selected "slightly satisfied," and two selected "satisfied."

In response the question about the distinctive aspects of our training course compared to previous CBT training, five mentioned the continuity and practicality of our course, in contrast to classroom lectures for a short period. Additionally, four trainees appreciated the colleagues they had made through the training, and noted that they still support each other. Moreover, two pointed out that they obtained a wider perspective of CBT because both psychologists and psychiatrists were instructors in the training course. Regarding the difficulties trainees had during the training, three referred to their reluctance to record the sessions, although their clients usually agreed to be recorded. Finally, two noted that it was difficult to write clinical case reports.

Discussion

The purpose of this study was to report the preliminary outcomes of individual CBT for OCD, BN, and SAD delivered by the trainees of the Chiba CBT training course. We included

patients with comorbid mood disorders if OCD, SAD, or BN was the principal diagnosis to reflect routine clinical practice. The results demonstrated that individual CBT for OCD, BN, and SAD in Japan led to significant reductions in symptom severity for these primary diagnoses. The effect size for OCD was comparable with those obtained in past trials involving psychological treatment for OCD (Rosa-Alcázar et al., 2008), and those for BN and SAD were large. Our study was designed not only to recruit patients similar to those seen in routine clinical practice but also to train clinicians who will be engaged in routine clinical practice; they were not fully trained therapists before this study.

Although it is difficult to directly compare our effect sizes with other published data due to a variety of factors (e.g., patient demographic and type/intensity of CBT), the overall effect sizes of 0.63 for PHQ-9 (medium) and 0.66 for GAD-7 (medium) were less than were those in other IAPT and other studies (Clark et al. 2009; Radhakrishnan et al. 2013; Richards & Borglin, 2011; Richards & Suckling, 2009; Westbrook & Hill, 1998; Westbrook & Kirk, 2005). It is possible that severity of depression and anxiety among our recruited patients was lower than that observed in previous reports, and thus resulted in a lower effect size. However, it is noteworthy that our results showed the lowest scores of PHQ-9 and GAD-7 at post-treatment (Table 4).

Table 4 about here

Our training course was highly evaluated by the trainees regarding the satisfaction with the length of the training course, the content of the workshops, and the frequency and duration of the supervision. This was confirmed by their comments suggesting that our course offered more comprehensive training than other courses. The trainees valued colleagues, probably because most of them do not have someone to consult (even to talk) about CBT at their workplace. In order to address the difficulties in writing case reports, the supervisors addressed this issue by providing a special seminar about academic writing.

Dissemination of CBT across Japan

As noted in the Introduction, CBT is only covered by national health insurance for the treatment of mood disorders, primarily because the quantity of outcome research in CBT, particularly using randomized control trials, is exceptionally low in Japan. As Gunter and Whittal (2010) proposed, we need to conduct studies and evaluate more research-based data to obtain required funding and organizational support. The other issue hindering the dissemination of CBT in Japan is the paucity of training opportunities. Opportunities are limited for both pre- and post-qualification training. More than 160 universities and colleges provide postgraduate master's programs in clinical psychology, but only a few courses incorporate CBT in their curricula because of the scarcity of CBT experts. Our hope is that post-qualification training courses will be established in other areas of Japan so that more health professionals can attend workshops and benefit from regularly supervised practice.

Through the development and administration of the training course, the supervisors gained a wealth of professional knowledge concerning the dissemination of CBT in Japan. For example, approximately two years before the commencement of the training course, a survey was conducted with a number of psychiatric hospitals and clinics in Chiba province to identify the type of therapies that patients desired and clinicians would like to learn (Haraguchi et al., submitted for publication). The result of this survey revealed the strong need for CBT and provided rationale for establishing our training course. Additionally, as they ran the training course, supervisors had to identify and solve problems and difficulties as these arose. For instance, some trainees had difficulties with academic writing because they had completed their undergraduate or postgraduate course many years ago. A special workshop was organized for the improvement of writing skills. To modify bias in their assessments, supervisors occasionally watched a video of a session together and compared each other's scores on the CTS-R. Moreover, they asked their supervisees to rate the Process Evaluation of Training and Supervision scale (Wilson, 2007) to assess the duration, frequency, supportive,

and formative factors of supervision.

The concept of CBT as a Western therapy requiring major adaptation for effective use in Japanese culture must be considered further in on-going research. Compared to Western cultures, more emphasis is placed on interpersonal relationships than on self-fulfillment or self-development in Asian cultures. However, we believe that similar factors support the efficacy and utilization of CBT in Japan. For example, in a randomized trial, Nakatani et al. (2005) demonstrated that behavioral therapy is highly effective for Japanese patients with OCD. Matsunaga et al. (2008) elucidated the transcultural stability of the symptom structure of OCD, which is consistent with the hypothesis that OCD is mediated by universal psychobiological mechanisms.

The limitations of this study

Although the present study provided valuable information, it does have several limitations. This was a single-arm study without a concurrent control group. Moreover, our waiting period was not fixed, and scores were not obtained at a pre-treatment baseline point. Although these design factors reflect the real-world nature of mental health services, it remains unknown whether the observed improvements in symptom severity was related to the natural extinction of the disorders. More studies employing psychological placebo conditions to control for nonspecific factors, such as positive outcome expectancy and self-efficacy for problem management, are needed.

This study established the acute effectiveness of the treatment, but the lack of follow-up data limits the generalizability of the study (e.g., long-term effects, relapse rates). Further, there was no control for the patients' use of medication, although our patient group had typically taken antidepressant medication for an extended period before referral to Chiba University Hospital. Again, this circumstance reflects the reality of the population of patients who access secondary mental health services in Japan. Further studies will need to include

fixed waiting periods, control groups, and long-term follow-up to provide more insight into the implementation of CBT in routine practice in Japan. Currently, our research team is running a randomized control trial for SAD (Yoshinaga et al., in press: trial number: UMIN000007552) and single-arm trials for OCD and BN with fixed waiting periods. Changes in employment status, such as fewer days absent from work, should be examined after completion of the therapy. This would be a crucial test of whether increased access to psychological therapies would largely pay for itself by reducing other depression- and anxiety-related public costs (e.g., welfare benefits and medical costs) and increasing revenues (e.g., taxes, increased productivity).

This study focused on the effectiveness of CBT delivered by trainees to evaluate our training program. However, it remains unknown if the result of the CBT is due to the training or whether trainees had been already competent. Thus, other measures could also be employed to gain a better understanding of the ways training should be provided. Comparing scores on the cognitive therapy awareness scale (Sudak et al., 2003)— a multiple-choice questionnaire (Maunder et al., 2008; Myles & Milne, 2004)—between pre- and post-training would reveal how competent trainees felt as they progressed through training. A video assessment task (Myles & Milne, 2004) would provide a more objective perspective of the trainee competence.

References

Andrews G, & Titov N (2009). Hit and miss: innovation and the dissemination of evidence based psychological treatments. Behaviour Research and Therapy 47, 974–979.

Blackburn I, James IA, Milne DL, Baker C, Standart S, Garland A, & Reichert FK (2001). The revised cognitive therapy scale (CTS-R): psychometric properties. Behavioural and Cognitive Psychotherapy 29, 431–446.

Clark D, & Wells A (1995). A cognitive model of social phobia. In: Social Phobia: Diagnosis, Assessment, and Treatment (ed. R. G. Heimberg & M. R. Liebowitz), pp. 69-93. New York: Guilford Press.

Clark DM, Layard R, Smithies R, Richards DA, Suckling R, & Wright B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. Behaviour Research and Therapy, 47, 910-920

Cohen J (1988). Statistical Power Analysis for the Behavioral Sciences, Hillsdale, NJ: Erlbaum.

First MB, & Gibbon M (1997). User's Guide for the Structured Clinical Interview for DSM-IV Axis I Disorders SCID-I: Clinician Version, Arlington: American Psychiatric Pub.

Foa EB, Kozak MJ, Salkovskis PM, Coles M, & Amir N (1998). The validation of a new obsessive-compulsive disorder scale: The Obsessive-Compulsive Inventory. Psychological Assessment 3, 206–214.

Gunter RW, & Whittal ML (2010). Dissemination of cognitive-behavioral treatments for anxiety disorders: overcoming barriers and improving patient access. Clinical Psychology Review 30, 194–202.

Haraguchi T, Shimizu, E, Nakazato M, Kobori O, & Iyo M. (submitted for publication). Current status of cognitive behavioural therapy in Chiba prefecture: a questionnaire survey.

Henderson M, & Freeman CP (1987). A self-rating scale for bulimia. The 'BITE'. British Journal

of Psychiatry 150, 18–24.

Houghton, S., Saxon, D., Bradburn, M., Ricketts, T., & Hardy, G. (2010), The effectiveness of routinely delivered cognitive behavioural therapy for obsessive-compulsive disorder: A benchmarking study. British Journal of Clinical Psychology, 49: 473–489

Kessler RC, Andrews G, Colpe LJ, Hiripi E, Mroczek DK, Normand SLT…Zaslavsky AM (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. Psychological Medicine 32(6), 959–976.

Liebowitz MR (1987). Social phobia. Modern Problems of Pharmacopsychiatry 22, 141–173.

Löwe B, Decker O, Müller S, Brähler E, Schellberg D, Herzog W, & Herzberg PY (2008). Validation and standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the general population. Medical Care 46, 266–274.

Maunder L, Milne D, & Cameron L (2008). Pilot evaluation of brief training in CBT for primary care practitioners. Behavioural and Cognitive Psychotherapy 36, 341–353.

Matsunaga H, Maebayashi K, Hayashida K, Okino K, Matsui T, Iketani T,…Stein DJ (2008). Symptom structure in Japanese patients with obsessive-compulsive disorder. American Journal of Psychiatry 165, 251–253.

Myles PJ, & Milne DL (2004). Outcome evaluation of a brief shared learning programme in cognitive behavioural therapy. Behavioural and Cognitive Psychotherapy 32, 177–188.

Nakatani E, Nakagawa A, Nakao T, Yoshizato C, Nabeyama M, Kudo A,..Kawamoto M (2005). A randomized controlled trial of Japanese patients with obsessive-compulsive disorder: Effectiveness of behavior therapy and fluvoxamine. Psychotherapy and Psychosomatics 74, 269–276.

Radhakrishnan M, Hammond G, Jones PB, Watson A, McMillan-Shields F, & Lafortune L (2013). Cost of improving Access to Psychological Therapies (IAPT) programme: an analysis of cost of session, treatment and recovery in selected Primary Care Trusts in the East of England.

Richards, DA, & Borglin, G. (2011). Implementation of psychological therapies for anxiety and depression in routine practice: Two year prospective cohort study. Journal of Affective Disorders. 133, 51–60.

Richards DA, & Suckling R (2009). Improving access to psychological therapies: phase IV prospective cohort study. *British Journal of Clinical Psychology 48,* 377-96.

Rosa-Alcázar AI, Sánchez-Meca J, Gómez-Conesa A, & Marín-Martínez F (2008). Psychological treatment of obsessive-compulsive disorder: a metaanalysis. Clinical Psychology Review 28(8), 1310–1325.

Schmidt U, & Treasure J (1983). Getting Better Bit(e) by Bit(e): A Survival Kit for Sufferers of Bulimia Nervosa and Binge Eating Disorders, Hove, UK: Psychology Press, Ltd.

Shafran R, Clark DM, Fairburn CG, Arntz A, Barlow DH, Ehlers A…Wilson GT (2009). Mind the gap: Improving the dissemination of CBT. Behaviour Research and Therapy 47(11), 902–909.

Sudak DM, Beck JS, & Wright J (2003). Cognitive behavioral therapy: A blueprint for attaining and assessing psychiatry resident competency. Academic Psychiatry 27, 154–159.

Westbrook, D. & Hill, L. (1998). The long-term outcome of cognitive-behaviour therapy for adults in routine clinical practice. Behaviour Research & Therapy, 36, 635-643.

Westbrook, D. & Kirk, J. (2005). The clinical effectiveness of cognitive behaviour therapy: outcome for a large sample of adults treated in routine practice. Behaviour Research & Therapy, 43, 1243-1261.

Wilson, M. (2007). Can experiences of supervision be qualified? My PETS: A new tool for measuring supervisees' satisfaction with clinical supervision. Unpublished undergraduate thesis, available from the Psychology Department, Newcastle University, NE1 7RU.

Yoshinaga N, Niitsu T, Hanaoka H, Sato Y, Ohshima F, Matsuki S,…Shimizu E (2013). Strategy for treating selective serotonin reuptake inhibitor-resistant social anxiety disorder in the

clinical setting: A randomised controlled trial protocol of cognitive behavioural therapy in combination with conventional treatment. BMJ Open 3, e002242 doi:10.1136/bmjopen-2012-002242.

Tables

Table 1.

Demographic and clinical characteristics for OCD[a] (N = 14)

Variable		Value
Gender, female, n (%)		11 (79)
Age, years, mean (SD)		36.79 (9.88)
Comorbid Axis I diagnosis, N (%)	No comorbid condition (OCD only)	8 (57)
	With comorbidity	6 (43)
Age of onset, years, mean (SD)		31.57 (9.18)
Duration of OCD, years, mean (SD)		5.21 (4.67)
Employment status, N (%)	Employed full-time	2 (14)
	Part-time/homemaker	7 (50)
	Unemployed	5 (36)
Marital status, N (%)	Single	6 (43)
	Married	7 (50)
	Dating	1 (7)
Educational background, N (%)	High school	3 (22)
	Diploma	4 (28)
	Degree	7 (50)
Currently on medication, N (%)	AD and/or BZ	12 (86)

[a] Abbreviations: OCD = Obsessive–compulsive Disorder; BZ = Benzodiazepines; AD = Antipsychotics.

Table 2.

Demographic and clinical characteristics for BN[a] (N = 8)

Variable		Value
Gender, female, N (%)		8 (100)
Age, years, mean (SD)		31.3 (10.4)
BMI (kg/m^2)		23.5(5.7)
Comorbid Axis I diagnosis, N (%)	Without comorbidity (BN only)	5 (62.5)
	With comorbidity	3 (37.5)
Age of onset, years, mean (SD)		20.8 (7.1)
Duration of BN, years, mean (SD)		10.4 (8.9)
Employment status, N (%)	Employed full-time	1 (12.5)
	Full-time student	3 (37.5)
	Homemaker	2 (25.0)
	Unemployed	2 (25.0)
Marital status, N (%)	Single	5 (62.5)
	Married	3 (37.5)
	Divorced	2 (25.0)
Educational background, N (%)	Junior high school	0 (0)
	High school	1 (12.5)
	Diploma	3 (37.5)
	Degree	4 (50.0)
Currently on medication, N (%)	BZ and/or AD and/or MS	5 (62.5)

[a] Abbreviations: BN = Bulimia Nervosa; BZ = Benzodiazepines; AD = Antipsychotics; MS = Mood Stabilizers

Table 3.

Demographic and clinical characteristics for SAD[a] (N = 19)

Variable		Value
Gender, female, N (%)		14 (74)
Age, years, mean (SD)		32.3 (9.7)
Subtype, generalized, N (%)		16 (84)
Comorbid Axis I diagnosis, N (%)	Without comorbidity (SAD only)	11 (58)
	With comorbidity	8 (42)
Age of onset, years, mean (SD)		17.9 (8.8)
Duration of SAD, years, mean (SD)		14.3 (10.5)
Employment status, N (%)	Employed full-time	6 (32)
	Full-time student	5 (26)
	Part-time/homemaker	4 (21)
	Unemployed	4 (21)
Marital status, N (%)	Single	12 (63)
	Married	6 (32)
	Divorced	1 (5)
Educational background, N (%)	Junior high school	2 (13)
	High school	7 (37)
	Diploma	6 (32)
	Degree	4 (21)
Currently on medication, N (%)	AD and/or BZ	17 (87)

[a] Abbreviations: SAD = Social Anxiety Disorder; BZ = Benzodiazepines;

AD = Antidepressants

Table 4.

Comparison of effect sizes among various studies

Symptom	Data source	Intensity of CBT[a]	N (Dep , Anx)	Outcome	Pre Mean (SD)	Post Mean (SD)	ES[b]
Depression	Current data	High	45 (0%, 82%)	PHQ-9	10.6 (6.3)	6.6 (5.5)	0.63
	Westbrook (1988)	N/A	36 (27%, 36%)	BDI	18.2 (9.9)	10.9 (10.4)	0.79
	Westbrook (2005)	N/A	776 (19%, 56%)	BDI	16.9 (10.5)	9.8 (9.0)	0.68
	Clark (2009): Doncaster	High and low	1648 (95%, 5%)	PHQ-9	15.8 (6.2)	7.5 (6.9)	1.34
	Clark (2009): Newham	High and low	221 (46%, 43%)	PHQ-9	15.3 (6.2)	8.2 (7.2)	1.15
	Richards (2009)	High and low	1274 (N/A)	PHQ-9	16.0 (6.15)	8.1 (7.2)	1.28
	Richards (2011)	High and low	4183 (77%, 8%)	PHQ-9	16.2 (6.2)	9.0 (7.3)	1.17
	Radhakrishnan (2013)	High	2230 (N/A)	PHQ-9	14.4 (6.7)	9.2 (9.0)	0.79
		Low	4854 (N/A)	PHQ-9	12.5 (6.3)	8.0 (9.4)	0.72
Anxiety	Current data	High	45 (0%, 82%)	GAD-7	9.1 (5.8)	5.2 (4.6)	0.66
	Westbrook (1988)	N/A	36 (27%, 36%)	BAI	15.2 (10.4)	11.4 (11.1)	0.37
	Westbrook (2005)	N/A	473 (25%, 48%)	BAI	17.0 (11.8)	10.6 (8.9)	0.54
	Clark (2009): Doncaster	High and low	1648 (95%, 5%)	GAD-7	13.9 (5.2)	6.8 (6.2)	1.37
	Clark (2009): Newham	High and low	221 (46%, 43%)	GAD-7	13.7 (5.1)	6.8 (5.8)	1.35
	Richards (2009)	High and low	1274 (N/A)	GAD-7	14.0 (5.2)	7.2 (6.3)	1.07
	Richards (2011)	High and low	4183 (77%, 8%)	GAD-7	14.1 (5.1)	8.1 (6.4)	1.17
	Radhakrishnan (2013)	High	2230 (N/A)	GAD-7	12.9 (5.3)	8.2 (8.2)	0.89
		Low	4854 (N/A)	GAD-7	11/7 (5.4)	7.3 (9.0)	0.82

Abbreviations: CBT = Cognitive Behavioural Therapy; PHQ-9 = Patients Health Questionnaire-9 items; GAD-7 = Generalized Anxiety Disorder-7 items; BDI = Beck Depression Inventory;

BAI = Beck Anxiety Inventory; Dep = Depressive disorder; Anx = Anxiety disorder; ES = Effect Size.

[a] High = one-to-one, face-to-face psychological therapy; Low = guided self-help (e.g., using books, leaflets or computer support) and goup psychoeducation.

[b] Effect sizes (cohen's *d*) for each study were recalculated using same formula.