



Learning Cognitive-Behavioral Therapy through Peer-Assisted Learning: A Novel Experience

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Dear Editor,

Cognitive-Behavioral Therapy (CBT) is vital in psychiatric training due to its strong evidence base and broad applications. Integrating CBT's knowledge, attitudes, and skills into the residency curriculum is challenging, yet crucial. Educational centers are working to enhance these skills among residents (1). In Iran, psychiatry residency lasts four years, during which nine months (approximately 1,800 *hr*) are dedicated to psychotherapy training. Typically, three months are allocated to CBT, and residents are required to independently conduct CBT with at least five clients, in accordance with the national curriculum approved by the Ministry of Health. In a study in Iran, however, the satisfaction rate of psychotherapy training was less than 50% (2). In addition, traditional teaching methods -including lectures or reading educational texts- often prove ineffective. Although Peer-Assisted Learning (PAL) has been shown to be efficient in boosting clinical skills (3,4), literature review found no evidence of its use in CBT training. There was a need for a peer-assisted CBT training course, considering the learners' needs and capabilities.

The authors' experience with a CBT course at Iran University of Medical Sciences, which incorporates some of PAL principles and flipped-classroom techniques, suggests that such innovative approaches may enhance training outcomes and satisfaction. This educational program was designed by two of the authors who are faculty members (N.S.M. and S.M.H.M.). The main goal was learning at three levels: knowledge, attitudes, and skills. To achieve this goal, effective use of time, employment of active learning methods, and the simultaneous presence of order and appeal were necessary.

Weekly 90-*min* sessions, about 50 sessions per year, were conducted with around 8 participants. Psychiatry residents with at least 6 months of study could join voluntarily. A reference book was determined, and the topic for each session was predefined. Pre-session study was the only condition for participation in the next session. Therefore, all the attendees studied the topic and marked any interesting, useful,

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or ambiguous sentences to open discussions in the session. Active participation was encouraged, with no mandatory attendance, allowing flexibility within the broader residency program. Each session fostered interpersonal engagement, with room for empathetic discussions if there was a personal or social crisis. Then, all attendees would open the page related to the session's topic; the headings and occasionally short sections of the book were read by one of the attendees, and everyone was invited to share any interesting, practical, or thought-provoking points. The participants would express their opinions or feelings with regard to the raised point, review scientific evidence and article results, and share related clinical experiences, sparking discussion. This process continued, covering the entire topic of the session.

The creative methods and ideas used in this program are reviewed below:

The teaching role of the two faculty members (N.S.M. and S.M.H.M.) was subdued, sometimes only as facilitators. Learners raised questions, expanded on book concepts, and provided constructive feedback. Experienced residents shared their clinical experiences and theoretical knowledge.

Learners studied topics at home, and highlighted important or ambiguous points, discussing them in class and reviewing functional points for the group.

The session time was dedicated to practicing and deepening the material and understanding its clinical correlations.

Learners were also invited to share their perspectives or experiences; their active contribution allowed for correcting misconceptions from the text and gaining a deeper understanding of the content. Occasionally, the class turned into a clinical case conference or supervision session.

Various teaching methods were used. Methods included role-playing, group discussion, watching educational videos, short lectures, and voluntary article presentations.

Diverse viewpoints were encouraged. Residents from various entry years provided diverse viewpoints, enhancing teaching and learning opportunities. Sessions were kept under 10 participants to ensure active involvement.

A supportive environment was maintained. All

members, especially faculty members (N.S.M. and S.M.H.M.) fostered trust, self-esteem, and uninhibited speaking by carefully avoiding ruthless criticism and judgmental attitudes.

Personal responsibility was emphasized. By avoiding attendance checks, the implicit message was conveyed to the residents that everyone is responsible for their education. By prohibiting attendance in class without studying the topic, repetition of basic points was prevented, and the importance and quality of the session were established.

Choosing an innovative class name (CBTeam), creating a friendly atmosphere, supporting responsible humor, encouraging members to bring and share snacks, and striving to show the enjoyable aspect of learning new knowledge and skills all contributed to making this experience more attractive.

Showing empathy for acute personal or social tensions at the beginning of sessions was a humane act. It prevented discussions from starting without the focus and readiness of the attendees and was also educational at the level of the hidden curriculum.

Limitations included the absence of a formal effectiveness assessment, the inability of all residents to attend every session due to their rotation schedules, and the need to limit participant numbers to maintain interactivity. Despite the mentioned limitations, some observations show the sessions' effectiveness. The average class had orderly sessions for almost a year with around 6 to 8 voluntary participants, even with changing rotations. Enthusiastic and active participation was evident despite being scheduled at the end of a workday. The online discussion forum remained active for questions and experience transfer a year after completing the sessions. Feedback from learners highlighted improvements in knowledge, attitudes, and skills which was translated into clinical practice. Enhanced relationships between residents of different entry years and with faculty fostered a network conducive to future research. Incorporating small, creative clinical exercises between sessions and reviewing them in subsequent sessions could further enrich the program.

Studies indicate that learning the micro skills of psychotherapy, maintaining a low resident-to-attending psychiatrist ratio, and involving genuinely committed residents can enhance psychotherapy

training (5). This experience integrates these elements, emphasizing the importance of up-to-date, measured, and empathetic educational design to improve training for residents.

Keywords: Cognitive-behavioral therapy, Medical education, Medical residency, Peer group, Psychotherapy

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Conflict of Interest

The authors declare that they have no competing interests.

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