

Postgraduate Diploma in Cognitive Psychotherapy

Trinity College, Dublin

Course Handbook for Students 2008-09

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Course Welcome

Firstly we would like to welcome you to the course and hope that this will be a stimulating and satisfying experience for each student. Like all postgraduate courses, but especially those running in tandem with work commitments, it will pose an array of challenges.

Students will differ in regard to their levels and experience in cognitive psychotherapy. Some are relative novices, some have already read extensively and experimented with cognitive psychotherapy methods in clinical practice. Equally, trainees' professional backgrounds and current orientations differ widely.

It is our observation, derived from experience in running the course, that the feeling of being "deskilled" is a common experience, even for trainees with a high level of pre-existing experience and ability. Each year, trainees reach a point where they feel that they will never get it "right", and moreover each tends to believe that they are alone in this feeling. It is also common for people to feel pressurised by the demand of the written work, or indeed by the demands of fitting a one-day course into an already busy life. Sharing concerns with each other will help you to appreciate how common they are and find support in coping with them. Equally, you are welcome to discuss worries with the Course Director or Course staff if you would like to do so. We should like you to see the course as an opportunity to extend the knowledge and expertise you already possess through a process of active engagement in your own learning. You are not here to sit passively absorbing knowledge, but to think critically and take an active part in your own development. This means that we appreciate feedback from you on your needs, ideas and reactions to what we provide. You will be invited to give written feedback on teaching sessions, on supervision and on the course as a whole. The sooner we receive feedback from you the quicker we can mend any problems that arise for you.

Aims of the Course

The course offers post-qualification training in the theory and practice of cognitive psychotherapy, as applied in a variety of mental health settings. Competence is developed through a combination of weekly clinical supervision, lectures, workshops and written assignments. Assessment is based on the submission of case studies and theoretical reviews, oral presentations and standardised rating of recorded therapy sessions.

The following are the specific aims of the postgraduate diploma year:

- To provide a sound knowledge of the theory and practice of cognitive psychotherapy.
- To present specific adaptations of the cognitive model for a variety of clinical disorders and related research on outcome and efficacy.

- To develop confidence in assessing patient suitability for cognitive psychotherapy; to develop cognitive case formulations; to devise and implement individual treatment programmes and to evaluate their success.
- To develop the ability to convey clearly the central concepts of cognitive psychotherapy and communicate basic treatment skills.
- To critically evaluate the current status of different treatment approaches within cognitive psychotherapy.
- To cultivate an attitude of enquiry as to how the model may need to be adapted to cater to the unique circumstances of each individual patient.

Course Structure

This course is designed as a one-year Postgraduate Diploma in Cognitive Psychotherapy. It is run under the auspices of the School of Medicine and Health Sciences, TCD; the Postgraduate Diploma awards are conferred by the University of Dublin, Trinity College.

The Diploma course is run on a part-time basis and will be based in 2008/2009 at St. Patrick's Hospital. The Diploma class meets every Friday in each of the three academic terms, from 9:00am to 5:00pm.

Course Objectives

In the Diploma year, the curriculum emphasises the following learning objectives:

- Understanding the cognitive basis of emotional disorders
- Structuring a cognitive therapy session
- Assessing the scope of presenting difficulties and agreeing specific therapeutic goals
- Building and maintaining a therapeutic alliance through collaboration and feedback
- Developing individual cases formulations
- Applying cognitive and behavioural interventions in a clinically sensitive manner
- Fostering resilience and creativity in clients through self-help assignments
- Terminating therapy and preparing clients for inevitable lapses in their recovery

Course Outline

The first term will focus on "classical" short-term cognitive psychotherapy for acute disorders will develop basic skills and concepts, broadly applicable to a range of patients and problem areas. We will work on developing a generic cognitive conceptualisation and on the acquisition of generic skills, like identifying and finding alternatives to negative automatic thoughts, identifying and re-evaluating dysfunctional assumptions, and working with process issues in psychotherapy.

In the second term we will consider how these generic skills and concepts should be refined and modified when they are applied to specific disorders, for example

depression, panic disorder, OCD, social phobia and PTSD. We shall introduce specific diagnostic conceptualisations which aim accurately to pinpoint the specific cognitive and behavioural difficulties that characterise particular disorders and shall describe specific treatment interventions designed to target them.

In the third term we will introduce specific issues in treating more difficult, complex cases and work on developing individualised developmental cognitive conceptualisations. We will also examine the application of cognitive therapy in the context of multidisciplinary teams and self help organisations.

This course will offer the opportunity to explore in depth the theory and practice of cognitive psychotherapy. This does not mean that you pursue this approach exclusively when you have completed the course. Rather it should mean that you have the knowledge and skills to use cognitive psychotherapy consistently and effectively if you wish to do so. In order to reach this point, we suggest that you take advantage of this unique opportunity to immerse yourself in cognitive psychotherapy to the full.

Necessarily, your performance will be evaluated over the year. It is important, however, that awareness of assessment should not be at the expense of your creativity, or your willingness to express your own ideas openly and to experiment with new ways of thinking and working. The course is an opportunity for you to learn and develop in a classroom atmosphere of openness and inquiry.

Students will attend teaching sessions on the theory and practice of cognitive psychotherapy in relation to a variety of different problem areas and disorders. Our intention is that at the end of this period you should be competent to assess and treat acute (Axis I) emotional disorders and be acquainted with the concepts and methods of schema-focused cognitive psychotherapy, which are more appropriate to long-term and recurrent disorders.

During the course, students must receive supervision with a minimum of three cases. To be considered “cases” rather than “assessments” patients must be seen for at least five sessions. The course aims to provide students with approximately 50 hours of supervised case work with students seeing 4 to 6 patients with a range of different problems, each for 8 to 16 sessions.

The course on its own does not aim to train you to the level of accreditation as a cognitive therapist. However we hope that you will develop sufficient knowledge, confidence and skill to be able to relax into cognitive psychotherapy and carry it out comfortably with your own personal style. You may not have reached this point by the end of the course, but you should have established a solid basis for further development and with further supervised case work and training you will be firmly on the path to accreditation.

Teaching Methods

Lectures/Workshops

Course Timetable and Structure for 2007 – 2008 Academic Year

This academic year starts with an introductory week. There is an emphasis in the first term on the Basic Tenets of Cognitive Therapy and the Therapeutic Relationship. We have incorporated Self Practice/ Self Reflection (SP/SR) tutorials approximately every 2nd week in all three terms. Students will meet with the Course Director as the course commences to establish if any supplementary teaching would be helpful/necessary. This might include attendance at other teaching available within the Department of Psychiatry (e.g. psychopathology, psychiatric diagnosis, mental state examination), IT skills, writing skills etc.

Module 1

Understanding Basic Theory in Psychotherapy and the Cognitive Model

Specific Learning Objectives

- Understanding the Principles of Psychotherapeutic practice
- Understanding the Cognitive and Behavioural basis of emotional disorders
- Understanding the Structure and Purpose of a Cognitive Therapy session

Module 2

Introduction to the application of the Cognitive Behavioural Model

Specific Learning Objectives:

- Assessing the scope of presenting difficulties and agreeing specific therapeutic goals
- Building and maintaining a therapeutic alliance through collaboration and feedback
- Developing individual cases formulations
- Applying cognitive and behavioural interventions in a clinically sensitive manner

Assessments – First Tape self-rated by student and submitted to supervisor

Evaluated by Student's Supervisor

with feedback to student & Course Director

Formative assessment with no marks carried forward

First Case Study – rated by Course Director / Lecturer

Formative assessment with no marks carried forward

Introductory Week – Medical Teaching Centre, St Patrick’s Hospital

| | Topic / Lecturers |
|-----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Monday 22nd September 9am – 12.30am</p> <p>12.30 – 1 pm</p> <p>2 - 4pm</p> | <p>Welcome to Course and Introduction to Structure of Course and Assessments Dr Brian Fitzmaurice</p> <p>Tour of St Patrick’s Hospital Ms Sinead O’Connell</p> <p>The Inside Track – The Former Student’s Experience Ms Neasa Guiney</p> |
| <p>Tuesday 23rd September 9am – 3 pm</p> <p>3pm - 5pm</p> | <p>Learning Theory Classical/Operant Conditioning in Anxiety Craig Chigwedere</p> <p>Exposure – 3 systems model Hot Cross Bun Hierarchy of exposure tasks Flooding Mr Craig Chigwedere</p> |
| <p>Wednesday 24th September 9- 5pm</p> | <p>The Cognitive Behavioural Model of Anxiety</p> <ul style="list-style-type: none"> • Phobias • Panic • Safety Behaviours • Safety Signals • Different Appraisals, different disorders • Why disorder specific treatments <p>Mr Craig Chigwedere/ Dr Mick McDonough</p> |
| <p>Thursday 25th September 9 – 4pm</p> <p>4:30 - 6.15pm</p> | <p>The Cognitive Behavioural Model of Depression</p> <ul style="list-style-type: none"> • Behavioural Activation • Self-monitoring, diary keeping • Cognitive Triad • NATs, Assumptions, Core Beliefs • Applying CBT for Depression <p>Ms. Colette Kearns</p> <p>Registration in Examinations Hall, Front Square, TCD</p> |
| <p>Friday 26th September 9 – 11am</p> <p>11.30 – 12.30pm</p> <p>2 – 3.45pm</p> <p>2 - 4.45pm</p> | <p>Introduction to Self Practice / Self Reflection Dr Brian Fitzmaurice & Mr Craig Chigwedere</p> <p>Review of Week Dr Brian Fitzmaurice</p> <p>Postgraduate Orientation Day Edmund Burke Theatre, TCD</p> <p>Registration in Examinations Hall</p> |

Friday Lectures / Workshops for Michaelmas Term– Emmet Ward Group Room

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| <p>Friday 3th October</p> <p>9- 10.30am</p> <p>11am – 5pm</p> | <p>Introduction to Web CT and E-learning resources Including Discussion Board Katie Armstrong, PC Lab, Trinity Centre for Health Sciences, St James’s Hospital</p> <p>The Basic Structure of CBT Sessions</p> <ul style="list-style-type: none"> • Collaboration • 2 way Feedback • Agenda Setting • Prioritizing and keeping focus • In session therapist assisted interventions • Linking sessions • Homework Review • Homework setting <p>Mr Craig Chigwedere</p> |
| <p>Friday 10th October</p> <p>9 – 10.30am</p> <p>11.00 am – 1pm</p> <p>2 – 4.30pm</p> | <p>Introduction to Library, PC Lab, Trinity Centre for Health Sciences, St James’s Hospital David Mockler Self Practice / Self Reflection Tutorial</p> <p>Therapeutic Relationship in CBT (1)</p> <ul style="list-style-type: none"> • Collaboration • Enablement • Empiricism – Scientist Practitioner Stance • Patient Centredness • Non-judgemental stance & Respect • Own beliefs • Empathy <p>Dr Brian Fitzmaurice</p> |
| <p>Friday 17th October</p> <p>9am – 10.30pm</p> <p>11am – 4.30pm</p> | <p>Selecting Patients for CBT Course Dr Brian Fitzmaurice</p> <p>Assessment in CBT</p> <ul style="list-style-type: none"> • Description of problems • Onset & Development of current problems • Maintenance cycles • Contextual factors – developmental factors, family, social & medical history, etc. • Patient Suitability <p>Mr Eamonn Butler</p> |

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| <p>Friday 24th October 9.00 – 11am</p> <p>11.30am – 1pm</p> <p>2 – 5pm</p> | <p>Self Practice / Self Reflection Tutorial</p> <p>Identifying Negative Automatic Thoughts</p> <ul style="list-style-type: none"> • Different types of thoughts • What are NATs • How do we elicit NAT's <p>Dr Brian Fitzmaurice</p> <p>Self Monitoring & Using Mood Logs</p> <p>Dr Brian Fitzmaurice</p> |
| <p>Friday 31st October 9am – 5pm</p> | <p>Behavioural Experiments</p> <ul style="list-style-type: none"> • Rationale and Evidence • Contrast with Exposure work • Identifying opportunities for B.E. • Setting up behavioural experiments and surveys • Evaluation and Review of B.E. <p>Setting Homework</p> <ul style="list-style-type: none"> • Rationale and Evidence • Collaborative identification of homework targets • Review of Homework • Problems/Resistance completing Homework <p>Ms Yvonne Tone</p> |
| <p>Friday 7th November 9 – 11.30pm</p> <p>From 11.30</p> | <p>Self Practice / Self Reflection Tutorial</p> <p>Verbal Challenging of Cognitions</p> <ul style="list-style-type: none"> • Socratic Questioning • Appraisal of Evidence • Decentring • Responsibility pies <p>Dr Odhran McCarthy</p> |
| <p>Friday 14th November 9 – 5pm</p> | <p>Using Written Thought Records</p> <ul style="list-style-type: none"> • Thought – Emotion linkage • 3/5 columns • Identifying Hot Thoughts • Building formulation <p>Mr Craig Chigwedere</p> |

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| <p>Friday 21st November 9 – 11am</p> <p>11.30 – 1pm</p> <p>2 - 5pm</p> | <p>Self Practice / Self Reflection Tutorial</p> <p>Cognitive Therapy Scale - Revised Dr Brian Fitzmaurice</p> <p>Writing Skills for CBT Mr Craig Chigwedere</p> |
| <p>Friday 28th November 9am – 5pm</p> | <p>Identifying & Testing Underlying Assumptions</p> <ul style="list-style-type: none"> • Downward Arrow • Thinking Errors • Evidence & Logic for and against Assumption <p>Mr. Simon Wale</p> |
| <p>Friday 5th December 9am – 10.30pm</p> <p>11.00 – 5</p> | <p>Self Practice / Self Reflection Tutorial</p> <p>Therapeutic Relationship (II) Dr Linda Finnegan</p> <p>First Recording & Case study to be submitted to supervisor for rating (Monday 8th December)</p> |
| <p>Friday 12th December</p> | <p>Introduction to Formulation in CBT Mr Eamonn Butler</p> |
| <p>Friday 19th December 9 – 11am</p> <p>11.30am – 1pm</p> | <p>Self Practice / Self Reflection Tutorial</p> <p>Review of 1st Term Dr Brian Fitzmaurice</p> <p>Afternoon Free</p> |

The learning objectives for **Hilary Term** are

Modules 3

Application of Cognitive Behavioural Model to Mood and Anxiety Disorders

- Understanding of adaptations of cognitive model to specific mood and anxiety disorders
- Application of wider range of interventions to meet individual patient needs
- Fostering resilience and creativity in clients through self-help assignments
- Terminating therapy and preparing patients for inevitable lapses in their recovery

Module 4

Application of Cognitive Behavioural Model to more complex disorders

Specific Learning Objectives:

- Understanding Adaptations of Cognitive Model to more complex disorders
- Understanding use of underlying schema in CBT
- Understanding limitations of CBT's evidence base

Assessment - Write-up of Case Study at end of second term

Literature Review and Final Essay Plan

Submission of 2nd tape with self-rating using Cognitive therapy scale

Both the Tape and Case Study are double marked and the average of the two examiners' marks is awarded

(Mark of 33/72 on CTS-R is a pass on this recording)

Essay Plan and Literature Review marked by Course Director/Lecturer

| | Topic / Lecturers |
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| Friday 9th January 9.00 – 11 11.15 - 1 from 1 | Self Practice / Self Reflection Tutorial Introduction to Database Searches David Mockler, PC Lab St James's Individual Student Meeting with Course Director / Lecturer – Feedback on First Term (14 Individual student appointments) |
| Friday 16th January | Cognitive Therapy for Depression Dr Sonya Collier |
| Friday 23rd January 9:30 – 11:00 11.15- 4.30 | Self Practice / Self Reflection Tutorial Panic in CBT Dr Edmond O'Dea |
| Thursday 29 th January Friday 30 th January | Cognitive Therapy for Psychosis (2 day Workshop) Prof Douglas Turkington and Alison Brabben |
| Friday 6 th February 9 – 11:00 11:00- 16:30 | Self Practice / Self Reflection Tutorial Social Phobia Dr Odhran McCarthy |
| Friday 13 th February | Cognitive Therapy for Phobic Anxiety Dr Michael Mc Donough |
| Friday 20th February | Mid Term Break |
| Friday 27 th February 9 – 11:00 11:00 – 4:30 | Self Practice / Self Reflection Tutorial Obsessive Compulsive Disorder Ms Yvonne Tone |

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| Friday 6 th March | Building the Formulation with the Patient Prof. Willem Kuyken |
| Friday 13 th March | Self Practice / Self Reflection Tutorial Understanding the use of Schema in CBT Dr Eamonn Butler |

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| Friday 20 th March | CBT for Trauma Dr Kate Gillespie |
| Friday 27 th March | Self Practice / Self Reflection Tutorial Termination in CBT TBC Monday 30 th March 2 nd Recording & Case study to be submitted |
| Friday 3 rd April | CBT for Treatment Resistant Depression Dr Anne Garland |

The learning objectives for **Trinity Term** are

Modules 5

Adoption of CBT Model to patients with adverse life conditions, low-ability patients and other challenging clinical contexts

Specific Learning Objectives:

- Understanding of use of CBT model in more challenging clinical contexts
- Adaptation of CBT model to different developmental stages
- Understanding that delivery of CBT is often determined by context of individuals

Module 6

Integration of individual and group CBT into the work of multi-disciplinary teams and use of self help and peer support models

10 ECTS - Lead

Specific Learning Objectives:

- Understanding of Application of CBT in Groups and Multidisciplinary Teams
- Integration of different models of CBT into own practice

- Personal Reflection and Articulation on own learning from Course

Assessment – Written Assessment Final Essay

Oral Presentation to Class on integration of CBT principles into own practice

Submission of 3rd Tape with self Rating on Cognitive Therapy Scale

The essay will be double marked by two examiners with the average of the 2 marks awarded

The Oral Presentation to the class will be marked by two examiners with the average of the two marks awarded.

The submitted Tape will be marked by two supervisors with the average of the two marks awarded. (A score of 36/72 on CTS-R is required for a pass)

Friday Lectures / Workshops for Trinity Term

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| Friday 24 th April 9:30 – 11:00 | Self Practice / Self Reflection Tutorial |
| 11:00 – 4:30 | Mindfulness Based CBT Dr Tony Bates / Judy Moran |
| Friday 1st May 9:30 – 1pm | CBT for Chronic Fatigue Mr Craig Chigwedere |
| 2pm to 5pm | CBT for Health Anxiety Dr Sonya Collier |
| Friday 8 th May | Self Practice / Self Reflection Tutorial CBT for Older Adults Dr Simon Wale |
| Friday 15 th May | CBT within multidisciplinary teams Dr Brian Fitzmaurice & Dr Anne O’Grady-Walsh |
| Friday 22 nd May | Class Presentations Mon 25 th May Submit Reflective Diary |
| Friday 29 th May | Supervision Masterclass Dr Stirling Moorey |
| Friday 5 th June | Deadline for submission of all course work Final Essay and 3 rd Recording |

Supervision

a) Overall Objectives

Supervision is the point where theory is translated into practice, and knowledge into skill. It is your opportunity to gain regular feedback on how your skills are developing. We should like again to encourage you to take an active role in supervision. This means, for example, thinking carefully about your objectives for each term, monitoring your own performance regularly by listening to your own therapy tapes, considering before each session what you particularly wish to work on, giving your supervisor feedback on what you find helpful and unhelpful, and so forth. You might wish to complete a supervision consultation sheet (appended and available on-line) in advance of supervision to crystallize issues to be discussed.

b) Minimum Requirements

While the course expects that you should see 5-6 patients for CBT during the academic year, you must have a supervised practice with a minimum of five patients in the course of the year. At the end of the course you must be able to demonstrate a minimum of 30 hours of supervised casework and demonstrate that you have used 3 disorder specific models (e.g depression, low self-esteem, panic, social phobia, simple phobia, GAD, OCD, PTSD, bulimia nervosa etc.) with different patients. We strongly advise you to have at least two patients in treatment at any time as a backup if the first patient drops out of therapy. You should also aim to practice cognitive psychotherapy skills with as many suitable clients as possible. There are two reasons for this: to ensure that you are not left unable to obtain supervision of case work by patients leaving treatment prematurely, and to broaden your range of experience.

Clinical responsibility for treatment carried out rests with you and the patient's original clinical team. If you have any doubts about clinical responsibility, you should discuss them at your place of work, with the patient's treating consultant, your supervisor, or with the Course Director.

c) Division of Time

Supervision takes place on a one-to-one or one-to two basis. Given the brief time available, it is important that supervision is clearly focused. You should decide what particular issue or question you wish to address in each session (remember that it is important to report successes as well as failures). Bringing recordings of therapy sessions is essential and you should pre-select relevant sections of therapy tape. You and your supervisor are jointly responsible for staying on track and ensuring discussion sticks to the point. It may also be helpful to ask yourself at the end of the session: "What have I learned/gained from today?" This means that supervision sessions should mirror the structure of cognitive psychotherapy sessions (agenda, items for discussion, closure/feedback).

d) Audio/Videotaping

The use of audio/video tapes of therapy sessions in supervision has been found to be of tremendous help in CBT training. It is worth experimenting with the use of audio/video taping before the course begins. Please ensure that you record sessions on a good quality machine with an external microphone. Inaudible tapes are frustrating and unhelpful. Ideally you should make two tapes of each session, one for you and one for the patient to take away and listen to at home.

Recordings of therapy sessions should be routinely brought to supervision and used as a focus for discussion. It is helpful to isolate in advance particular incidents on the tape on which you wish to focus (for example, agenda-setting, problems in applying a particular method, a hiccup in therapeutic relationship) rather than just listening freely.

We strongly advise you to make time to listen regularly to your own tapes and monitor your skills development using the Cognitive Therapy Scale Revised (CTS -

R). Listening to or watching tapes is often difficult to begin with, but improves with exposure!

e) Supervision Rotation

Trainees will be supervised by a different supervisor in the first and second half of the academic year. This is to give you a chance to experience different therapeutic and supervisory styles.

f) Monitoring Progress

The Cognitive Therapy Scale Revised, CTS-R, in essence encapsulates the skills we are expecting people to acquire over the course of the year, and can be used as a guide to good practice and a means of self-monitoring therapy tapes.

Supervisors will use the CTS-R to rate at least one of your therapy tapes each term. CTS-R ratings at the end of each term will be accompanied by a brief report pinpointing strengths and weaknesses and making suggestions for personal goals for the following term. We suggest that you rate your own tapes on the CTS-R and identify strengths, weaknesses and future goals for yourself.

At the end of the course, clinical performance will be evaluated on the CTS-R. Trainees must obtain a score of least 2 on all sub-scales in order to meet criterion for the award of Diploma. Scores of 2 mean that you are carrying out recognisable (but not necessarily good) cognitive psychotherapy. You however need to aim higher than this. The pass mark on CTS-R for your term 2 tape is 33/72 and on your term 3 tape the pass mark is 36/72 (50%).

g) Feedback

At the end of each term, you will be invited to provide feedback on the term's supervision. What have you learned? How far have you progressed towards your objectives? What did you find helpful? What would you have preferred more of? Less of? Different?

If there are any aspects of supervision you are not happy with, please do not wait until the end of term to say so. Please first address any problems with your supervisor directly. If things cannot be resolved, you and/or your supervisor should approach the Course Director. If the Course Director is the supervisor concerned, another member of the Course Steering Group may be approached.

h) Absences

It is inevitable that both students and supervisors will occasionally be absent because of annual leave, illness or other commitments. If there is a gap in supervision for more than three weeks for any reason, please inform the Course Director.

Evaluation/ Assessment

The mechanisms for assessment and examination of candidates for the Postgraduate Diploma course are outlined below.

Students will be required to write up two treated cases, one in the first and one in the second term. Each student will submit audiotapes/recordings of selected therapy sessions with clients they are treating during the year for evaluation. Tapes submitted by each student will be rated by the external examiner for the Diploma course using a standardised cognitive therapy rating for competency. Finally, students will be required to complete one long essay in the third term.

a) Attendance Requirements

You will need to attend at least 80% of course sessions. A session means a full day, from 9.00 am to 5.00pm. Naturally you will gain more from the course if you exceed the minimum, and again the expectation is that you will attend every week.

b) Assignments

Assessments

Term 1: Recording and Case Study

Deadline Monday 8th December 2008 at 5pm

At the end of the first term Students will submit a case study and one recording to be assessed for formative assessment (a learning exercise not contributing to end of year score). The case study will be submitted to the course administrator (cbtadmin@tcd.ie) by email and in hard copy, and the tape will be submitted to your own supervisor, who will rate it and give feedback to the student and the Course Director. You will receive feedback on both of these assignments and your general progress at the beginning of the second term.

The technical requirements for these recordings are as follows:

- The only media accepted are standard audio tapes, CDs and DVDs.
- Video submitted should be playable on a standard DVD player and using good quality media.
- Audio only submissions should be playable on a standard CD player.
- When buying media (DVD-R, DVD+R or CD-R) it is important that you do not buy the cheapest you can find. It is best to buy from a store that has a good selection and choose media from around the mid-range of prices. Do not insert more than one disc per disc holder, as this leads to scratches and damage. It is best not to submit discs that can be erased such as DVD+RW, DVD-RW, DVD-RAM or CD-RW.
- Voice recorders: These units are available in most consumer electronics stores such as Dixons, Argos and Peats. Prices range from €50 to €200+. You should ensure that you can transfer files to a computer with the model you purchase. You can also get accessories to improve recordings, such as standalone

microphones. One recommendation from a student last year is the Olympus Digital Voice Recorder (€129). It also doubles as a memory stick.

- Software for making a DVD-Video or CD-Audio is usually included with a PC that has the ability to make a DVD or CD. If you need to purchase this software it is widely available from PC software retailers. Roxio, Ahead Nero and iDVD (Apple) are some of the more well known DVD/CD creation software brands. For example, use Micromail for an educational discount:
<http://www.micromail.com/MMprodDetail.aspx?productid=7858>
- Trinity Public Access Computer room (including in St. James and in Tallaght or main campus) also have CD burning software installed as standard. Here are the instructions: http://isservices.tcd.ie/facilities/cd_burning.php
- Please submit **three** copies of recordings to Course Administrator on the submission dates.

Term 2: Recording (20% of final mark) and Case Study (20% of final mark)
Deadline Monday 30th March 2008

Each recording should be accompanied by a self rating of the therapy session using the CTS-R. These will be double marked with an average of scores awarded. There is a special sheet to be included with all recordings that must be fully filled out and sent along with your CTS-R self assessment, it is included as an appendix to this document as 'Recording Submission Sheet' and can also be downloaded as a Word document on WebCT. **These are marked out of 72. Pass mark in term 2 is 33/72 = 45.8%**
Pass mark in Term 3 is 36/72 = 50%

ONE further case study is to be submitted, at the end of the second term.

Term 3: Essay Plan (late penalties apply to final essay mark)
Deadline Mon 20th April 2008
Reflective Diary Mon 25th May
Recording (20% of final mark) and Final Essay (16% of final mark)
Deadline Mon 8th June 2008

There is an essay plan with literature review to be submitted at the beginning of the third term. This is really documenting the early steps of the process of writing your essay. It equates to a more elaborate form of the "rough work" that might be submitted with an essay on an exam paper. It would include an outline of the sections you might hope to cover in the final essay eg. introduction, historical perspective, recent evidence, limitations in evidence, models and theory, clinical relevance, future directions, discussion, conclusions. The headings given above are not necessarily going to be appropriate or fit for each essay title and students will need to think a little bit about what angle they want to take on a particular subject and where they are going to source information for each section – books, review articles, research papers.

The finished essay plan might just be a number of bullet points for each section with possible references to be cited and what the points they illustrate. There is no specific format that has to be followed. 3 or 4 x A4 pages would be sufficient and certainly it should be no more than 2000 words. It simply needs to demonstrate that you have

chosen your topic, are drawing together materials and have started to think about how you will present the essay. The essay plan does not confine or limit you to use only the literature cited or to follow the essay plan precisely. It would be anticipated that feedback and the intervening months would reshape the essay and its contents.

In terms of assessment – marks will be allocated for both the essay plan and the final essay. The essay plan would be worth 4% of the overall marks available for the essay with 16% of the marks going for the completed final essay. Students will get feedback on the essay plan and literature review by the end of April to allow them incorporate any feedback into the final essay. (Final essays – double marked with average of 2 marks awarded)

Overall Marking for the course:

Term 2 Case Study – 20%

Term 2 recording – 20% *

Term 3 recording – 20% *

Essay plan & Final Essay = 20%

Class Presentation – 20%

(*overall pass required on each recording is 33/72 in Term 2 and 36/72 in term 3).

No Compensation is allowed if students fail on recordings. Students are allowed to resubmit failed assignments once. Students may be offered further opportunities to resubmit work only at the discretion of the Course Director.

Students with a borderline fail (>40% and less than 50%) on written assessments might compensate if one of their other assessments scores >60%. Pass mark for the year is 50%.

Distinction is awarded to students who score at or above 70% on all assessments.

Handing in Assignments:

It is essential that you label your work carefully. It is also essential that you meet the deadlines laid out in this handbook, on the grounds of fairness and in order that we can return work to you in good time. When written assignments are submitted late, an initial 5% penalty will be incurred on work submitted after deadlines except in the case of illness where a doctor's note may be required. Furthermore a further 1% will be deducted for each week thereafter. Failure to submit a written assignment after 5 weeks will mean the assignment is failed. The course will reserve the right to deduct 1 mark from CTS-R scores on recorded material for every week after deadline for submission, up to a maximum of 4 points. Failure to submit a recording after 5 weeks will result in the assignment being failed.

Please submit assignments in two ways 1) place in envelope for Katie Armstrong and leave at reception of St. Patrick's Hospital and 2) email cbtadmin@tcd.ie (no need to email recordings).

Students who receive a fail mark on a submitted assignment, must resubmit the assignment within 6 weeks of being informed of their assignment result. Failure to do so will result in the assignment being failed. **N.B. Students can only resubmit an assignment once.**

In the case of essays and case studies these must be submitted as Microsoft Word documents (.doc) and should have the full title, a word count and your full name included on the title page. For those of you who do not have Microsoft Office, you can buy a copy of this software from Information Systems Services for approx €25. More information is available here: <http://isservices.tcd.ie/software/mscampus.php>

You can also avail of free training courses with ISS services. The timetable is available here: <http://isservices.tcd.ie/training/schedule.php>

Facilities and Practical Points

St. Patrick's Hospital

Students and Staff participating in the CBT course are guests of St. Patrick's Hospital and as such it is very important that we respect the excellent facilities that have been provided for us. In particular students must make sure they take all of their belongings and leave the room tidy at the end of teaching sessions. Failure to do so could jeopardise our access to these excellent facilities in future. Students can use St. Patrick's car park but will have to pay the relevant parking fees.

Seeing Patients

CBT is a practical skill and to get the most out of the course students should take the opportunity to see as many patients as is feasible during the year. We would like students to have an experience of some success with casework. Accordingly we recommend that cases chosen at the outset are not highly complex. Ideally the first cases chosen should be anxiety disorders or depression that is not too chronic in nature. All cases should be discussed with your supervisor before contracting to take a patient on as a training case.

We would like to see students working with two different patients each week, so that they are getting maximal benefit from teaching and supervision. Students often discover that finding appropriate cases is more challenging than they had anticipated. If you are encountering difficulties please let your supervisor and/or the Course Director know as soon as possible. We encourage students to see patients in their normal working hours but accept that this may not be feasible for all students and patients. It is important that students have appropriate protected time for seeing patients during the course and if you are experiencing problems with this please inform the Course Director.

Confidentiality

Students are reminded of the importance of patient confidentiality. Whilst it is inevitable that during workshops and supervision there will be dialogue about patients you are treating, one must remember that there is the possibility that the patient in question may be known by someone within the class or course staff. The identity of patients must not be discussed with colleagues especially in public places such as corridors, canteens, buses etc where conversations may be overheard.

Because recording is an essential part of supervision and assessment students must ensure that no patient identifiers are included with the recorded material e.g. initials, date of birth etc. Recordings are best marked with your name and as 'case 1, session 4' etc. Ideally, they should have your name and contact details on the box in case they are mislaid.

Library Access

The facilities of the Trinity Library are completely at your disposal. Specialised texts in cognitive psychotherapy have been assembled for the course and to borrow these materials contact the Course Coordinator. The staff of the John Stearne Medical Library in the TCD Health Sciences Building, St. James's Hospital, are especially helpful in locating core texts in cognitive psychotherapy. It is anticipated that Library facilities in St Patrick's will also be available to students.

E-Learning Resources

Our e-learning resources are based in WebCT, an online learning support system which houses your lecture notes and other important course materials. You can access WebCT at:

<http://webct.tcd.ie>

You need to enter your Trinity username and password (the ones given to you at registration) in order to log on.

Once inside WebCT you can access all of the information from the welcome page. You can choose to download course materials onto your own machine or look at them online by clicking 'save' or 'open' respectively. Some documents are also in PDF format and can be opened from within WebCT or downloaded.

Study Time

You are expected to do some 10 hours of private study each week throughout the year. The amount you actually need to do will, to some extent, depend on how much you already know about cognitive psychotherapy. However, we would strongly encourage you to keep your Fridays free, not only during term time, but throughout the year, so as to give yourself ample time to read, to listen to therapy tapes and to complete written assignments. Your work colleagues and managers (and families) will need to know this is a priority.

Lunch

Lunch is available in the St. Patrick's Hospital Canteen.

Good Practice

The course endorses good clinical practice through informing students of relevant literature and current research and promoting the systematic evaluation of therapy interventions. At all times, reflection and creativity is encouraged in adapting the model to the unique circumstances of each patient and to the therapists individual style.

We encourage all students to join the British Association of Behavioural and Cognitive Psychotherapies(BABCP) as a relatively inexpensive way of orientating yourself to current issues in this area and to become more aware of opportunities for professional development such as attendance at conferences, books, journals etc. Further information is available at www.babcp.com. It also provides the latest information on the process of accreditation as a cognitive behavioral therapist.

Students must maintain high standards of professionalism and practice cognitive therapy in an ethical manner. If course staff become aware of any lapses of professional standards or unethical conduct, the course reserves their right to report this to the relevant College Officers and/or the students professional body or employer. The student will be informed of such action in writing by the Course Director.

Complaints Process

The philosophy of the course is that students and staff are nurtured as individuals and are encouraged to achieve their full potential. The course is committed to excellence in teaching and supervision and to the enhancement of the learning experience of each student. Each year, we ask the class to elect a class representative who will sit on the course advisory committee and this can be an effective means of raising student issues on a regular and structured basis.

We are, however, aware that at times the student experience may fall below the expected standard. In these instances we encourage and welcome feedback from students. In the first instance minor issues might be raised informally with your supervisor or the course director, or indeed any member of the course staff. If this fails to remedy the situation then we would encourage you to make a formal complaint directly to the Course Director. This may either be verbal or in writing. If the complaint is regarding the Course Director then the complaint would be best addressed to the Head of Department of Psychiatry, Professor Michael Gill, Trinity Centre for Health Sciences, St. James's Hospital, Dublin 8, tel. (01) 896 2463/2241.

Plagiarism

The course and Department of Psychiatry takes any form of plagiarism very seriously. Written work will be checked using anti-plagiarism software, see <http://www.turnitin.com>.

The attention of students is drawn to the Calendar entry on plagiarism in section G13, paragraph 56-63.

College regulations

The Senior Lecturer has requested that the following paragraph be included in Departmental Handbooks to reflect the primacy of the General Regulations over information contained in departmental handbooks.

‘During the registration process, all students must sign the registration form to confirm, among other things, that they have received a copy of the Board’s General Regulations for students and that they are applying for registration in accordance with the provisions of such regulations.

In the event of any conflict or inconsistency between General regulations and the departmental handbooks, the provisions of the General regulations shall prevail.

Course Staff and Contact details

| Name | Email Address | Title |
|------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Dr Brian Fitzmaurice | cbtdir@tcd.ie | Course Director, Department of Psychiatry, TCD |
| Katie Armstrong | cbtadmin@tcd.ie | Administrator |
| Professor Michael Gill | mgill@tcd.ie | Head of Department, Department of Psychiatry, TCD |
| Dr Gary Donoghue | donoghug@tcd.ie | Lecturer in Psychology, Department of Psychiatry, TCD |
| Dr Brendan McCormack | mccormackbenno@eircom.net | Consultant Psychiatrist & Psychotherapist, Adelaide and Meath Hospital incorporating the National Children's Hospital (AMNCH) |
| Dr Michael Mc Donough | mmcdonough@stpatsmail.com | Consultant Psychiatrist and Cognitive Behavioural Therapist, St Patrick's Hospital, Dublin |
| Dr Sonya Collier | scollier@stjames.ie | Principal Clinical Psychologist, Department of Psychological Medicine, St James's Hospital, Dublin |
| Dr Deirdre Dunne | ddunne71@eircom.net | Principal Psychologist, Dublin West & South West Mental Health Services & Department of Psychiatry, Adelaide & Meath Hospital incorporating the National Children's Hospital (AMNCH), Tallaght |
| Mr Odhran McCarthy | omccarthy@mater.ie | Senior Clinical Psychologist, Mater Misericordiae Hospital, Dublin 7 |
| Ms Yvonne Tone | ytone@tcd.ie | Student Counsellor, The Student Counselling Service, Trinity College Dublin |

For further information contact:

The Course Coordinator
Katie Armstrong
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Trinity Centre for Health Sciences
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St James's Street
Dublin 8
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Appendices

Reading List 08-09

Introductory texts for Cognitive Behavioural Therapy

- Beck, A.T; Rush, A.J; Shaw, B.J; Emery,G. (1979) *Cognitive Therapy of Depression*. Guilford Press, New York
- Beck, A.T; Emery,G; Greenberger, R.L (1985) *Anxiety Disorders and Phobias: A Cognitive Perspective*. Guilford Press, New York
- Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford.
- Blackburn, I; Davidson K. (1995) *Cognitive Therapy for Depression and Anxiety*. Blackwell
- Greenberger, D; Padesky, A. (1995) *Mind over Mood - Change How you feel by Changing the way you Think*. Guilford Press, New York
- Kinsella, P, Garland, A (2008) *Cognitive Behavioural Therapy for Mental Health Workers: A Beginner's Guide*. Routledge.
- Moore, RG & Garland, A. (2003) *Cognitive Therapy for Chronic and Persistent Depression (Wiley Series in Clinical Psychology)*. John Wiley & Sons Ltd, England
- Padesky, A; Greenberger,D. (1995) *Mind over Mood - Clinician's Guide*. Guilford Press, New York
- Persons, J.B. (1989) *Cognitive Therapy in Practice: A case formulation approach*. Norton, New York
- Stone,R; Drummond,L. (1991) *The Practice of Behavioural and Cognitive Psychotherapy*. Cambridge University Press
- Hawton, K., Salkovskis, P.M., Kirk, J., & Clark, D. M. (1989). *Cognitive behaviour therapy for psychiatric problems: A practical guide*. Oxford: Oxford University Press.
- Schuyler,D. (1991) *A Practical Guide to Cognitive Therapy*. Morton & Co, New York
- Wells, A. (1997) *Cognitive Therapy of Anxiety Disorders*. John Wiley and Sons

Introductory Texts for Mental Health Disorders:

- ICD-10 International Statistical Classification of Diseases and Related Health Problems: Tabular List v. 1 Tenth Revision. Second Edition. World Health Organisation, Geneva. 2004
- DSM IV - Diagnostic and Statistical Manual Version 4, American Psychiatric Association, Washington D.C. by American Psychiatric Association

Oxford handbook of psychiatry (2005) Edited by David Semple, Roger Smyth, Jonathan Burns, Rajan Darjee, Andrew McIntosh. Published by Oxford University Press, Oxford.

Kaplan, H.I. and Sadock B.J. (1991) *Synopsis of Psychiatry* (6th Ed.). Baltimore: Williams & Wilkins.

More Advanced Texts

Leahy, R.L. (2003) *Cognitive Therapy Techniques: A Practitioner's Guide*. Guilford Press

Salkovskis, P.M. (1996) *Frontiers of Cognitive Therapy*. Guilford Press, New York

Segal, Z.V et al (2002) *Mindfulness based Cognitive Therapy for Depression*. Guilford Press, New York

Tarrier, N; Wells, A; Haddock, G. (1998) *Treating Complex Cases: The Cognitive Therapy Approach*. John Wiley and son

Vallis, T.M; Howes, J.L; Millar, P.C. (1991) *The Challenge of Cognitive Therapy: Applications to Non-Traditional Populations*. Plenum Press, New York

Specialist Texts

Beck, A.T et al (1990) *Cognitive Therapy of Personality Disorder*. Guilford Press, New York

Davidson, K. (2000) *Cognitive Therapy for Personality Disorder*. Arnold Publishers

Foa, E; Freedman, I.E; Keen, T. (2002) *Effective Treatments for Post Traumatic Stress Disorder*. ISTSS Guidelines

Follette, C. (2001) *Cognitive-behavioral Therapies for Trauma*. Guilford Press, New York

Fowler, D; Garety, P; Kuipers, E.. (1995) *Cognitive Behavioural Therapy for Psychosis*. Wiley and Sons, West Sussex

Jenike, M.A (1998) *Obsessive-Compulsive Disorders*. Mosby

Linehan, M. (1992) *Cognitive Therapy for Borderline Personality*. Guilford Press, New York

Roth, A; Fonagy, P. (1996) *What works for whom?* Guilford Press, New York

Snyder, U; Orner, R.O. (2002) *Reconstructing Early Intervention After Trauma*. Oxford University Press

Young, J.E. (1991) *Cognitive Therapy for Personality Disorders: A Schema Focused Approach*. Practitioner Resource Series, Professional Resource Exchange inc, Sarasota, Florida

Self Help Texts (Overcoming XXXX Series, Constable Robinson, London)

Butler,G. (1999). *Overcoming Social Anxiety and Shyness*

Davies, W. (2000). *Overcoming Anger and Irritability.*

Fairburn,C.G. (1995) *Overcoming Binge Eating.* (Guilford Press, New York)

Fennell, M. (1999). *Overcoming Low Self-Esteem*

Freeman, C. (2002) *Overcoming Anorexia Nervosa: A self-help guide using Cognitive Behavioural Techniques.*

Gilbert, P. (1997) *Overcoming Depression: A self-help guide using Cognitive-Behavioural Techniques.*

Herbert, C. (1999) *Overcoming Traumatic Stress.*

Scott,J. (2001) *Overcoming Mood Swings.*

Veale, D & Wilson, R.(2005) *Overcoming Obsessive Compulsive Disorder*

How to Use the Harvard Referencing System

1. How to refer to an author's work within the text

🕒 **The author(s) and year of publication are cited in the text.**

Example 1

One study has shown that there was an increased incidence of cerebral palsy in preterm babies monitored by continuous electronic fetal heart rate monitoring as compared to those babies monitored by intermittent auscultation (Sky, 1990).

Example 2

The solid phase enzyme immunoassay has been shown to be an excellent technique for cytokine estimation generally (Hirano et al, 1992; Moscovitz et al, 1994; Kita et al, 1994).

In the examples above the sources are cited chronologically i.e. the oldest source first and separated by a semicolon. The full stop is placed after the closing bracket.

🕒 **If the author(s) surname is part of a sentence then the date only appears in brackets.**

Example 1

Booth (1996) states that the time spent thinking carefully about the essay title and examining precisely what is required is a vital part of producing a good essay.

Example 2

Booth (1996) and Smith (1997) agree that...

Example 3

According to Roper, Logan and Tierney (1990) no individual model of nursing can be perfect.

Example 4

Gold et al (1997) found that ...

If there are three authors or less, all names are included in the text, as shown in Examples 1, 2 and 3.

If more than three authors have written the item only the first author's name followed by et al needs to be included in the text as is shown in Example 4.

🕒 **Works published by the same author(s) in the same year**

Works published by the same author(s) in the same year are assigned the letters of the alphabet in ascending order.

Example

Gold (1998a, 1998b) has suggested that...

This principle also applies to different authors with the same surname and same year of publication.

2. Using quotations

Quotations are borrowed phrases that state something effectively and economically. However, be very careful not to overuse them as the logical flow or theme can become disjointed. A collection of random quotations, even though they relate to the same topic, is unacceptable.

Do not begin a sentence with a quotation but integrate it into your essay/assignment/ project i.e. within a sentence or at the end of a sentence.

Direct quotations must be reproduced exactly as they are printed in the original text and enclosed within quotation marks. The author, year and page number on which the quotation is to be found must also be included.

Example

As Faulder (1995:34) has already stated, informed consent is “the right to know and the right to say no”.

2.1 Short quotation as part of a sentence

A short quotation is a sentence or part of a sentence quoted with the text.

Example 1

According to Slade and Churchill (1997:5) there are “several potential targets in the life cycle

of the virus for drugs to act against HIV”.

Example 2

It has been stated that “good quality infection control procedures remains the prime means of prevention of occupationally acquired blood borne viruses” (Moyle, 1997:2).

2.2 Block or large quotation

Block quotations should be used sparingly. These are quotations that comprise more than one sentence and should be enclosed in quotation marks. The quotation should be indented 1 centimetre from both text margins, printed in single line spacing and must also include the page number(s) of the source. Use triple space at the beginning and at the end. Do not use bold or *italic* in this section, unless it appears in the original text. Then continue as usual again with the essay or project text.

Example of block or large quotation

Kitzinger (1980:290) describes the adjustment to motherhood in the following way:

“Psychologically, the first months after birth are a time in which great adjustments are necessary. The mother - even though she hesitates to admit it often harbours a secret resentment against the baby who has deprived her of her freedom and the leisure of bachelor girl life... Now she may have no money of her own, no personal allowance and no joint bank account, she has to squeeze money for her clothes, her personal luxuries and presents from housekeeping money. She feels tied down by maternity and domesticity. She struggles with tasks for which she has not been trained and which recur day after day with monotonous regularity.”

3. Using primary and secondary sources

A primary source is defined as the original piece of work by an author. A secondary source would be defined as work cited within the literature you are using. Secondary sources should only be used when primary sources are not available.

Example of a secondary source

Melzack and Wall (1965), as cited by Moore (1997:24) introduced the gate-control theory as an explanation for pain perception.

Secondary source in the reference list

Moore, S. (1997) *Understanding Pain and its Relief in Labour*. London: Churchill Livingstone.

4. How to write a bibliography

A bibliography is a list of literature e.g. journal articles or books on a given subject which you have read or consulted and found relevant but not cited in your text. A bibliography is also found at the end of the text and after the reference list and is presented in the same way.

5. How to write a reference list

A list containing the full details of all the references used in the text must be included at the end of the assignment. This should appear on a separate page and be entitled **References**. The list must be arranged in alphabetical order using the surname of author(s).

Definitions of phrases used within this section.

🕒 **Title case:**

Capitalise the first letter of each word with the exception of small words e.g. and, an, in, of

Example 1

The Research Process in Nursing

Example 2

Understanding Pain and its Relief in Labour

🕒 **Sentence case:**

Capitalise the first letter of the first word and use lower case letters for all other word, except where the word would normally have a capital letter e.g. name of country

Example 1

The research process in nursing

Example 2

Understanding pain and its relief in labour

5.1 Referencing a book

- Author(s) surname plus initial(s) in full. Initials should be in the format 'A.B.'
- Year of publication
- Title, underlined (use title case) followed by a full stop
- Volume number, if the book has more than one volume number
- Edition no. if later than first edition
- Place of publication: if there is more than one place name given, use the first on the list
- Publisher's name. Publication details should be in the format 'Publisher: Place'

Example - please take note of the punctuation used:

Stuart, G.W. and Sundeen, S.J. (1987) Principles and Practice of Psychiatric Nursing. St Louis: C.V. Mosby.

5.2 Referencing a chapter in an edited book

- Surname of chapter author(s), followed by initial(s) in full
- Year of publication of chapter (if not available, use year of publication of book)
- Title of chapter (use sentence case)
- In:

- Surnames of editors followed by initial(s) in full
- Followed by (ed) or (eds)
- Year of publication of book, if different from year of publication of chapter
- Title of book, underlined (use title case)
- Edition number
- Place of publication: if there is more than one place name given, use the first on the list
- Publisher's name

Example 1 - please take note of the punctuation used:

Hunt, M. (1991) Qualitative research In: Cormack, D.F.S. (ed) The Research Process in Nursing. Oxford: Blackwell Scientific.

Example 2 - please take note of the punctuation used:

Morse, S.A. (1995) Cell structure In: Brooks, G.F., Butel, J.S. and Ornston, L.N. (eds) Medical Microbiology. 20th Edition. London: Prentice-Hall International.

5.3 Referencing a journal article

- Author(s) surname plus initial(s) in full
- Year of publication
- Title of article (use sentence case) followed by a full stop
- Title of journal in full, underlined (use title case)
- Volume number
- Issue number, in brackets
- The number of the first and last pages on which the article appears

Example 1 - please take note of the punctuation used:

Nikkonen, M. (1995) The life situation of a long-term psychiatric patient: Some restrictions in, and possibilities of, open care. Journal of Advanced Nursing 22 (1): 101-109.

Example 2 - please take note of the punctuation used:

Hek, G. (1996) Guidelines on conducting a critical research evaluation. Nursing Standard 11 (6): 40-43.

5.4 Referencing a publication by a government agency or other organisation

When referencing a book or report published by a government agency/organisation/corporation, and no individual is named as the author, the general rule is to name the department or body that issued the document in both text and reference list. If the country of origin is other than Ireland, this should be identified as in Example 2.

If the report has a chairperson then the name of the chairperson is referenced in both the text and also in the reference list. If the Department of Health reference refers to the United Kingdom just add UK after the word Health as in the following examples. The reference is in the same style as that of a book.

Examples-please take note of the punctuation used: In the text

Example 1

The main issues of concern here are... (Department of Health, 1994).

Example 2

A report was carried out and found that... (Department of Health UK, 1993).

Example 3

Mac Glennain (1983) found...

In the Reference list

Department of Health (1994) A Health Promotion Strategy: Making the Healthier Choice the Easier Choice. Dublin: Department of Health.

Department of Health UK (1993) Changing Childbirth Part 1: Report of the Expert Maternity Group. London: HMSO.

Mac Glennain, S. (1983) The Education and Training of Severely and Profoundly Mentally Handicapped Children in Ireland. Dublin: Stationery Office.

5.5 Referencing a dictionary/directory/encyclopaedia

The reference is in the same style as that of a book.

Example - please take note of the punctuation used:

Anderson, K. N. and Anderson, L. E. (1995) Mosby's Pocket Dictionary of Nursing, Medicine and Professions Allied to Medicine. UK Edition. London: Mosby.

5.6 Referencing an open learning package

The reference in the text is in the same style as that of a book.

Reference list example - please take note of the punctuation used:

Open College (1992) Nursing Studies: Unit 12: Nursing Models. Manchester: Open College.

5.7 Referencing a video

The reference in the text is in the same style as that of a book.

Reference list example - please take note of the punctuation used:

Open Space (1994) Open Space: Scratching the Surface. London: BBC (Video recording).

5.8 Referencing unpublished sources/theses/dissertations

These sources are used in exceptional circumstances and for information that is not already published. However, these sources should be used economically in assignments. Referencing within the text is the same as journal articles or books. In the reference list, the word 'unpublished' is used.

Examples - please take note of the punctuation used:

In the text

Decreased serum levels of IL-6 was found in this small patient group post prednisolone treatment (Clemenger, 1996).

“Participants identified that the initial experience was a difficult, but a satisfying and interesting one, and that utilising the framework became easier with practice and gave them confidence” (Fleming, 1997:75)

In the reference list

Clemenger, M. (1996) Variation in Serum Interleukin-6 and C Reactive Protein in Polymyalgia Rheumatica/Giant Cell Arteritis. University of London: Unpublished Masters Thesis.

Fleming, S. (1997) Developing a Framework for Introducing Self-Directed Learning Skills for First Year Student Nurses. Dublin City University: Unpublished Masters Dissertation.

5.9 Referencing a personal communication

A personal communication should only be used in exceptional circumstances with the permission of the individual concerned and is usually confined to issues/comment not freely available in text form.

In the text

Monaghan (1997, personal communication) agrees that the heart without words is better than words without heart.

In the reference list

Monaghan, A. (1997) Personal Communication

5.10 Referencing reprints

Reprints will be accepted for referencing purposes providing the article is from a journal not readily available to you. You must however acknowledge that you have not accessed the original journal. The journals MIDIRS Midwifery Digest, and Learning Disability Bulletin, reprint articles from a wide variety of journals. The references should be cited as follows:

Examples - please take note of the punctuation used:

In the text

Levy (1999) states that in order to make choices, women needed information that they trusted.

Turner and Sloper (1996) found that...

In the reference list

Levy, V. (1999) Maintaining equilibrium: A grounded theory study of the processes involved when women make informed choices during pregnancy. Midwifery 15 (2): 109-119 In: MIDIRS Midwifery Digest (1999) 9 (4): 454-462.

Turner, S. and Sloper, P. (1996) Behaviour problems among children with Down's Syndrome and parental appraisal. Journal of Applied Research in Intellectual Disabilities 9 (2): 129-144 In: Learning Disability Bulletin (1997) 107: 4.

5.11 Referencing a newspaper

Newspaper articles are referenced similar to a journal article in both the text and in the reference list. It is recognized however that not all of these details are always available on newspaper articles. You should use as much detail as you can obtain.

- Name of journalist (if known)
- Date of paper by year
- Title of article (use sentence case)
- Title of newspaper in full, underlined (use title case)
- Date of publication
- The number of the first and last pages on which the article appears

Example 1 - please take note of the punctuation used:

Hoff, M. (2000) Quality of life in rural Ireland. The Irish Weekend Herald 24th May: 5-6.

5.12 Referencing from the Internet and other electronic sources

This could include sources from full text compact discs, electronic journals or other sources from the Internet. This can be quite a complex source to include in referencing for your work.

Electronic sources of journals can be referenced similar to manual copies with the addition of the electronic details.

5.12.1 Referencing a journal article from the Internet

In the text

The reference in the text is in the same style as that of a book.

In the reference list

- Author(s) surname plus initial(s) in full
- Year of publication
- Title of article (use sentence case)
- Title of journal, underlined (use title case)

- Type of medium in brackets (use 'Electronic' if you are unsure if it is online or networked CD-ROM)
- Volume number
- Issue number
- The number of the first and the last pages or indication of length
- "Available" statement: supplier/database name/identifier or number if available
- Item or accession number
- Access date

Not all of these details will necessarily be applicable to every electronic source however the site, path and file are usually found at either the bottom or the top of each downloaded page.

Example - please take note of the punctuation used:

Skargren, E.I. and Oberg, B. (1998) Predictive factors for 1-year outcome of low-back and neck pain in patients treated in primary care: Comparison between the treatment strategies chiropractic and physiotherapy. Pain (Electronic) 77 (2): 201 (7pp) Available: Elsevier/ScienceDirect/SO304-3959(98)00101-8 (8th February 1999).

5.12.2 Referencing a World Wide Web (www) page

- Author(s) surname plus initial(s) in full
- Year of publication
- Title, underlined (use title case)
- Type of medium
- Publisher, is available
- Site/Path/File
- Access date

Example - please take note of the punctuation used:

Smith, M. (no date) The Culture in Nursing Education (online). Available: <http://www.aol.com/astanart/smith/smith.html> (10th November 1997).

Supervision Contract

Section 1 Nature of Supervision

1A. Supervision will occur at roughly weekly intervals during academic terms at a mutually convenient time and place. Individual supervision will last 1 hour and joint supervision of 2 supervisees will last for 90 minutes.

1B. We agree that supervision may address, as appropriate, any of the following

(Delete any that do not apply)

- 1) Assessment issues including suitability
 - 2) Diagnostic issues and their implications
 - 3) Risk to patient, therapist, staff or others
 - 4) Case conceptualisation / formulation
 - 5) Therapeutic relationship and engagement issues
 - 6) Treatment planning including relapse prevention, discharge, boosters and follow-up
 - 7) Fundamental therapeutic skills and techniques
 - 8) In session practice or rehearsal of skills / techniques
 - 9) Discussion of therapeutic strategies
 - 10) Review of video or audio tapes
 - 11) Direct observation
 - 12) Supervision homework
 - 13) Reading
 - 14) The therapist's own reactions to and beliefs about aspects of their clinical or professional practice
 - 15) Factors that may interfere with the therapist's ability to act in a competent or professional manner
 - 16) Clinical guidelines, manuals, patient material, etc.
 - 17) The supervisory relationship, as necessary
- Contextual or organisational issues that may impact on practice or supervision

1C. Describe for access to supervisor in the event of emergency with one of the supervised cases?

1D. Describe steps if the supervisor is absent, whether planned or unplanned?

1E. Describe steps that will be taken if the supervisee is absent, whether planned or unplanned?

Section 2 – Responsibility and Indemnity

2A. If applicable, is a Letter of Access for supervisee obtained from General Manager of host organisation for supervisee to see patients?

2B. Explicit clinical responsibility issues for patient(s)

Person holding clinical responsibility:

.....

2C. If applicable, is there professional Indemnity Insurance if patient not seen within the Health Service/Hospital.

Supervisee Insured?

Supervisor Insured?

2D. Clear provision for taping sessions, including explicit patient consent for use in supervision?

2E. Explicit agreement with patient about conditions of tape viewing

By supervisor?

By fellow supervisee/s?

By other parties (e.g. assessors)?

2F. Are supervision tapes part of the medical record?

Section 3 Conditions of Supervisory Relationship

3A. Explicit discussion of confidentiality of supervision (including supervision records)

We agree that it is expected that the content of supervision be strictly confidential unless

- 1) issues arise that concern codes of professional practice such as professional malpractice or where disclosure is necessary for the safety of patients, people around them, or staff,
- 2) requested by Court of Law, Coroners Office, or Professional Body,
- 3) serious difficulties arise in supervisory relationship,
- 4) serious issues arise related to course or placement requirements.

In all cases, especially the last two, whenever possible, it is considered good practice for either party to inform the other(s) before disclosure to the relevant person.

Please append any outcome of discussion or additional agreements or action plans

3B. Explicit discussion of procedures in event of deterioration of the supervisory relationship.

We agree that in the event that the supervisory relationship deteriorates when there is no question of inappropriate behaviour by either party, supervisor and supervisee will first attempt to resolve the issue together, and in the event that the difficulty is not resolved or both parties agree that outside help is required, then the following person(s) should be contacted immediately.

Name _____

Role _____

Name _____

Role _____

Please append any outcome of discussion or additional agreements or action plans

3C. Explicit discussion of procedures should personal circumstances or placement requirements necessitate review of supervision arrangements.

We recognise that supervisors and course directors have a duty of care for supervisees and those affected by their actions. We agree that should personal circumstances or placement requirements necessitate the review or alteration of current supervision arrangements, these matters will first be discussed by those parties involved in the initial supervision agreement.

We also agree that an approach may be made by those parties affected by a revision of supervision agreements to those persons who would necessarily be involved in the organisation of the placement, namely:

Name _____

Role _____

Name _____

Role _____

Please append any outcome of discussion or additional agreements or action plans

Consent Form for Audio/Visual Recordings

USE HOSPITAL OR SERVICE HEADED PAPER

Consent form for Audio / Video Recordings

Patient Name.....

Patients Consultant.....

Date of Recording.....

Place of Recording.....

Clinician Responsible for recording.....

Nature of Recording:

Audio Recording to be used in clinical supervision

Video Recording to be used in clinical supervision

Purpose of Recording:

For Supervision and Assessment of a therapist as part of clinical training

Restrictions to use of Recording:

This recording will not be used by non-clinical staff.

It will only be listened to / watched by the therapist, their supervisor, co-supervisee, and assessors.

The recording will be erased after one year.

Special Comments:

Consent:

I have read, understand and agree with the information given above. I understand that I may withdraw my consent to use of this recording at any time in the future and that to do so I should contact the responsible clinician noted above.

.....
Signature

.....
Date

Supervision Planning

Setting Up Supervision: Strengths, Needs, Goals...

Time spent in carefully setting up supervision will save time later and will enhance the quality of the supervisory experience (and therefore, we hope, improve the service clients receive). Use this guide to help you and your supervisor to:

- Select the best points of focus for your supervision (what will you most need to talk about, practice, read around, experience...);
- Set the goals you need to meet in order to get the best out of your diploma training (what are you going to try and achieve with respect to your knowledge of cognitive therapy? Which skills do you most need to improve to what level? What steps forward in self-awareness will you need to make?)
- Agree the roles that you, your supervisor, your fellow-supervisee will need to adopt at different points in order to meet your goals.

Using This Guide

The guide offers you four areas within which supervision goals might fall: specific therapeutic skills (using CTS-R as our guide); awareness (of self, interpersonal processes and theory); learning styles or emphases (using a Kolbian approach); likely responses to the stresses of developing new skills. It is unlikely that you will use all four areas equally. Therefore read through the guide first, before selecting the areas that strike you as being most likely to help you in developing your goals. Also listen to your supervisor's perspective on which areas of the guide might be of use to you. Remember also to come back to your goals at frequent intervals to check how you are getting on towards achieving them, and to consider what new goals you might want to set. Use this guide in conjunction with the "Strengths and Needs" sheet in your supervision folder. You will find examples of goal-setting presented on the sheet, together with a format that you may find helpful for documenting the goals you identify as you work through the guide.

Specific Therapeutic skills

In order to pass the course, you will need to demonstrate competence on the core skills of cognitive therapy. More importantly, you will need to consistently use these skills in your therapy sessions for your clients to get maximum benefit from seeing you. You will be assessed using the Cognitive Therapy Scale Revised (Blackburn, James, Milne & Reichelt 2001), which outlines twelve areas of competence. The scale and its manual are included in your course folder.

- Look through the scale, first by yourself and then with your supervisor and consider which areas represent your strengths, which the aspects of your practice needing most work.
- Write into your supervision folder the areas you and your supervisor agree to focus on most strongly, and use this record each week in guiding your agenda setting in supervision
- As soon as possible on starting the course, make your baseline tape and "mark" yourself using CTS-R. Then give the tape to your supervisor to mark "blind" to your mark. Then compare notes and reconsider your first thoughts on the skills you will most need to address in your supervision

- It is important that skills development and practice forms a regular part of your supervision sessions. These are intended to actively develop your skills, not only function as case discussion/management forums.
- Realistically, it is unlikely that you will be able to focus on a great many of these items, so as a rough guide, try choosing no more than three or four areas on which you will focus
- Review your progress in these skills at least on a termly basis, and make adjustments in your agreement re skills focus according to progress made and difficulties encountered.

Self- Interpersonal- and Theoretical Awareness

Delivering therapy does not just entail an encounter with the feelings, thoughts, behaviours and lives of our clients, but also an important and often powerful encounter with our own attitudes. Likewise, undergoing training is not, for a lot of us, simply a technical matter of developing new knowledge and technique, but a journey requiring us to reconsider our views of ourselves as practitioners.

Consider, in your personal reflections, and in dialogue with your supervisor, what are the issues that are likely to be of personal importance in these areas. You might find the following headings a useful guide to your reflections.

- How do I get on with **recognising** my clients feelings in therapy? With noticing emotional shifts, non-verbal communications, subtle resistances to change?
- How am I at **showing** my clients that I understand their problems, their difficulties in achieving learning, that I grasp the reasons for their "stuck" and unhelpful actions? How do I get on sharing a rationale for change with my clients, especially if they have difficulties in grasping it?
- Are there emotional hotspots for myself in treating clients? Perhaps I find certain disorders difficult, or certain interpersonal actions in my clients? **How am I at noticing my own thoughts, feelings, actions** in therapy?
- The interpersonal encounter does not happen in a theoretical vacuum. We are seeking to deliver therapy based on cognitive and behavioural principles, and on specific models of psychological processes. Are there areas of such **knowledge** that I will need to particularly develop over my diploma training?
- Note down your thoughts on these matters in your supervision folder.
- Discuss with your supervisor & incorporate the findings of your discussion into your goals.
- Use baseline tape observations/discussions to review your initial ideas on these issues.
- Having identified issues, make sure you reflect on them before each supervision session so that they will inform your agendas
- Review regularly -at least each term

How I respond to learning

Learning can be viewed as a four-phase process incorporating concrete experience, reflection, conceptualisation, and planning (Kolb 1984). It appears that each of us is likely to have a learning style that leans to one or more of these phases, perhaps at the

expense of due attention to the others. Some of us are active doers, revelling in concrete experience and perhaps its planning, but missing out on reflection and conceptualisation. Others will reflect at length, but be light on action. Some will conceptualise till the cows come home, but this might be a largely intellectual exercise because it does not rest on a period of reflection on inner experience; conceptualisation might only rarely be taken back into concrete experience via planning.

We can assume both trainees and supervisors will have their individual learning "signatures". It is therefore important to recognise the phases we will naturally veer towards and those we will tend to avoid, in order that we can balance up attention to all phases *and* maintain complementarity between supervisors and supervisees. Therefore consider

- How do I respond to the **concrete experiential** aspect of treatment and supervision: getting therapy concretely into supervision via showing tapes, engaging in role plays, practicing skills? Will I revel in this, steer clear, avoid at all costs? Get anxious? Feel under pressure and resentful of scrutiny? If this is an area I will tend to lean away from, what needs to be put in place in my supervision to guard against this?
- Consider. Discuss. Document. Incorporate into agendas. Review.
- How am I on **reflection**? Do I naturally spend time staying with, thinking about, noticing feelings related to experience? Do I like lots of time to dwell on therapy before making up my mind about theory and action? Or do I prefer to "get on with it", moving more rapidly to formulating, preparing, doing? What will be the effects if I dwell over-long in this phase? What if I skip past it to other areas?
- Consider. Discuss. Document. Incorporate into agendas. Review.
- How do I relate to **conceptual** thinking? Do I tend to give only slight attention to theories, models, concepts, preferring either more "freeform" reflection, or to hurry on with the business of bringing about change? Or do I enjoy the intellectual stimulus of making sense of experience via conceptual thinking? What will be the effects if I dwell over-long in this phase? What if I skip past it to other areas?
- Consider. Discuss. Document. Incorporate into agendas. Review.
- How do I get on with **planning and experimentation** - the business of considering how to translate my reflections and formulations back into clinical action? Do I tend to feel that, as long as we have thought through our understanding of a matter thoroughly enough, plans can look after themselves? Or do I appreciate the structure of more clearly thinking through *how* this will be done, experimenting with different versions, considering alternatives? What is likely to happen if I brush past this phase? What are the likely effects if I come *too quickly* to this point, planning and experimenting in the absence of reflection and conceptual thought?
- Consider. Discuss. Document. Incorporate into agendas. Review.

Operating outside of my Comfort Zone

Lastly, consider how you respond to being stretched. If Diploma training is going to be of any real use to you, it will recurrently put you in a position where you are doing new things, asking new questions, being confronted with challenges that are outside of your current competence. You will need to work with your supervisor and your fellow supervisee in order to consistently stay in this zone that occupies the space between shrinking away from challenge, and setting the bar to high for successful achievement. This Zone of Proximal Development (Vygotsky 1978) will be one that will keep you engaged, interested, "just anxious enough".

But the experience will often be stress-inducing, and the way we respond to this stress will strongly affect how much benefit and enjoyment we reap from supervision. Therefore think about how you tend to act when you are stretched in this way. Do you have particular strategies you tend to use? (You may not have considered these until now, since we may tend to go on to "autopilot" at these times.) Do you notice your own patterns of resistance to change or to newness? Or do you jump in at the deep end, taking on more of a challenge than you are equipped to manage? What do you know about how you tend to act and think when you get anxious (e.g. about that tape you will need to hand in)? Or annoyed (e.g. about that criticism, or that mark that wasn't as good as I wanted)?

References

Blackburn IM, James IA, Milne D & Reichelt K (2001) *Cognitive Therapy Scale Revised (CTS-R)*, Northumberland, Tyne and Wear NHS Trust. Available from Newcastle Cognitive and Behavioural Therapies Centre.

Kolb, D (1984) *Experiential Learning*, Englewood Cliffs, MJ: Prentice-Hall

Vygotsky LS (1978) *Mind In Society: The Development of Higher Psychological Processes*. Cambridge, MA MIT Press

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Supervision Consultation Worksheet (Christine Padesky)

Consultation Question: _____

1. Is there a cognitive model for understanding and treating this client problem? If so, write or draw it here. If not construct a cognitive model for conceptualization and treatment.
2. Are you following the cognitive conceptualization and treatment plan? If not discuss advantage/disadvantages of cognitive or alternative conceptualizations and treatment plans.
3. Does the therapist have the knowledge and skill to properly implement the CT treatment? If not help the therapist learn these skills and knowledge.
4. Is the therapeutic response following expected patterns? If not, formulate hypotheses about why client response is different from expected. Consider client beliefs, skill deficits, emotional responses, interpersonal patterns, life circumstances and developmental history. Also consider the factors in #5 below
5. What else might be interfering with success? Include hypotheses about:

The therapist (beliefs, skills deficits, emotional responses, interpersonal patterns, life circumstances, developmental history)

The therapy relationship (e.g. is it positive and collaborative?):

The cognitive conceptualization (e.g. is something missing or inaccurate?):

The treatment plan (e.g. are there additional approaches which might help?):

FEEDBACK SCORE SHEET to be used with CTS-R MANUAL

Name of Rater: _____

Tape Name & Term: _____

Date of marking: _____

Score: _____

Perceived Rating of patient suitability (1 = not suitable, 6 = highly suitable) _____

Important

The 'Key Features' on the CTS-R describe important features that need to be considered when scoring each item. When rating the item, you must first identify whether some of the features are present. You must then consider whether the therapist should be regarded as competent with respect to the features. If the therapist includes most of the key features and uses them appropriately (i.e. misses few relevant opportunities to use them), the therapist should be rated very highly. The 'Examples' given on the CTS-R are only guidelines and should not be regarded as absolute rating criteria. Rate score as 0-6 as per CTS-R Manual.

| CTS-R Items | Score | Comments Regarding Improvement |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--------------------------------|
| <p>1. Agenda setting and adherence. Did the therapist set a good agenda and adhere to it?</p> | | |
| <p>2. Feedback Did the therapist regularly provide and elicit feedback?</p> | | |
| <p>3. Collaboration. Was good teamwork evident?</p> | | |
| <p>4. Pacing efficient use of time. Was the session well paced and the time used efficiently?</p> | | |
| <p>5. Interpersonal effectiveness. Was a good therapeutic alliance evident?</p> | | |
| <p>6. Eliciting appropriate emotional expression. Did the therapist elicit relevant emotions and promote an effective emotional ambiance?</p> | | |
| <p>7. Eliciting key cognitions. Did the therapist elicit relevant cognitions? (thoughts, beliefs, etc).</p> | | |

| | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| | | |
| <p>8. Eliciting Behaviours Appropriate behaviours focused on? Links with emotions/problems made clear? Elicited and verbal or written format?</p> | | |
| <p>9. Guided Discovery. Did the therapist's approach enable the patient to make his/her own connections and discoveries?</p> | | |
| <p>10. Conceptual integration. Did the therapist make explicit the overarching cognitive rationale and formulation?</p> | | |
| <p>11. Application of change methods. Therapist applies a range of cognitive or behavioural methods with skill and flexibility?</p> | | |
| <p>12. Homework setting Did the therapist set an appropriate homework?</p> | | |

Further Comments:

Guidelines for marking Case Studies

(Based closely on the guidelines of Melanie Fennell, Oxford, April 2000)

Checklist of contents

This covers items specified in the case presentation guidelines. Marks are deducted where significant content is omitted, unless its inclusion is judged unnecessary.

1. Contents page

2. Introduction

Brief introduction relating case presentation guidelines. Marks are deducted where significant content is omitted, unless its inclusion is judged unnecessary

3. Presenting Problem

Presenting problem(s) and associated goals

Diagnosis

Scores on standard and idiographic measures (refs as appropriate)

Outline of previous treatment

Current coping

4. Conceptualisation

Specific theory-based cognitive model used as framework for conceptualisation, including:

- Maintenance cycles (links between clarified and appropriate emphasis given to role of cognitive elements)
- Triggers/ critical incidents
- Underlying core beliefs / Dysfunctional Attitudes Scale (DAS)
- Experiences which have contributed to /reinforced the above

Diagrams/ flowcharts

Missing/ unclear data identified

Hypotheses about originating and maintaining factors clear

5. Course of therapy

Goals

Description of cognitive-behavioural methods used: Verbal, behavioural, imaginal, other

Continued refinement of conceptualisation, if appropriate

Problems in therapy related to conceptualisation and completely resolved

6. Outcome

Changes in original problems

Progress towards goals

Changes in standard and idiographic measures

Illustrative graphs/ diagrams/ tables

Plans for continuing therapy plus hypothesised outcome, if appropriate

7. Discussion

Appropriateness of original formulation/ reformulation
Patient and therapist factors that helped/ hindered therapy
Helpful/ unhelpful treatment procedures identified
What the therapist might have done differently, given the benefit of hindsight.

Guidelines for marking Case Studies

(Based closely on the guidelines of Melanie Fennell, Oxford, April 2000)

Marking Scale

| | | | | | | | | | | |
|------|------------|----|----|-----------------|------|-----------|-------------|----|----|-----|
| 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Fail | Clear Fail | | | Borderline Fail | Pass | Very Good | Distinction | | | |

We recognise four classes of results:

- **DISTINCTION** (for marks over 70)
- **PASS** (incorporating the categories GOOD PASS 60-69%, PASS 50-59%)
- **BORDERLINE FAIL** (40-49%)
- **CLEAR FAIL** (below 40%)

In addition to marks, we supply trainees with written feedback summarising the strengths and weaknesses of each piece of work.

Please mark each case presentation on the above scale, according to how far it meets the requirements of the attached guidelines. Please take into account:

- The writer's ability to understand the patient's difficulties and to conceptualise their development and maintenance in terms of the cognitive model of emotional disorder.
- The extent to which treatment follows logically from conceptualisation and is clearly cognitive-behavioural in nature
- Outcome is evaluated on relevant dimensions
- The discussion shows awareness of factors contributing to or preventing change and an ability to present and structure material clearly, coherently and concisely
- Where there is a discrepancy between content and style, please give priority to the *content* in your mark.

The following guidelines should help you pitch marks appropriately:

DISTINCTION (70% or over)

- Excellent conceptualisation/treatment, based on sound knowledge of theory and research
- Penetrating clinical judgement (sophisticated clinical skills; highly sensitive to individual client needs; measures and interventions apt and well implemented)
- Evidence of independent thought; finely developed ability to reflect on/learn from practice
- Excellent presentation (concise, coherent and articulate)

PASS GRADES (50-69%)

60 - 69% VERY GOOD

- Very good work, showing sound knowledge of theory and research
- Balanced, careful clinical judgement, good clinical skill and sensitivity
- Some initiative, and good ability to reflect on and learn from practice
- Consistently good presentation: clear and concise

50-59% PASS

- Conceptualisation /treatment informed by some knowledge of theory and research
- Some clinical judgement (skills quite good, but lacking consistency; follows CBT protocol, but without much ability to adapt to the individual patient)
- Some evidence of independent thought; good attempt to reflect on and learn from practice
- Uneven presentation (eg diffuse report; some sections unclear or insufficiently developed)

FAIL GRADES (less than 50)

40-49% BORDERLINE FAILURE

- Basic contribution, reflecting elementary knowledge of related theory and research
- Limited clinical judgement (basic clinical skills; conceptualisation insufficiently precise; appropriate measures and/or interventions omitted; limited attempt to adapt protocol to the individual patient; interventions, though cognitive-behavioural in nature, do not follow logically from conceptualisation/ problem list, or are not integrated into a coherent treatment plan
- Minimal evidence of independent thought; minimal ability to reflect on/learn from practice
- Careless presentation, confused expression (interventions not clearly described; report does not follow case guidelines; repetitive; too long/ short)

Under 40% CLEAR FAIL

- Significant ignorance or misunderstandings of CT theory and research (errors in understanding of CT literature; inappropriate or incorrect model conceptualisation)
- Poor clinical judgement (serious omissions in treatment, or persistence in using inappropriate interventions; treatment poorly carried out, mechanically applied, or not cognitive-behavioural in nature; interventions poorly selected and unrelated to diagnosis, conceptualisation or problem list; insensitivity to individual patient's needs)
- Little or no evidence of ability to reflect on or learn from practice
- Poor presentation (many errors, rambling, incoherent, difficult to follow)

Trainee _____ Marker _____ Case No. _____

Marking Scale

| | | | | | | | | | | |
|-------------|-------------------|-----------|-----------|------------------------|-------------|-----------|-----------|--------------------|-----------|------------|
| 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Fail | Clear Fail | | | Borderline Fail | Pass | | | Distinction | | |

Comments on the following:

| | |
|------------------|-------------------|
| CONTENT | |
| Strengths | Weaknesses |
| | |

| | |
|------------------|-------------------|
| STRUCTURE | |
| Strengths | Weaknesses |
| | |

| | |
|------------------|-------------------|
| STYLE | |
| Strengths | Weaknesses |
| | |

OVERALL MARK _____

GRADE _____

CASE STUDIES FEEDBACK FOR TRAINEES

Case Studies are marked on this scale:

| | | | | | | | | | | |
|-------------|-------------------|-----------|-----------|------------------------|-------------|-----------|-----------|--------------------|-----------|------------|
| 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| Fail | Clear Fail | | | Borderline Fail | Pass | | | Distinction | | |

We recognise four classes of result:

- **DISTINCTION** (for marks over 70)
- **PASS** (incorporating the categories VERY GOOD 60 - 69%, PASS 50-59%)
- **BORDERLINE FAIL** (40-49%)
- **CLEAR FAIL** (below 40%)

We take into account:

- Ability to describe the patient's problems, identify relevant goals and conceptualise development and maintenance of difficulties in cognitive terms
- Ability to design and carry out a treatment programme which follows logically from the conceptualisation and is clearly cognitive-behavioural, and to assess outcome on relevant dimensions
- Awareness of factors contributing to or preventing change, ability to reflect on therapy and learn from experience
- Ability to present and structure relevant material clearly , coherently and concisely

In addition to marks, we supply trainees with written feedback summarising the strengths and weaknesses of each piece of work.

Essay Scoresheet

The Essay is to be marked out of 20 as follows

0 – 7.9 (Clear Fail < 40%)

- Student shows little or no understanding of how the subject is addressed in the cognitive therapy literature.
- Little knowledge of / reflection upon what has been taught throughout the year or its relevance to the essay subject.
- Major points of essay poorly communicated / presented

8 – 9.9 (Borderline Failure 40 – 49 %)

- Very Basic understanding of of how the subject is addressed in the cognitive therapy literature.
- Themes poorly integrated with insufficient effort to bring together / reflect upon a range of important themes.
- Basic presentation with many errors / omissions

10 – 13.9 (Pass / Good Pass 50 - 69 %)

- Student shows a good / solid understanding of the subject and an awareness of how the Cognitive therapy literature addresses the subject area.
- Student has shown an attempt to integrate theory and practice elements from the Cognitive therapy literature.
- Student has shown evidence of reading and reflection upon the course curriculum and integrated a range of concepts but sometimes with minor inconsistencies.
- Student has communicated their knowledge and opinions in a way that can be readily understood (including the use of diagrams or illustrations, use of appropriate quotations etc).

14+ (Distinction > 70 %)

- Student shows an excellent understanding of the subject and a comprehensive awareness of how the Cognitive therapy literature addresses the subject area.
- Student has intelligently integrated theory and practice elements from the Cognitive therapy literature into well balanced perspectives or well reasoned arguments on the subject area.
- Student has shown evidence of reading and reflection beyond the course curriculum and integrated a range of concepts sometimes in a novel manner.
- Student has communicated their knowledge in a concise and succinct way that is readily accessible and understandable to the reader.

NB : MARKS SHOULD NOT BE DEDUCTED SOLELY BECAUSE OF SPELLING / GRAMMATICAL ERRORS

(Please comment on these in the presentation skills section)

1. Content of Essay

Comments: _____

2. Structure of Essay

Comments: _____

3. Presentation Skills

Comments: _____

OVERALL SCORE

| |
|-----|
| /20 |
|-----|

Signed by Assessor _____

Date _____

Class Presentation Guidelines

Guidelines for students

The presentation to the class is designed to prompt students to reflect upon their professional and personal learning during the academic year of the course. It is important that we assess the capacity to reflect upon and bring together / synthesize what has been taught. You need to demonstrate also its application i.e. that it is starting to be integrated into your professional practice.

Key aims : Describing your most important professional learning whilst on the course and what were the main one or two main contributions to achieving that learning. The capacity to communicate what has been learnt clearly and succinctly to your peers is the second important challenge that is set in this assessment.

It is appreciated that whilst on a course such as this many students will sometimes become more aware of their own anxieties, fears and other emotions. Through their engagement with casework, supervision, workshops or other components of the course the student may develop some very significant personal insights. This may prove very helpful and positive but may also sometimes cause some upset or unease. It is not the purpose of this assessment to prompt students to share their personal (and intrinsically private) development as we are not proposing to put in place the type of safeguards that would help contain and manage any significant self disclosure.

Students may use Powerpoint, but in many cases this may be unnecessary and detract and distract from the message to be communicated. Each presentation will last no more than 15 minutes. Students might respond to questions from their peers or the assessors but this would only occur to a very limited extent. Students will be marked by a pair of assessors and the average of their marks will be awarded.

The Class Presentation is to be marked out of 20 as follows

0 – 7.9 (Clear Fail)

Student shows little or no understanding of how cognitive therapy might be integrated into their professional practice.

Little knowledge of / reflection upon what has been taught throughout the year or its relevance to their future practice

Learning points poorly communicated / presented

8 – 9.9 (Borderline Failure)

Basic understanding of role of cognitive therapy in their professional practice.

Themes poorly integrated with insufficient effort to bring together / reflect upon a range of important themes.

Basic presentation with many errors / omissions

10 – 13.9 (Pass / Good Pass)

Student shows a good / solid understanding of the nature and range of professional roles they undertake and how Cognitive therapy might interact with these roles.

Student has shown an attempt to integrate theory from Cognitive therapy into their engagement with patients and interaction with colleagues

Student has shown evidence of reading and reflection upon the course curriculum and integrated a range of concepts but sometimes with minor inconsistencies

Student has communicated their learning in a way that can be reasonably well understood by their peers and the assessors.

14+ (Distinction)

Student shows an excellent understanding of the nature and range of professional roles they undertake and how Cognitive therapy might interact with these roles.

Student has intelligently integrated theory from Cognitive therapy into their engagement with patients and interaction with colleagues

Student has shown evidence of reading and reflection beyond the course curriculum and integrated a range of concepts sometimes in a novel manner

Student has communicated their learning in a concise and succinct way that is readily accessible and understandable to their peers and the assessors

Class Presentation Scoresheet

The Class Presentation is to be marked out of 20 as follows

0 – 7.9 (Clear Fail)

- Student shows little or no understanding of how cognitive therapy might be integrated into their professional practice.
- Little knowledge of / reflection upon what has been taught throughout the year or its relevance to their future practice
- Learning points poorly communicated / presented

8 – 9.9 (Borderline Failure)

- Basic understanding of role of cognitive therapy in their professional practice.
- Themes poorly integrated with insufficient effort to bring together / reflect upon a range of important themes.
- Basic presentation with many errors / omissions

10 – 13.9 (Pass / Good Pass)

- Student shows a good / solid understanding of the nature and range of professional roles they undertake and how Cognitive therapy might interact with these roles.
- Student has shown an attempt to integrate theory from Cognitive therapy into their engagement with patients and interaction with colleagues.
- Student has shown evidence of reading and reflection upon the course curriculum and integrated a range of concepts but sometimes with minor inconsistencies.
- Student has communicated their learning in a way that can be reasonably well understood by their peers and the assessors.

14+ (Distinction)

- Student shows an excellent understanding of the nature and range of professional roles they undertake and how Cognitive therapy might interact with these roles.
- Student has intelligently integrated theory from Cognitive therapy into their engagement with patients and interaction with colleagues.
- Student has shown evidence of reading and reflection beyond the course curriculum and integrated a range of concepts sometimes in a novel manner.
- Student has communicated their learning in a concise and succinct way that is readily accessible and understandable to their peers and the assessors.

1. Understanding of CBT and integration into own practice

Comments: _____

2. Degree of Reflection on Learning

Comments: _____

3. Presentation Skills

Comments: _____

OVERALL SCORE

| |
|-----|
| /20 |
|-----|

Signed by Assessor _____

Date _____

Map of St. James's Hospital Showing Trinity Centre

