

Curriculum for Couple Therapy for Depression

**CONTINUING PROFESSIONAL DEVELOPMENT
FOR QUALIFIED THERAPISTS DELIVERING
HIGH INTENSITY INTERVENTIONS**

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March 2011

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Acknowledgements

This training curriculum draws on the Competency Framework for Couple Therapy for Depression commissioned by the Department of Health from Relate and the Tavistock Centre for Couple Relationship, and written by Dr Christopher Clulow, Senior Fellow of the Tavistock Centre for Couple Relationships, drawing on the work of the Expert Reference Group, Chaired by Nick Turner of Relate. The format of the curriculum draws on the Reach Out training materials for Psychological Wellbeing Practitioners developed by Professor David Richards and Mark Whyte.

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Note to Trainers

Practitioners coming on the Couple Therapy for Depression training are all expected to be qualified Couple Therapists or experienced in clinical work with couples to an equivalent level. They will have different professional and theoretical backgrounds and will be expected to make extensive use of these in assimilating the learning from the training. Each participant will reflect on the overall aims of each Unit and the range of techniques presented, and how these can be integrated with or added to their existing model. Over the course of the training they will develop a critical understanding of their choice of techniques.

To enable this, trainers need to engage vigorously with the participants about the appropriate choice of technique for the variety of couples, and their presenting problems, that they are likely to see in their IAPT Service.

The training should encourage learning from and between the participants in such a way that they can also be a resource for each other in their subsequent ordinary day-to-day clinical work with couples.

How to use this Curriculum

This document sets out the Overall Aims of the National Curriculum for Couple Therapy for Depression training and gives a model Training Programme based on the Specific Techniques of Couple Therapy for Depression to be found in the Competency Framework. It is a companion document to the **Couple Therapy for Depression Training: IAPT National Curriculum for Participants** that participants on the course should be given.

The training is divided into Units, each with aims and learning outcomes etc. Where this document differs from the participants' version is that it includes background information for some of the Units, and guidance in the delivery of some of the training and assessment elements. Trainers must ensure they are familiar with the Participants' version, as well as the Curriculum Framework for Couple Therapy for Depression and the Suggested Pre-Course Reading, below.

Training Materials in the form of Power-point slides are available on the national IAPT Website as part of this curriculum.

Introduction

Couple Therapy for Depression Training: IAPT National Curriculum

This curriculum is for a training that enables Couple Therapists to provide a depression-specific 20 session therapy in an IAPT setting for couples where there is both relationship distress and depression in one of the partners.

The competences required to deliver effective Couple Therapy for Depression were drawn up using the tried-and-tested methodology developed at the Centre for Outcomes Research & Effectiveness at University College London (www.ucl.ac.uk/CORE). Relate and the Tavistock Centre for Couple Relationships were jointly commissioned to lead this work because of their expertise in couple therapy. An Expert Reference Group was set up with a membership drawn from national experts selected for their experience of developing, evaluating, providing training for and supervising different approaches to couple therapy. The Membership of the ERG was:

Susanna Abse	Chief Executive, Tavistock Centre for Couple Relationships
Peter Bell	Chair, British Association for Sexual & Relationship Therapy
Jeremy Clark	Programme Leader, IAPT
Michael Crowe	Psychiatrist, Maudsley Hospital
Peter Fonagy	Professor, University College London
David Hewison	Head of Research, Tavistock Centre for Couple Relationships
Julian Leff	Professor, Institute of Psychiatry
Alessandra Lemma	Professor, Tavistock & Portman NHS Trust
Viveka Nyberg	Psychotherapist, St Bartholomew's Hospital
Anthony Roth	Professor, University College London
Nick Turner	Director, Relate Institute (CHAIR)
Rebecca Walker	Secretary to the Expert Reference Group
Ben Wright	Psychiatrist, East London NHS Trust

In addition, Janet Reibstein, Professor, University of Exeter, provided advice on systemic couple therapy.

The ERG reviewed the evidence base identified by the National Institute for Health and Clinical Excellence (NICE) for the treatment of depression by couple therapy and felt that, on its own, it was insufficient to enable the development of a coherent set of therapy competencies. Accordingly, the ERG also looked at other Randomised Controlled Trial studies that examined the effectiveness of key couple therapy modalities and integrated competencies from these into the modality. Most of these approaches are based on behavioural principles as developed since the 1970s in the USA. Other evidence-based approaches that have been utilised include: Interpersonal Therapy-Conjoint Marital (IPT-CM); Systemic Therapy; Emotion-focused Therapy (EFT); and Insight-oriented Therapy. As a result the Couple Therapy for Depression competencies include a range of approaches that may not usually sit side-by-side; nonetheless all have been shown to increase relationship satisfaction and so reduce depression in couples.

The resulting Competencies Framework was then peer reviewed and approved by:

Professor Guy Bodenmann	University of Zurich
Professor Steven Beach	University of Georgia
Professor Andrew Christensen	University of California at Los Angeles
Dr David Scharff	International Psychotherapy Institute, Washington

The Competency Framework and the Background documentation are available on the CORE website: http://www.ucl.ac.uk/clinical-psychology/CORE/Couple-Therapy-for-Depression_framework.htm

Couple Therapy for Depression is specifically designed to address presenting symptoms of depression and for delivery within the context of the IAPT programme. It is an add-on skill to existing

advanced competence in Couple Therapy. The training to deliver this therapy within the IAPT programme consists of two linked elements: a five-day course; and an additional period of supervised clinical work with an approved supervisor, during which two cases must be satisfactorily completed in order to be accredited as a *Couple Therapy for Depression IAPT Practitioner*. The accrediting body is the British Society of Couple Psychotherapists and Counsellors.

Clinicians treating couples with depression and relationship distress within IAPT Services will be expected to draw on competencies from their existing model of Couple Therapy and integrate these with competencies specified for use with this patient group, as outlined in this training curriculum.

Aims of the Training

1. To develop practical competency in Couple Therapy for Depression as a development of existing Couple Therapy skills.
2. To ensure clinical practice in accordance with Local and National IAPT Service policy including the need to work appropriately with difference.
3. To enable Couple Therapy for Depression practitioners to act as an expert resource to professional colleagues, so ensuring appropriate referrals for Couple Therapy for Depression

Overarching meta-competency for Couple Therapy for Depression:

Capacity to use different therapeutic approaches appropriately and coherently

A capacity to select from, integrate and move between different therapeutic models and techniques to provide a coherent and appropriate therapeutic response to the different and changing needs of couples, for example by:

- applying a graded model of intervention tailored to the nature and severity of the couple's areas of concern
- exploring behavioural contracting, communication and conflict management skills in conjunction with more complex, in-depth work, and determining the appropriate level on which to work
- drawing on other, more complex approaches, such as insight-oriented ones, where the couple can both benefit from and work with a deeper understanding of underlying developmental factors that may be interfering with their relationship
- focusing on accepting limitations for the partnership set by factors within, between and external to the partners as a means of increasing relationship satisfaction

Overarching elements common to the practice of Couple Therapy for Depression:

- knowledge of depression;
- working with difference.

Knowledge of depression

An ability to draw on knowledge of the cluster of symptoms associated with a diagnosis of depression:

- depressed mood most of the day
- marked loss of interest or pleasure in daily activities
- sleep problems
- loss of appetite and significant loss of weight
- fatigue/exhaustion
- difficulties getting to sleep or excessive sleep
- psychomotor agitation (feeling restless or agitated) or psychomotor retardation (feeling slowed down)
- feelings of worthlessness or excessive guilt
- low self-confidence
- difficulties in thinking/ concentrating and/or indecisiveness
- recurrent thoughts of death, suicidal ideation, suicidal intent (with or without a specific plan)

An ability to draw on knowledge:

- that a diagnosis of depression is based on the presence of a subset of these symptoms
- that of these symptoms, depressed mood; loss of interest or pleasure; and fatigue are central
- that symptoms need to be present consistently over time (e.g. DSM-IV-TR criteria specify two weeks, ICD-10 criteria specify one month)

An ability to draw on knowledge of the diagnostic criteria for all mood disorders (including minor depression/dysthmic disorder and bipolar disorder) and to be able to distinguish between these presentations

An ability to draw on knowledge of the incidence and prevalence of depression, and the conditions that are commonly comorbid with depression

An ability to draw on knowledge of the patterns of remission and relapse/ recurrence associated with depression

Ability to work with difference (cultural competence)

An ability to maintain an awareness of the potential significance for practice of social and cultural difference across a range of domains, but including:

- For all clients with whom the therapist works, an ability to draw on knowledge of the relevance and potential impact of social and cultural difference on the effectiveness and acceptability of an intervention
- Where clients from a specific minority culture or group are regularly seen within a service, an ability to draw on knowledge of that culture or area of difference

An ability to draw on knowledge of cultural issues which commonly restrict or reduce access to interventions e.g.:

- An ability for therapists of all cultural backgrounds to draw on an awareness of their own personal/cultural values and how these may influence their perceptions of the couple, the couple's problem, and the therapy relationship
- An ability to take an active interest in the cultural background of couples, and hence to demonstrate a willingness to learn about the couple's cultural perspective(s) and world view
- An ability to work collaboratively with the couple in order to develop an understanding of their culture, worldview, and any culturally-specific expectations for the therapeutic relationship

An ability to take an active interest in the couple's experience of difference:

- An ability to discuss with the couple the ways in which individual and family relationships are represented in their culture(s) (e.g. models of individuality and personal or collective responsibility), and to consider the implications for organisation and delivery of therapy

An ability to ensure that standardised assessments/ measures are employed and interpreted in a manner which is culturally-sensitive e.g.:

- Where there is evidence that social and cultural difference is likely to impact on the accessibility of an intervention, an ability to make appropriate adjustments to the therapy and/or the manner in which therapy is delivered, with the aim of maximising its potential benefit to the couple

An ability to draw on knowledge that culturally-adapted treatments should be judiciously applied, and are warranted:

- Where the therapist does not share the same language as the couple, an ability to identify appropriate strategies to ensure and enable the couple's full participation in the therapy (including the ability to work with an interpreter)

An ability to enable service provision that meets the requirements of the Equality Act 2010

Key Texts relating to Equalities and Difference

Depression-focused texts are listed in the relevant Units, below.

Bhugra, D. & Bahl, V., 1999. *Ethnicity: an agenda for mental health*. London: Royal College of Psychiatrists/Gaskell.

CCAWI website,
www.lincoln.ac.uk/ccawi/publications/Ten%20Essential%20Shared%20Capabilities.pdf

Department of Health, 2002. *A sign of the times: modernising mental health services for people who are deaf*. London: HMSO.

Department of Health, 2005. *Delivering race equality in mental health care: a summary*. London: Department of Health.

Department of Health, 2007. *Positive steps: supporting race equality in mental healthcare*. London: Department of Health.

Ethnicity Online. Useful web resources and good practice guidelines at www.ethnicityonline.net/resources.htm

Equality Act 2010: http://www.equalities.gov.uk/equality_act_2010.aspx

HM Government Office for Disability Issues: <http://www.officefordisability.gov.uk/index.php>

MIND information on different community groups:
http://www.mind.org.uk/help/people_groups_and_communities/

O'Hagan, K., 2001. *Cultural competence in the caring professions*. London: Jessica Kingsley.

Prior, P., 1999. *Gender and mental health*. Basingstoke: Macmillan.

Rogers, A. & Pilgrim, D., 2003. *Mental health and inequality*. Basingstoke: Palgrave Macmillan.

Royal National Institute for the Blind at <http://www.rnib.org.uk/Pages/Home.aspx>

Ryan, T. & Pritchard, J. eds., 2004. *Good practice in adult mental health*. London: Jessica Kingsley.

Stokes, G., 2000. Mental health problems in older people. In Bailey, D. (ed.) *At the core of mental health: key issues for practitioners, managers and mental health trainers*. Brighton: Pavilion Publishing Ltd, p.80-128.

Thornicroft, G., 2006. *Shunned: discrimination against people with mental illness*. Oxford: OUP.

High Intensity Curriculum - Couple Therapy for Depression

This curriculum aims to develop skills in Couple Therapy for Depression at an advanced level, building on existing proficiency in the fundamental techniques of Couple Therapy and developing competency in the specialist techniques used in the treatment of depression in couples.

The curriculum will comprise the following:

- phenomenology, diagnostic classification and epidemiological characteristics of depression
- common factors linked to predisposition and precipitation, course and outcome of depression
- current evidence-based pharmacological and psychological treatments for depression to include the role of combined treatment
- an overview of the principles of the stepped-care system, knowledge of low-intensity interventions with depression and the role of high-intensity psychological therapy within that framework.
- risk assessment, risk management, suicide risk, mental state examination, personal and medical history
- application and suitability of Couple Therapy for Depression (to include contra-indications such as inter-partner violence and bipolar disorder) and awareness of referral pathways for unsuitable cases
- role of co-morbid disorders such as anxiety, PTSD, plus personality disorders and substance abuse
- theory and application of Couple Therapy models of depression, and the role of the relationship in precipitating, maintaining, and preventing depression
- development of therapeutic competency in the application of integrative Couple Therapy interventions with depression
- the role of the therapeutic relationship in Couple Therapy for Depression
- the importance of practitioners' selection of specific techniques that are congruent with their Couple Therapy training
- use of standard and idiosyncratic clinical measures to monitor Couple Therapy for Depression process and outcome in depression
- relapse prevention and prevention planning
- values, culture and diversity (the need to attend to access, ethical, professional and cultural considerations in a way that promotes Equality and reduces Inequality – Equalities Act 2010)
- effective use of supervision to help practitioners identify their own values and beliefs in working with couples with depression to enhance and regulate good practice
- enabling appropriate referrals for Couple Therapy for Depression so as to maximise the effectiveness of the service

Structure of the Training

The Units & associated competencies

Each Unit is half a day; the training aims at covering all the Specific Technique Competencies for the treatment of depression by couple therapy outlined in the Competencies Framework. It also includes refreshers on basic principles of couple therapy and emphasises the role of feelings and emotional states as well as behavioural interactions between the couple, and the need for rigorous assessment of risk. Each Unit, therefore, has its own associated competencies which link, as follows:

Unit 1a – Introduction to IAPT Context, Couple Therapy, and Depression

Competency: Knowledge and understanding of the basic principles of couple therapy

Competency: Knowledge of depression

Unit 1b – Depression *cont* and Risk *in Couples*

Competency: Knowledge of depression

Competency: Ability to use techniques that focus on relational aspects of depression

Unit 2a – The Therapeutic Relationship – engagement, balance and involvement

Competency: Ability to use techniques that engage the couple

Competency: Promoting acceptance

Unit 2b – The Therapeutic Relationship - engagement, balance and involvement, *cont.*

Competency: Revising perceptions

Competency: Ability to use measures to guide therapy and to monitor outcomes

Unit 3a – The Couple Relationship: improving interactions i

Competency: Improving communication

Unit 3b - The Couple Relationship: improving interactions ii

Competency: Coping with stress

Unit 4a - The Couple Relationship: improving interactions iii

Competency: Solving problems

Unit 4b- The Couple Relationship: improving interactions iv

Competency: Changing behaviour

Unit 5a - The Couple Relationship: managing feelings and emotions and Video Assessment

Competency: Managing feelings

Unit 5b – The Couple Relationship: managing feelings; endings & maintenance and Video Assessment

Competency: Ability to end couple therapy

Method of Training

The 5 day course will be a mix of:

Didactic teaching – there are certain elements of the training that require a basic knowledge across participants so that they can work in a consistent way in their IAPT Services. These include the Overarching elements common to the practice of Couple Therapy for Depression of ‘working with depression’ and ‘working with difference (cultural competence)’. Similarly, a

shared understanding of the fundamental place of Acceptance and Tolerance work with couples is key to enabling engagement with the variety of techniques put forward in the course. For some of the case discussions and role-plays the group all needs to have the same information and then to branch off into smaller groups for more detailed study.

Large and small group discussion – the participants are all experienced professionals and so will bring this to the learning experience of the course. Trainers need to ensure that any didactic teaching is followed by sufficient time to explore the different perspectives of the participant group – particularly as there will be potential conceptual and theoretical differences between group members in some instances. More intimate, self-exposing, discussion should take place in small groups and it is sensible to keep the group membership consistent throughout the 5 days. Trainers should be aware that participants may have strong personal reactions and feelings about their own relationships at points in the course.

Trainers should ensure that the aims and competencies for each unit are outlined at the beginning of that unit's teaching and they should consider having a plenary session at the end of each day with the whole group to consolidate learning.

Extensive use of case-discussion and role-play – these will most likely form the largest part of any training course, for two reasons: firstly, the Specific Competencies underpinning the training are ones of technique, rather than knowledge; and, secondly, this allows participants to examine their own existing skills and practices in an experiential way, so learning by comparing and contrasting with each other.

DVD material – some case discussions make use of DVD material. Trainers may use any appropriate material and focus the discussions accordingly. The pilot trainings both used "The Impact of Unemployment on Couples and the Family" produced by the Tavistock Centre for Couple Relationships (<http://www.tccr.org.uk/>).

Video assessment of a role-play using actors – these should focus on the fundamental skills of a balanced position in relation to each of the couple, and the promotion of Acceptance and Tolerance in the way Jacobson and Christensen (1996) describe. Participants should get clear feedback about their performance in such a way that enables them to identify skills deficits and see how they may be remedied. It is unlikely that any participant will be assessed as failing the course on the basis of the videoed role play alone, as there may be a range of influencers on their performance in what is, after all, a very short, stressful, activity. Their overall performance in the course should also be taken into account and pointers for subsequent supervision should be noted and made available to both participant and supervisor.

Self-reflection questionnaires – these are specifically designed to encourage reflexivity in the participants about the relationship between their existing skills and those specified as effective in treating both relationship distress and depression in couples. They should be completed for each Unit that specific techniques are outlined and should form part of the overall assessment of the participant. Whilst the idea is to encourage self-assessment and engagement with the course, copies of the questionnaire should also be kept by the training team for the purposes of final assessment, in conjunction with the rating of the videoed role-play, and overall performance on the course.

Suggested reading – the suggested reading for each unit stems largely from the equivalent topics in the 'Reach Out' materials or from the background manuals from which the competencies were drawn. As such they are necessarily limited and incomplete. Trainers should encourage participants to share their own ideas about appropriate reading and resources, so enabling the whole group (and subsequent course participants) to benefit.

Supervised Clinical Work

Back in their local IAPT service practitioners will continue to work with couples. 2 cases have to be brought to supervision to supervisors approved for the Couple Therapy for Depression training where they will be helped to continue developing the skills needed to work with depression. These supervisors may be part of the course training team. 3 taped sessions from each therapy will be assessed by the supervisor to ensure competence in the practitioner. Once this is achieved, the practitioner will be eligible for accreditation. This clinical assessment process may take up to 12 months, based on 20-24 weekly group supervisions of no more than 5 participants for 1.5 hours, or their equivalent pro-rata.

Appropriate participants should be encouraged to become Supervisors in their own right, so forming a larger resource for the modality. For some participants it will be clear that they have the capacities and skills to supervise Couple Therapy for Depression; for others, they will need a process of development over the course of their clinical work leading to accreditation as a Couple Therapy for Depression IAPT Practitioner. Supervisors should encourage future supervisees, wherever possible and be mindful of the capacity to develop in their supervisees.

Becoming a Supervisor will require the assessment of 2 further cases, as well as a further day of training. Any training team that finds itself in the position of developing supervisors should consider the expertise within the team to do this and seek assistance where this is lacking.

Assessment of competence

There is a self-assessment tool for practitioners to rate themselves against the list of competencies for Couple Therapy for Depression. Trainers and Supervisors will also rate practitioners against these, using the Couple Therapy for Depression Competency Adherence Scale. The videoed role play with actors will be rated against the key competencies it is designed to draw out.

An acceptable standard overall is competence in 80% of the list. This figure has been chosen as some of the competencies come from different (and contrasting) modalities, and it allows lee-way to enable practitioners to continue to work in their original couple training rather than having to adapt too much to what might be an alien methodology. It is the treatment of depression via the treatment of the relationship that is the focus of the training, not any specific therapeutic method, as the training is Continuing Professional Development for couple therapists and not a new clinical modality.

The training is designed, however, to increase the range of relevant techniques available to the practitioner in their work with depressed couples; a further part of the assessment process in the training is the participant's self-reflection on their choice of technique and how these can be integrated into their existing practice.

The training team will need to hold a balance between endorsing the existing skills that a participant brings to the course and encouraging the development of new skills. There may be some resistance in particular participants who have a strong clinical identity in a particular model of couple therapy, and this should be tackled in a straight-forward but non-judgemental way. The 'Practitioners Technique Selection Rationale' Form can be used as a way of enabling such participants to see more clearly the partiality of their view, and should be used as a basis for discussion of alternatives. No participant will be expected to adhere to all the techniques discussed on the course; they will, however, be expected to be able to justify their choice of any particular technique at any one time. The Overarching Meta-competency of **A Capacity to use different therapeutic approaches coherently and appropriately** is key to the learning outcomes of the course. As couple therapists, they will be expected to be able to work comfortably with the relationship between the partners and should not become too caught-up in focusing on one or other of them for too long.

Accreditation

Successful completion of the training course plus successful assessment of competence in two cases by an approved supervisor of Couple Therapy for Depression enables the practitioner to apply for accreditation as a *Couple Therapy for Depression IAPT Practitioner* with the British Society of Couple Psychotherapists and Counsellors. Their names will be included in the BSCPC's list of accredited practitioners on their website. Therapists are also encouraged to register their advanced skills with their original Registering body (eg BACP; BABCP; BPS; etc) where relevant.

Trainers should encourage accreditation and registration of advanced skills as this makes the modality more visible as a viable clinical tool, and it recognises the achievements of the participants.

General learning outcomes

This 5-day Continuing Professional Development training course will provide opportunities for participants to develop and demonstrate knowledge, understanding and skills as follows.

Participants must demonstrate competency in:

- i. The knowledge, skills and techniques of Couple Therapy for Depression as a development of their existing Couple Therapy skills as applied to couples with relationship distress and depression.
- ii. Working clinically in accordance with Local and National IAPT Service policy including working with difference.
- iii. Sensitively adapting the competencies of Couple Therapy for Depression, and ensuring equitable access for people from diverse cultures and with different values.
- iv. Developing an ability to recognise one's own reaction to people who are perceived to be different and values and belief about the issue of difference.
- v. Understanding a definition of culture, related values and factors effecting culture e.g. age, disability, marital status, ethnicity, parental status, sexual orientation, gender, education, language, socio-economic status, and religion or belief.
- vi. Capable of taking responsibility for responses and actions taken with people who are different or are perceived to be different
- vii. Developing ability to accept ambiguity of not knowing what to expect or what to do initially during an inter-cultural situation.
- viii. Risk taking in order to communicate effectively with people from diverse cultures.
- ix. Working effectively with interpreters, establishing ways of working together and considering clinical implications.
- x. Raised awareness of one's reaction to people who are different and the implications of these reactions during sessions.
- xi. Working with co-morbid presentations of depression and taking personal responsibility for clinical decision making in complex and unpredictable situations
- xii. Acting as an expert resource to professional colleagues, so ensuring appropriate referrals for Couple Therapy for Depression

Specific learning outcomes

1. holding a balanced professional position that treats the relationship as the patient, without neglecting the individuals in the couple
2. a working knowledge of the principles and practice, and ability to deliver high-intensity psychological therapy for depression in couples within a stepped-care system.

3. a critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of depressive disorders
4. assessing patients with depression, taking into account clinical manifestations, co-morbidity, past history, present life situation, course and outcome of depression in suitability for Couple Therapy for Depression
5. assessing risk factors associated with depression in couples and the integration of risk management within treatment plans
6. assessing suicidal risk and implementing practical strategies for managing suicidality in couples
7. addressing relational aspects of depression through the appropriate use of depictive, challenging and supportive techniques
8. identifying unhelpful cycles of between the couple and enabling the couple to observe and use ways of changing their interactions
9. addressing the role of the couple's sexual relationship in their difficulties
10. using techniques to establish a collaborative alliance between the couple and between the couple and the therapist
11. moving between the concerns and perspective of each partner and their shared relationship in such a way that the relationship itself becomes a resource for them
12. developing tolerance in the couple for the exploration of their competing positions and perspectives
13. using techniques that focus on the development of empathic acceptance of difference between the couple
14. identifying cognitive, perceptual and emotional distortions and misconstruals and using a variety of techniques to enable the couple to change or correct these
15. enabling the couple to see the impact of repetitive patterns between them, and to identify their roots in each of their developmental and relationship histories, so enabling change in appropriate ways
16. consistently using outcome measures in the therapy in a way that promotes balance, curiosity and enables the revision of fixed or problematic perceptions of each partner in the relationship.
17. using measures to provide appropriate feedback to the couple which helps support the couple's own awareness of their emotional state and encourage self-monitoring.
18. using and teaching communication skills including listening and disclosing in such a way as to further the development of acceptance and tolerance in the couple
19. modelling appropriate use of communication, including silence and care in expression, so that the couple's experience of appropriate and helpful communication is reinforced
20. enabling the empathic use of curiosity and receptivity about each other
21. enabling the couple to express and explore things they find stressful in a carefully managed way, ensuring that the exploration itself does not become over-stressful
22. enabling the couple to recognise and accept that some stressors cannot be got rid of, but can be lived with as part of an ordinary relationship
23. maintaining a balance between each of the partners in a way that is not rigidly equal but which matches the emotional needs of the couple at any one time
24. enabling the couple to identify and distance themselves from influential and repetitive family 'scripts' or expectations that arise from their developmental histories so enabling accurate perception of the current interactions between them
25. using problem-solving techniques in a way that matches the each of the partners' abilities and sensitivities to manage conflict, either actual or feared, at any one time
26. enabling the couple to accept and tolerate the insoluble differences between them that usually lead to conflict
27. promoting empathic bonding between the couple through the use of techniques that enable an empathic understanding of each other's position in the conflict
28. enabling and containing discussions of common conflict-areas of a couple's life such as sex, money, family and parenting, in such a way as to enable the couple to self-regulate more effectively

29. building on the collaborative engagement of the couple in the relationship and in the therapy by encouraging a collaborative approach to behavioural change
30. using behavioural-exchange techniques in a way that prioritises the increase in positive behaviours over the reduction of negative ones
31. enabling the couple to accept and tolerate their differences between them about reciprocity of wished-for behaviours, so promoting greater trust in the relationship
32. promoting empathic bonding between the couple through the use of techniques that enable an empathic understanding of each other's view of the behaviours in question through identifying and articulating the underlying relationship themes and meanings for each partner
33. engaging the couple in active and open discussion of their emotional states, both positive and negative, in a way that promotes empathic joining between the couple
34. enabling the safe exploration of 'strong' emotions including anger and despair and helping the couple see these as normal in the circumstances of their lives and relationship, whilst assessing the couple's ability to cope with such exploration at any one time
35. surfacing hidden emotions, such as 'soft' feelings of vulnerability underlying 'hard' feelings of anger, in such a way as to enable greater understanding and acceptance of each partner's emotional worlds (including the ways they perceive and react to feelings)
36. widening the range of emotional expression in the couple through techniques designed to make emotional states intelligible as part of each partner's life experience and history, so promoting empathic understanding
37. working collaboratively with the couple in constructing an idiosyncratic relapse prevention plan or blueprint of therapy to maintain and consolidate gains and identify future stresses that might lead to further distressed feeling
38. dealing with the mixed feelings that ending therapy brings, including helping the couple understand the impact of the loss of the therapy relationship on them, and linking this to the characteristic ways that they deal with such events
39. judging the interaction between ending therapy and outcome measure scores for any particular couple
40. liaising with referring professionals about the ending case in such a way as to increase their understanding of the nature of Couple Therapy for Depression, so enabling better informed referrals

Suggested Pre-course Reading:

Clulow, C. 2010. The Competencies Required to Deliver Effective Couple Therapy for Partners with Depression: Background Document for Clinicians and Commissioners. TCCR: Unpublished. Downloadable from: http://www.ucl.ac.uk/clinical-psychology/CORE/Couple-Therapy-for-Depression_framework.htm

Dimdjian, S., Martell, C. R. and Christensen, A. 2008. Integrative Behavioral Couple Therapy. In: A. S. Gurman (ed). Clinical Handbook of Couple Therapy. New York, Guilford Press: 73-103.

Hewison, D. 2009. "Marital Therapy". In: Basant, P., & Treasaden, I. (eds.) Psychiatry – an evidence-based text for the MRCPsych. London: Hodder Arnold. Chapter 63.

THE UNITS

Each Unit represents half a day's training and has its own Aims and associated competencies, learning outcomes and Suggested Reading. In some respects the divisions between the Units are artificial – the consequence of their underlying competencies – and participants will find that techniques belonging to one competency are also to be found in others. This reflects the ordinary process of therapy, where there is no simple demarcation between competency-use at any one time.

Each competency is indicated by a boxed header: **like this** followed by the text of the competency. The text is identical to that in the Self-Assessment Tool and participants will already have made a judgement as to what degree they feel they already meet the requirements of the Unit. They will be asked to record the techniques they identify as appropriate to add to their existing skills, and to reflect on this selection process.

The Learning Outcomes distil the competencies for each Unit.

Note: Different training groups will need different emphases on clusters of these, depending on their mix of existing knowledge and experience.

The Suggested Reading for each Unit comes from the specific manuals used to generate each competency, as well as indicative reading from the 'Reach Out' materials. Where the manuals are unpublished or not available in English, they have not been listed.

Note: Trainers need to keep in mind the centrality of work around Acceptance and Tolerance as described by Jacobson & Christensen (1998), and draw the attention of participants back to this whenever they get too stuck in the detail of any particular technique. Techniques are in the service of enabling a particular quality of relating between the couple. At the same time, trainers will also need to be aware of the need to keep discussion of feelings (particularly low, stuck, or difficult ones) live in the training group as this helps their ability to work with couples who may feel themselves to be the helpless victims of such feelings.

Similarly, some of the exercises in the course involve the learning of structured techniques. Although the trainers will need to ensure that these are properly understood, they should invite the participants to reflect on how particular couples might experience and respond to these in their therapy. Not every technique will be appropriate for all couples.

Order of the Units

The Units can be delivered in a different order to that presented here, **with the proviso that** teaching on IAPT & Depression comes 1st & Engaging Couples and work with Acceptance comes 2nd; Work on Communication skills must come *before* Changing Behaviour; and Endings – naturally – comes last. Obviously, the Handbooks will need to be revised to fit the changed order.

Unit 1a – Introduction to Context, Couple Therapy, and Depression

Aims of the Unit – this unit covers the following

Couple Therapy for Depression is a Level 3 intervention within IAPT Services. Couple therapists need to have a good knowledge of the aim and methods of IAPT Services, including the stepped-care nature of the provision and the role of other mental health workers within it. In addition, they must have knowledge of the administrative and procedural requirements of IAPT Services such as the role of outcome measurement in monitoring and evaluation of couple's depressive symptoms.

This Unit reiterates the knowledge and understanding expected from couple therapists of relational dynamics and contextual processes (including life events) that influence the quality of a couple relationship. In addition, High intensity Therapists working with couples in IAPT Services need to identify the ways in which depression manifests in the diagnosed patient as well as in the couple as a system – in the relationship. This means that they have to have a good understanding of depression in individuals, its causes, course, phenomenology, range, incidence, and prognosis, as well as its impact on the ability to relate to, and get support from, others, and to relate this knowledge to couples.

IAPT Induction Outline

Background to the IAPT Programme: Access; NICE guidelines; Economic Case

Targets

- 900,000 people accessing psychological therapies
- 50% of attendees approaching recovery
- 3600 extra therapists

Model

- Stepped Care, referral criteria and self-referral, triage and assessment
- Low and High Intensity Interventions; medication
- Roles: Psychological Wellbeing Practitioners, High Intensity Therapists, GP Leads, Employment advisors
- Supervision and case management
- Risk and safe-guarding policies
- Return to work
- Choice and personalisation
- Diversity of providers

Education and training

- Competences and training drawn from research trials
- National curricula
- Collaboration between service and education providers
- Service standards and professional accreditation

Monitoring and evaluation

- Session by session monitoring of outcomes

- Prescribed measures
- Data protection issues
- Number of sessions
- Stepping up and stepping down
- When to complete/discontinue treatment based on amount of change in clinical outcomes
- Key Performance Indicators

Modalities based on NICE Guidance

- CBT
- Counselling for Depression
- Couple Therapy for Depression
- DIT
- IPT

Long term sustainability

- Realising the Benefits policy guidance
- Role of SHAs and PCTs
- Equity of access
- Tailoring to special populations and communities
- Workforce planning for the psychological workforce in the future
- New Ways of Working for Psychological Therapists

Knowledge and understanding of the basic principles of couple therapy

An ability to draw on knowledge that couple therapists focus on establishing and maintaining a balanced position in relation to the couple, in order:

- to focus attention on their relationship, rather than either partner, as the means of achieving change
- to provide a framework for understanding and managing presenting concerns

An ability to draw on knowledge that couple therapists focus on understanding the nature of the commitment that underpins a couple's relationship, which contributes to shaping its dynamics, including:

- the feelings the partners may have for each other, their understanding of why they chose each other, and their sense of being (or not being) a couple
- the conscious and unconscious expectations, assumptions, beliefs and standards they may share (or differ about) with regard to their relationship
- the role of external factors (such as religious affiliation, ethnicity and other social grouping) on their choice of partner and support for their partnership

An ability to draw on knowledge that couple therapists focus on understanding the interpersonal factors that shape the dynamics of couple relationships, for example:

- the effects of potentially different understandings and levels of awareness between partners about their roles, responsibilities and expected behaviour
- the degree to which the partners agree on matters such as what constitutes a comfortable distance in their relationship, or how feelings are managed
- the degree of fit within the couple over the values, beliefs and meanings each partner brings to interpreting events occurring inside and outside their relationship
- the degree to which each partner is aware of and responsive to the other's feelings, intentions and states of mind, especially in stressful situations
- the couple's communication skills, including their capacity to give, ask for and accept support from each other

- the rigidity or flexibility with which partners interact together, including their capacity to adapt and change over time

An ability to draw on knowledge that couple therapists focus on understanding developmental factors that contribute to shaping the dynamics of couple relationships, for example:

- the effects of family of origin, childhood and earlier partnership experiences on each partner's assumptions about and expectations of their relationship
- the ways in which couple and family relationships and meanings have been changed by predictable life events (such as the birth of a child)
- the ways in which couple and family relationships and meanings have been changed by unpredictable life events (such as unemployment, illness, or bereavement)
- the ways in which new partnerships are affected by past relationship conflicts, and ongoing commitments resulting from them (such as parenting or financial responsibilities)

An ability to draw on knowledge that couple therapists focus on understanding contextual factors that contribute to shaping the dynamics of couple relationships, for example:

- the influence of culture and ethnicity on each partner's assumptions about and expectations of their relationship
- the potential for social constructions of gender and sexuality to shape assumptions about roles and responsibilities in the couple
- the effects of socio-economic factors such as employment, relocation, and redundancy on couple and family relationships

Learning Outcomes

Competency in:

- holding a balanced professional position that treats the relationship as the patient, without neglecting the individuals in the couple
- a working knowledge of the principles and practice, and ability to deliver high-intensity psychological therapy for depression in couples within a stepped-care system.
- a critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of depressive disorders
- assessing patients with depression, taking into account clinical manifestations, co-morbidity, past history, present life situation, course and outcome of depression in suitability for Couple Therapy for Depression

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Self-reflection questionnaires

Suggested reading

Suggested Reading

American Psychiatric Association, 1994. The diagnostic and statistical manual of mental disorders (DSM) IV. 4th ed. Washington DC.: American Psychiatric Association.

Bazire, S., 2003. Psychotropic drug directory 2003/2004: the professionals' pocket handbook and aide memoire. Salisbury: Fivepin Publishing.

Beach, S., Sandeen, E. & O'Leary, K. 1990. Depression in marriage: A model for etiology and treatment. New York: Guilford.

BMA and RPS. 2010. British National Formulary 60. London: British Medical Association and Royal Pharmaceutical Society of Great Britain.

Care Services Improvement Partnership, 2006. Primary care services for depression – a guide to best practice, appendix 4: asking about risk. Hyde: Care Services Improvement Partnership.

Crowe, M. & Ridley, J. 2000. Therapy with couples. A behavioural-systems approach to couple relationship and sexual problems. Oxford: Blackwell. 2nd ed.

Gurman, A. (ed.) 2008. Clinical handbook of couple therapy. New York: Guilford Press, pp 383-429. 4th edition.

Jacobson, N. & Christensen, A. 1998. Acceptance and change in couple therapy. A therapist's guide to transforming relationships. New York: Norton.

Johnson, S. 2004. The practice of emotionally focused couple therapy. Creating connections. New York: Brunner-Routledge; 2nd edition.

Jones, E. & Asen, E. 2000. Systemic couple therapy and depression. London: Karnac.

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson

National Institute for Clinical Excellence, 2009. Depression in Adults (update), Depression: the treatment and management of depression in adults. London: National Institute for Clinical Excellence.

Norfolk & Waveney NHS Foundation Trust's web-based material on medications:
<http://www.choiceandmedication.org.uk/norfolk-and-waveney/>

Ruszczynski, S. (ed.) 1993. Psychotherapy with Couples. London: Karnac.

World Health Organization, 1992. ICD-10 Classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization.

Resource:

Invited workshop with Prof Steve Hollon¹, Professor of Psychology at Vanderbilt University, Nashville, Tennessee, USA.

Key issues rising from workshop held on 28th April 2010

1 Essential knowledge about depression for psychological therapists

1.1 Phenomenology, models and understanding

Phenomenology of depression including symptoms, syndromes and disorders. This should also include classification and diagnostic systems.

General characteristics of the disorder such as prevalence, prognosis and recurrence/relapse should also be known.

Practitioners should be aware that change is relatively easy to facilitate but sustainability of change is more challenging. Remission and recurrence rates.

The influence of factors such as severity and co-morbidity on prognosis and recurrence should be covered. Importance of previous number and duration of episodes on recurrence.

Some familiarity with general theories of depression and common aetiologies.

Recognition that different modalities will advocate different models and factors in understanding the origins of depression.

Importance of cultural factors in the phenomenology, experience and expression of depression across different cultures. Influence on community understanding and help seeking, relevance of religious and cultural beliefs, detection and referral by GPs, cultural sensitivity and appropriateness for different therapies.

1.2 Assessment

How to assess and use of common measures?

Detection by GPs and over/under diagnosis?

Defining severity and its importance in implementing NICE guidance.

Importance of assessing functioning and not just symptom severity.

Co-morbidity with anxiety disorders, personality disorder, and substance abuse; use of other assessment or screening tools (e.g. SAPAS)

Risk, domestic guidance and suicidality – see later.

1.3 Treatment considerations

1.3.1 Patient or client preference

When choosing a treatment for depression, therapists should consider individual suitability and patient preference for different therapeutic modalities, including medication. This should also

¹ IAPT are very grateful to Prof Hollon for conducting this workshop and also for comments on these guidance notes.

include factors such as risk, substance abuse, personality disorder, borderline personality disorder, other physical conditions, or medications.

Preference has been shown to influence attrition but rarely response to treatment. Models and preference may influence up take of treatment. Treatment modalities might weaken or strengthen particular models.

Many clients will distinguish between biological and psychological accounts of their depression. Similarly, whether patients consider the origins of their depression to be interpersonal or intrapersonal.

It will be important for therapists to facilitate *informed* choice of therapy for clients. Need for IAPT to make available easily accessible information about different therapies for patients. Information should be descriptive, indicate benefits and costs of a particular approach, and outline what the patient would need to take responsibility if they undertook a particular treatment.

Opportunities for choice within IAPT services if patient not seen to respond or make progress with a particular intervention?

1.3.2 Medication

All therapists should have background information on medication for depression including the spectrum of drugs, indicative effective doses and regimes, and side-effects.

Issues such as: influence of medication withdrawal on recurrence, medication compliance/adherence issues and side effects, largest drug responses for most severe presentations, preference to avoid medication for mild/moderate depression, individual differences in response, combined psychological therapies and medication, drugs and patient safety.

IAPT guides to medication and the use of combined psychological therapies and medication will be made available.

1.3.3 Outcome measurement

The importance of routine outcome measurement and the detection of deterioration.

Need to reassess if no treatment response after 4-6 weeks/sessions (4-12 months if PD or BPD).

Some modalities will need to develop innovative approaches to outcomes (e.g. couples).

Need to consider critical periods and sudden gains. The importance of supervision for outcome monitoring and reformulation.

1.3.4 End of treatment, maintenance and relapse prevention

Therapists should be able to agree when treatment should finish (e.g. maybe due to either an earlier resolution of problems or failure to observe a treatment response). More complicated patients with more comorbidity typically take up to a year or more as opposed to a couple of months for less complicated patients free of comorbidity.

Issues around Stepping Up and referral on.

Endings should be planned and congruent with a particular therapeutic modality.

Maintenance and relapse prevention strategies need to be discussed. Early signs monitoring and contingency planning for symptom return. Booster sessions and maintenance medication.

There is good evidence for enduring effects for the cognitive and behaviour therapies that last beyond the end of treatment. No such evidence for medications (hence the need for continuation and maintenance strategies).

Possibility of follow up and referral back into services.

1.3.5 *Suicidality, harm and self-harm.*

It is very important to assess risk for suicide (since people with mood disorders are at about 20 times the risk of the general population) and to have good strategies in place for dealing with such patients.

At the same time it is important to recognize that most depressed patients ideate about suicide (about 75%) and only a few are serious risks for acting upon that ideation (maybe about 10% or so). Being able to detect risk and deal with it is crucial; failure to detect serious risk can lead to patients dying and too much attention to ideation in the absence of genuine risk can derail the course of treatment.

Therapists should first make sure that they are familiar with the risk policy of the trust or organisation within which they work. There is no generic IAPT risk policy. However, the following advice for the management of risk should be included within all IAPT therapy training and made available to IAPT staff:

- Use PHQ9 on weekly basis and monitor item on suicide. If suicide is suspected – explore further and ASK: Talk about it, is there a plan? Do you think about it? Have you tried? Do you have access to a lethal means at home (e.g. medication)?
- Assess level of risk: use of risk assessments and hopelessness scale. Even gestures can be fatal.
- Assess risk for self-harm and domestic violence/dangers to others (e.g. harm to spouse and children may depend on gender).
- More frequent sessions and support – telephone contact.
- Therapist must take responsibility: know how to seek additional professional help – discuss with GP and consider hospital admission.
- Enhance coping and agree “suicide plan” with client to include:
 - Write an action plan – reasons for living*
 - Spend time with others*
 - Identify people to help – including others in the home/family/network*
 - Risks of alcohol*
 - Discuss with GP if very high risk*
 - Identify risk factors (moments when they may feel worse and will be alone)*
 - Take immediate action if necessary (take to A&E, call emergency team)*

Consider factors that might lead to increased risk: PD and substance abuse.

Consider effects of antidepressants on mood and mania, especially if family history for bipolar disorder. About 1 in 20 patients with depression only and not history of mania (as yet), will have an underlying bipolar disorder that can be triggered by antidepressant medications. Such patients will probably be prescribed an additional mood stabiliser.

1.3.6 *Modality specific issues*

- Behavioural and relational couples therapy - Impact of medication on sexual desire (female) or performance (male).

How to define if people are depressed because of relationship problems, or are relationship problems causing depression
Advice and guidance for partners

UNIT 1b – Depression *cont* & Risk in Couples

Aims of the Unit – this unit covers the following

In addition to a good understanding of the nature and incidence of depression, couple therapists need to be aware that depression in one partner can have an impact on the other partner's ability or wish to provide the support needed, and will invariably have an impact on children's wellbeing. Tensions and stresses in the relationship associated with depression can make recovery difficult. There are clear patterns of interaction between couples that influence the incidence of depression, and which in turn are affected by it – the couple's sexual relationship is one such important element.

Combined with this is the need to be aware of the level of risk of self- and other-harm associated with depression in couples (including suicide and physical assault), particularly when associated with other psychological, emotional, sexual and environmental stressors. Risk assessments and risk planning should focus on the couple's abilities to help themselves, together with an estimate of what other support might be needed, including other professional interventions. 'Suicide prevention plans' and 'Domestic violence safety plans' will be needed for some couples. Couple therapists will need to have a good working knowledge of their service's Risk Policy and associated procedures.

The particular role of depression in the couple relationship also needs to be addressed to identify precipitating and maintaining factors that may not be immediately apparent in the presentation of the depressed partner to professional services.

Knowledge of depression

An ability to draw on knowledge of the cluster of symptoms associated with a diagnosis of depression:

- depressed mood most of the day
- marked loss of interest or pleasure in daily activities
- sleep problems
- loss of appetite and significant loss of weight
- fatigue/exhaustion
- difficulties getting to sleep or excessive sleep
- psychomotor agitation (feeling restless or agitated) or psychomotor retardation (feeling slowed down)
- feelings of worthlessness or excessive guilt
- low self-confidence
- difficulties in thinking/ concentrating and/or indecisiveness
- recurrent thoughts of death, suicidal ideation, suicidal intent (with or without a specific plan)

An ability to draw on knowledge:

- that a diagnosis of depression is based on the presence of a subset of these symptoms
- that of these symptoms, depressed mood; loss of interest or pleasure; and fatigue are central
- that symptoms need to be present consistently over time (e.g. DSM-IV-TR criteria specify two weeks, ICD-10 criteria specify one month)

An ability to draw on knowledge of the diagnostic criteria for all mood disorders (including minor depression/dysthmic disorder and bipolar disorder) and to be able to distinguish between these presentations

An ability to draw on knowledge of the incidence and prevalence of depression, and the conditions that are commonly comorbid with depression

An ability to draw on knowledge of the patterns of remission and relapse/ recurrence associated with depression

Ability to use techniques that focus on relational aspects of depression

An ability to focus on and reduce negative cycles of influence between depression and couple interactions, for example by:

- educating couples about potential links between depression and stressful patterns of relating in the couple
- gathering in broader aspects of the couple's relationship and focusing on these (for example, concentrating on their roles as parents as well as partners)
- inviting the depressed partner to assume the caring role normally occupied by her or his partner
- asking the depressed partner to help her or his partner to express feelings supporting the depressed partner in being assertive
- discouraging blaming, denigration and contempt
- encouraging partners to maintain routines, surroundings and relationships that provide them with a sense of familiarity and security

An ability to take account of sexual functioning in the couple's relationship, for example by:

- exploring the current state of their sexual relationship
- identifying any changes that have taken place over time
- establishing if the couple wants specialist help for any sexual dysfunction
- making a referral, where appropriate, for specialist help

An ability to review interpersonal roles in the couple relationship, especially with regard to care giving and care receiving, for example by:

- using family life-space techniques (such as sculpting or button/stone games) to enable partners to represent how roles are divided between them, including any changes that have taken place
- encouraging each partner to depict graphically the amount of time and energy they believe they spend carrying out these roles, including any changes that have taken place
- using genograms to investigate family-of-origin roles
- reviewing how roles were allocated in previous partnerships
- highlighting similarities and differences between each partner in terms of their cultural expectations
- investigating how their audit of relationship roles compares with what each partner expects and desires
- identifying areas where changes might be achieved

An ability to consult with the couple about their interaction, for example by reflecting back observations about:

- recurring patterns of relating between the partners
- ways in which each partner and the couple use their therapist
- any relevance this might have to their relationship concerns

An ability to generate and test hypotheses that explain depressive symptoms through the relational contexts in which they occur, for example by:

- offering thoughts about the possible functions of symptomatic behaviour for each partner
- highlighting the roles played by each partner and others in creating and maintaining depressive symptoms, and exploring possible reasons for these describing interactive patterns that may maintain depressive symptoms

An ability to challenge repetitive sequences, for example by:

- interrupting monologues, or cycles of accusation, rebuttal and counter-accusation
- exploring possible functions performed by such repetitive sequences for each partner and the couple
- suggesting alternative behaviours or ways of communicating, including specific skills to regulate conflict

An ability to offer possibilities for altering interactions, for example by:

- tracking and reflecting back observations about patterns of relating and their possible purposes for each partner and the couple
- replaying and highlighting key interactions so they can be:
 - more directly be experienced in the session
 - made available for reflecting on in the therapy
 - providing opportunities for each partner to imagine what they think might happen if existing roles and relationship patterns were to change

Learning Outcomes

Competency in:

- assessing risk factors associated with depression in couples and the integration of risk management within treatment plans
- assessing suicidal risk and implementing practical strategies for managing suicidality in couples
- addressing relational aspects of depression through the appropriate use of depictive, challenging and supportive techniques
- identifying unhelpful cycles of between the couple and enabling the couple to observe and use ways of changing their interactions
- addressing the role of the couple's sexual relationship in their difficulties

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Self-reflection questionnaires

Suggested reading

Suggested Reading

Beach, S., Sandeen, E. & O'Leary, K. 1990. Depression in marriage: A model for etiology and treatment. New York: Guilford.

Crowe, M. & Ridley, J. 2000. Therapy with couples. A behavioural-systems approach to couple relationship and sexual problems. Oxford: Blackwell. 2nd ed.

Gurman, A. (ed.) 2008. Clinical handbook of couple therapy. New York: Guilford Press, pp 383-429. 4th edition.

Jacobson, N. & Christensen, A. 1998. Acceptance and change in couple therapy. A therapist's guide to transforming relationships. New York: Norton.

Johnson, S. 2004. The practice of emotionally focused couple therapy. Creating connections. New York: Brunner-Routledge; 2nd edition.

Jones, E. & Asen, E. 2000 Systemic couple therapy and depression. London: Karnac.

Ruszczynski, S. (ed.) 1993. Psychotherapy with Couples. London: Karnac.

Unit 2a – The Therapeutic Relationship – engagement, balance and involvement

Aims of the Unit – this unit covers the following

The overarching competency of the couple therapist working with any couple is the ability to successfully engage two people who may well have competing agendas in a therapy that promises to attend to the relationship between them as opposed to either of their individual positions. The skill required is to meet sufficient individual needs whilst enabling the couple to see the value of giving up some of their demands/resentments in the service of the relationship between them.

The fact that one partner has been diagnosed with depression and that the Couple Therapy is part of the treatment for it requires the practitioner to actively promote a balance between attending to the depressed person themselves, their partner, and the couple. Being able to shift focus between the three positions is a key skill of Couple Therapy for Depression.

What also promotes successful engagement is the capacity to use methods and techniques that involve each of the couple in the exploration of difference between them and that further the emotional connection and exploration needed to achieve an active state of acceptance and tolerance of each other's particular experience of the relationship.

Ability to use techniques that engage the couple

An ability to form and develop a collaborative alliance with each partner and to enlist their support for relationship-focused therapy, for example by:

- responding empathically in order to validate the experience of each partner, especially their emotional experience
- accepting and exploring each partner's reservations about engaging in couple therapy
- gauging when and whether separate sessions are needed to engage each partner in the therapy, or to overcome an impasse

An ability to form and develop an alliance with the couple as a unit, for example by:

- reframing any presentation of individual problems in relationship terms focusing attention on shared as well as separate concerns
- supporting the partners' sense of themselves as being part of a unit as well as two individuals

An ability to promote a collaborative alliance between the partners in the couple, for example by:

- using empathic questioning to help the partners explore and reappraise their respective positions
- encouraging the partners to address each other directly, rather than the therapist being drawn into a role as mediator or interpreter

An ability to engender hope about the therapeutic process, for example by:

- expecting neither too little nor too much about what can be achieved and by when engaging constructively with problematic issues

- encouraging, recognising and reflecting back positive cycles of interaction in the couple reinforcing achievements by marking and celebrating positive change

An ability to instigate therapeutic change, for example by:

- encouraging shared responsibility for the therapy by constructing agendas collaboratively;
- recapitulating and checking out key communications made during sessions encouraging couples to describe events and episodes in active rather than passive terms (for example, asking 'how did you make that happen?' rather than 'how did that happen?')
- creating openings for new relational experiences (for example, through collaboratively setting homework assignments)
- being clear and sensitive about the rationale for any homework assignment, and following up on how it is experienced as well as whether it has been completed

Promoting acceptance

An ability to work with couples in ways that respect each partner's experience of depression, for example through:

- educating the couple about depression:
 - naming and explaining the symptoms of depression
 - allowing depression to be viewed as an illness, and thereby:
 - reducing feelings of guilt or blame associated with the condition
- accepting the couple's reality of the depressed partner as patient:
 - especially in the early stages of therapy
 - helping the non-depressed partner play a supportive role (especially early on)
- accepting the reality of both partners' depression when this is the case, and the limitations on what each can do for the other in the short term
- engaging the supportive abilities of the non-depressed partner, for example by involving him or her in:
 - helping the depressed partner:
 - prioritise tasks
 - undertake manageable social activities
 - be assertive
 - recognise dysphoric symptoms
 - seek out situations that can relieve such symptoms
- evaluating and managing the patient's depressive symptoms, including the need for either social stimulus and/or medication
- relating to the depressed partner as 'more than his or her depression', to help reduce the effects of depression
- assisting the depressed partner to manage their condition for themselves

An ability to help partners empathically connect with each other around their concerns by:

- eliciting vulnerable feelings from each partner that may underlie their emotional reactions to their concerns
- encouraging them to express and elaborate these feelings
- conveying empathy and understanding for such feelings
- helping each partner develop empathy for the other's reactions through modelling empathy toward both partners

An ability to help the couple empathically connect with each other in distancing themselves from their concerns, for example by helping partners:

- step back from their concerns and take a descriptive rather than evaluative stance towards it
- describe the sequence of actions they take during problematic encounters to:
 - build awareness of the triggers that activate and escalate their feelings

consider departures from their behaviour and what might account for such variations
generate an agreed name for problematic repetitive encounters to help them call 'time out'

An ability to help the couple develop tolerance of responses that the problem can trigger, for example by:

- helping partners identify positive as well as negative functions served by problematic behaviour
- using desensitising techniques to reduce the impact of problematic behaviour (such as practising arguments in sessions)

Learning Outcomes

Competency in

- using techniques to establish a collaborative alliance between the couple and between the couple and the therapist
- moving between the concerns and perspective of each partner and their shared relationship in such a way that the relationship itself becomes a resource for them
- developing tolerance in the couple for the exploration of their competing positions and perspectives
- using techniques that focus on the development of empathic acceptance of difference between the couple

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Self-reflection questionnaires

Suggested reading

Suggested Reading

Beach, S., Sandeen, E. & O'Leary, K. 1990. Depression in marriage: A model for etiology and treatment. New York: Guilford.

Christensen, A. and Jacobson, N. S. 2000. Reconcilable Differences. New York: Guilford Press.

Jacobson, N. & Christensen, A. 1998. Acceptance and change in couple therapy. A therapist's guide to transforming relationships. New York: Norton.

Johnson, S. 2004. The practice of emotionally focused couple therapy. Creating connections. New York: Brunner-Routledge; 2nd edition.

Jones, E. & Asen, E. 2000 Systemic couple therapy and depression. London: Karnac.

Ruszczynski, S. (ed.) 1993. Psychotherapy with Couples. London: Karnac.

Unit 2b – The Therapeutic Relationship - engagement, balance and involvement, *cont.*

Aims of the Unit – this unit covers the following

Couple therapists need to help couples understand that some of their difficulties stem from misunderstanding or misreading each other's intentions towards them. This requires the couple to develop a capacity to stand back from their initial or habitual assumptions about each other, replacing 'closed' assumptions with 'open' inquiry about each other's experience. The couple therapist needs to be able to choose appropriately from a variety of techniques to enable them do this.

In addition, the couple therapist needs to help the couple understand why their initial assumptions and attributions make sense to them given the particular facts of their experience of relationships and relating in their families of origin and their own lives, and how these patterns of relating may be creating some of the difficulties in their current relationship. Some of the evidence for the influence of these patterns will come from the overt behaviour and implicit thinking of the couple, and some will come from the emotional and relational experience in the therapy sessions with them. The couple therapist should promote a sense of curiosity and interest in the couple about these areas of their experience.

Couple therapists must include the measures that form the minimum data set for IAPT therapies, together with those that focus on the quality of the relationship, in the ongoing work with the couple in such a way that promotes balance, curiosity and enables the revision of fixed or problematic perceptions of each partner in the relationship. In addition, the use of measures should help support the couple's own awareness of their emotional state, encouraging self-monitoring.

Revising perceptions

An ability to observe and reflect back on observations of seemingly distorted cognitive processing, for example through:

- marking selective inattention
- encouraging partners to check out the validity of attributions they make about each other
- encouraging partners to check out the validity of perceived (as compared with actual) criticism
- drawing attention to self-reinforcing problematic predictions and assumptions

An ability to reduce blame and stimulate curiosity in the partners about their own and each other's perceptions, for example through:

- 'circular' questioning (questioning that highlights the interactive nature of each partner's behaviour on the other)
- 'Socratic' questioning (questioning that re-evaluates the logic behind existing positions in order to create an alternative, more functional logic)
- encouraging partners to 'read' what their partner is thinking and feeling through:
 - picking up verbal and non-verbal cues and messages
 - listening to feedback about the accuracy of these readings
 - minimising unhelpful 'mindreading'

- imagining the effects their behaviour and feelings have on their partner, and to accept and reflect on feedback from their partner about this

An ability to use techniques that increase the partners' understanding of their own and each other's vulnerability to cognitive distortion, for example by encouraging them to:

- identify recurring behaviour and feelings that might act as flashpoints for each partner in their relationship
- explore the contexts in which they arise
- encourage reflection across relationship domains about similar experiences and reactions

An ability to engage the curiosity of partners about possible links between their current relationship perceptions and past developmental experiences, for example by:

- taking a thorough family and relationship history for each partner, or facilitating this to emerge in the context of the therapeutic process, that includes attachment patterns, events and themes
- using devices such as family genograms to identify cross-generational family meanings, norms, and/or expectations, especially with regard to relationship roles and scripts
- allowing embedded roles, scripts, themes, and patterns that might contribute to distortions in the representation of relationships to emerge and be worked with;
- linking past attachment themes and problematic experiences with current perceptions and predictions

An ability to develop shared formulations of central relationship themes, for example by:

- exploring the transference of representations of past attachment patterns, roles and affects into current couple and/or therapy relationships, and helping the couple distinguish between past and present meanings and realities
- exploring the therapist's own emotional and behavioural responses, both to each partner and to the couple itself:
 - to identify affects and experiences that may reflect and resonate with those of the couple
 - to make connections between the affective experiences of each partner and their therapist to build understanding from shared experience

An ability to identify and make links between specific arguments and central relationship themes, for example by highlighting:

- meanings, thoughts and feelings that accompany escalating arguments
- recurring tensions over the need for intimacy and autonomy
- conflicts that are structured around issues of dominance and submission
- roles that rooted in gender or cultural expectations that might be uncomfortable for one or other of the partners
- past attachment experiences that might be creating anxieties and fears

An ability to reframe events, actions, feelings or interactions to provide alternative, more positive and/or functional meanings to those posited by one or both partners in order to change perceptions of what is going on in the relationship, for example by:

- reconceptualising a partner's perceived negative motivations as misguided or misfired attempts to be supported by and/or supportive of the other
- emphasising the desire of partners to enable rather than disable each other

An ability to apply developing formulations to achieve changes in perception, for example by:

- working through past attachment difficulties, disappointments and losses
- making accessible and accepting feared emotions/experiences, and encouraging new ways that partners can be with each other

providing the context for a corrective emotional experience that encourages each partner to feel secure with each other

Ability to use measures to guide therapy and to monitor outcomes

Knowledge of measures

An ability to draw on knowledge of commonly used questionnaires and rating scales used with people with depression

Ability to interpret measures

An ability to draw on knowledge regarding the interpretation of measures (e.g. basic principles of test construction, norms and clinical cut-offs, reliability, validity, factors which could influence (and potentially invalidate) test results)

An ability to be aware of the ways in which the reactivity of measures and self-monitoring procedures can bias client report

Knowledge of self-monitoring

An ability to draw on knowledge of self-monitoring forms developed for use in specific interventions (as published in articles, textbooks and manuals)

An ability to draw on knowledge of the potential advantages of using self-monitoring

- to gain a more accurate concurrent description of the client's state of mind (rather than relying on recall)
- to help adapt the intervention in relation to client progress
- to provide the client with feedback about their progress

An ability to draw on knowledge of the potential role of self-monitoring:

- as a means of helping the client to become an active, collaborative participant in their own therapy by identifying and appraising how they react to events (in terms of their own reactions, behaviours, feelings and cognitions))

An ability to draw on knowledge of measurement to ensure that procedures for self-monitoring are relevant (i.e. related to the question being asked), valid (measuring what is intended to be measured) and reliable (i.e. reasonably consistent with how things actually are)

Ability to integrate measures into the intervention

An ability to use and to interpret relevant measures at appropriate and regular points throughout the intervention, with the aim of establishing both a baseline and indications of progress

An ability to share information gleaned from measures with the client, with the aim of giving them feedback about progress

An ability to establish an appropriate schedule for the administration of measures, avoiding over-testing, but also aiming to collect data at more than one timepoint

Ability to help clients use self-monitoring procedures

An ability to construct individualised self-monitoring forms, or to adapt 'standard' self-monitoring forms, in order to ensure that monitoring is relevant to the client

An ability to work with the client to ensure that measures of the targeted problem are meaningful to the client (i.e. are chosen to reflect the client's perceptions of the problem or issue)

An ability to ensure that self-monitoring includes targets which are clearly defined and detailed, in order that they can be monitored/recorded reliably

An ability to ensure that the client understands how to use self-monitoring forms (usually by going through a worked example during the session)

Ability to integrate self-monitoring into the intervention

An ability to ensure that self-monitoring is integrated into the therapy, ensuring that sessions include the opportunity for regular and consistent review of self-monitoring forms

An ability to guide and to adapt the therapy in the light of information from self-monitoring

Learning Outcomes

Competency in

- identifying cognitive, perceptual and emotional distortions and misconstruals and using a variety of techniques to enable the couple to change or correct these
- enabling the couple to see the impact of repetitive patterns between them, and to identify their roots in each of their developmental and relationship histories, so enabling change in appropriate ways
- consistently using outcome measures in the therapy in a way that promotes balance, curiosity and enables the revision of fixed or problematic perceptions of each partner in the relationship.
- using measures to provide appropriate feedback to the couple which helps support the couple's own awareness of their emotional state and encourage self-monitoring.

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Self-reflection questionnaires

Suggested reading

Suggested Reading

American Psychiatric Association, 1994. The diagnostic and statistical manual of mental disorders (DSM) IV, 4th edition. Washington DC.: American Psychiatric Association.

Barkham, M., Hardy, G. E. and Mellor-Clark, J., Eds. 2010. Developing and Delivering Practice-Based Evidence. A Guide for the Psychological Therapies. Chichester: Wiley-Blackwell.

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. The Oxford Guide to Low Intensity CBT Interventions. Oxford: Oxford University Press.

Gray, P. & Mellor-Clark, J. (eds.), 2007, CORE: A Decade of Development. CORE IMS: Rugby.

IAPT minimum data set. <http://www.iapt.nhs.uk/wp-content/uploads/iapt-data-handbook-v10.pdf>

Jacobson, N. & Christensen, A. 1998. Acceptance and change in couple therapy. A therapist's guide to transforming relationships. New York: Norton.

Johnson, S. 2004. The practice of emotionally focused couple therapy. Creating connections. New York: Brunner-Routledge; 2nd edition.

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Kroenke, K., Spitzer, R. & Williams, J., 2001. The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16, p.606-613.

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson.

Snyder, D. & Mitchell, A. 2008. Affective-reconstructive couple therapy: A pluralistic developmental approach. In A. Gurman (ed.) *Clinical handbook of couple therapy*. New York: Guilford Press, pp 353-382. 4th edition.

Spitzer, R. et al., 2006. A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, 166, p.1092-1097.

Stratton, P., Bland, J., Janes, E., & Lask, J., (2010) Developing a practicable outcome measure for systemic family therapy: The SCORE. *Journal of Family Therapy*, 32, p.232-258.

World Health Organization, 1992. ICD-10 Classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization.

Note to Trainers on Couple Measures:

The basic IAPT outcome measures need to be added to with specific couple relationship measures. The Locke-Wallace Marital Adjustment Test (as amended to make it applicable to unmarried couples) is one option; another is the Relationship Questionnaire developed by Professor Kurt Hahlweg. The disadvantage of the latter is that it is a 31-item measure, compared to the Locke-Wallace's 15 items); neither can really be used as a weekly monitoring tool, but they could have a role in periodic measurement (beginning, middle and end, for example) as they capture something dynamic between the couple. There's also the Relationship Dynamics Scale to consider, and the SCORE 15 for use in families.

Gradually, as more IAPT Services deliver Couple Therapy for Depression, a consensus will emerge as to which measure(s) are most helpful; until then, trainers might want to encourage participants to experiment with different measures to discover which ones are effective in ordinary clinical practice.

Unit 3a – The Couple Relationship: improving interactions i

Aims of the Unit – this unit covers the following

The couple therapist needs to further the engagement of the couple in the therapy and in the development of acceptance and tolerance between them by ensuring that the couple clearly and appropriately communicate their thoughts, perceptions and emotional states to each other and to the therapist. This requires the therapist to draw on techniques that promote clear and effective speaking and listening, as well as the accurate interpretation of the unspoken communications between the couple.

The therapist must take account of the negative as well as positive aspects of clear communication in the couple relationship consequent to the diagnosis of depression, enabling the couple to develop a sense of what can be said, when, to each other and its impact on their feelings.

Couple therapists should ensure that the teaching and development of communication skills is in the service of promoting greater awareness and understanding of the experience and needs of each partner in the relationship. The development of communication skills is not an end in itself; it is secondary to the emotional connection and exploration needed to achieve an active state of acceptance and tolerance of each other's particular experience of the relationship.

Improving communication

An ability to teach listening skills, for example by:

- encouraging partners to listen actively (clarifying but not debating what is being said) in a manner that supports and validates the speaker
- encouraging partners to summarise and reflect back what they have heard, especially in relation to key issues voiced
- discouraging either partner (or their therapist) from making unfounded assumptions about communications

An ability to teach disclosing skills, for example by:

- encouraging direct rather than ambiguous statements
- encouraging the expression of appreciation, especially before raising concerns softening the way concerns are introduced and voiced
- discouraging ending on a criticism when positive statements are made
- promoting 'I' statements (rather than 'We' or 'You' statements that attribute meanings and intentions to others)
- encouraging concise, specific and relevant speech
- encouraging expression of information about feelings as well as reports of thoughts and experiences

An ability to use exploratory techniques to aid communication, for example by:

- using open-ended questioning
- extending the issue being discussed
- using silence while actively and supportively listening

An ability to use explanatory techniques to aid communication, for example by:

- clarifying what has been said
- providing feedback about a communication
- reconstructing the content of a message, especially where contradictions may be embedded within it

Learning Outcomes

Competency in

- using and teaching communication skills including listening and disclosing in such a way as to further the development of acceptance and tolerance in the couple
- modelling appropriate use of communication, including silence and care in expression, so that the couple's experience of appropriate and helpful communication is reinforced
- enabling the empathic use of curiosity and receptivity about each other

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Self-reflection questionnaires

Suggested reading

Suggested Reading

Beach, S., Sandeen, E. & O'Leary, K. 1990. Depression in marriage: A model for etiology and treatment. New York: Guilford.

Crowe, M. & Ridley, J. 2000. Therapy with couples. A behavioural-systems approach to couple relationship and sexual problems. Oxford: Blackwell. 2nd ed.

Jacobson, N. & Christensen, A. 1998. Acceptance and change in couple therapy. A therapist's guide to transforming relationships. New York: Norton.

Unit 3b - The Couple Relationship: improving interactions ii

Aims of the Unit – this unit covers the following

High levels of stress in the couple relationship militate against the ability to communicate openly and sensitively together; yet stress is an inevitable part of any relationship and a particular ingredient of relationships where one partner is depressed. The couple therapist must enhance the couple's ability to cope with stress through carefully grading their discussions about stressors in the relationship: enabling a successful discussion of something relatively non-stressful allows the couple to feel safer in moving on to something more highly charged between them.

Care needs to be taken in managing the tension between the need for openness and exploration, and the inevitable feelings of blame and resentment that arise in the couple. The couple therapist needs to ensure that feelings of empathic curiosity about, and interest in, each other are recovered whenever they are lost. Explicit links may need to be made to developmental experiences in each of the partner's backgrounds, particularly those where these suggest a family 'script' of disappointment or criticism, in order to help couples distinguish between past and present experience.

Communication continued...

Coping with stress

An ability to help partners cope with their own and each other's stress, for example by:

- enhancing a sense of safety by encouraging each partner to talk first about low level stressors that are removed from home before going on to talk about higher level stressors that may be closer to home
- encouraging the speaking partner to identify what they might find helpful in coping with the stress
- enabling the listening partner to offer empathic support for the speaker in disclosing what they are finding stressful, and any specific needs they may have in order to cope with the stress
- encouraging the speaking partner to provide empathic feedback on their experience of being supported
- repeating these sequences with the partners changing speaker and listener roles
- maintaining fairness and equity in the balance of speaker and listener roles to ensure neither partner is privileged in either role

Learning Outcomes

Competency in

- enabling the couple to express and explore things they find stressful in a carefully managed way, ensuring that the exploration itself does not become over-stressful
- enabling the couple to recognise and accept that some stressors cannot be got rid of, but can be lived with as part of an ordinary relationship
- maintaining a balance between each of the partners in a way that is not rigidly equal but which matches the emotional needs of the couple at any one time

- enabling the couple to identify and distance themselves from influential and repetitive family 'scripts' or expectations that arise from their developmental histories so enabling accurate perception of the current interactions between them

Indicative Learning Methods

Didactic teaching
Large and small group discussion of theory, technique, and case examples
Extensive use of role-play
Self-reflection questionnaires
Suggested reading

Suggested Reading

Bodenmann, G. 2007. Dyadic coping and the 3-phase-method in working with couples. In L. VandeCreek (ed.), Innovations in clinical practice: Focus on group and family therapy (pp. 235-252). Sarasota: Professional Resources Press.

Bodenmann, G. 2010. New themes in couple therapy: The role of stress, coping and social support. In K. Hahlweg, M. Grawe & D. H. Baucom (Eds.), Enhancing couples. The shape of couple therapy to come. (pp. 142-156). Cambridge, MA: Hogrefe Publishing.

Example Questions when using DVD material

- 1] *What are the stressors impacting on these couples? How can you tell?*
- 2] *How might you work with these couples and help them become more conscious of their stress management as individuals and as a couple? How could they support each other with stress management?*
- 3] *How would you assess risk with these couples?*
- 4] *What kind of active techniques do you think might benefit this couple in relation to coping with stress?*
- 5] *How might the therapist's position model a different attitude to stress?*

Unit 4a - The Couple Relationship: improving interactions iii

Aims of the Unit – this unit covers the following

Couple therapists must ensure couples feel safe in discussing problems as without a feeling of safety the discussion can become destructive and encourage a dynamic between them that increases depressive feelings and attributions. The shared experience of identifying and resolving problems enhances the felt sense of the value of the relationship to each partner and of its ability to enhance closeness and act as a resource to either of them. This is particularly true when problems arise from the couple's sexual relationship and other highly emotionally-charged aspects of their experience such as issues around money, parenting, and relationships with extended family which can feel daunting to many couples.

The couple therapist will build on the work done developing acceptance and tolerance of each partner's experience by carefully grading how problems are worked with. There needs to be a clear assessment of the couple's abilities to manage a discussion about a particular problem, as some problems will be more destabilising to the couple than others; some will therefore need a much more structured approach than others will and it should not be automatically assumed that an ability to solve a problem in one area means that all other areas can be similarly resolved. The experience of successful problem solving will add to the quality of the relationship, however.

Solving problems

An ability to create and nurture shared systems of meaning within the couple as a prelude to addressing problems, for example by:

- encouraging partners to talk to each other about respective hopes and fears they have about their relationship, especially when they feel upset or threatened
- establishing and noting, to underline their intentional nature, the partners' daily rituals of connecting with each other (over meal times, shared activities and so on)
- identifying ways, and noting their intentional nature, in which partners already are supported by each other in their shared roles (parenting, home maintenance and so on)
- facilitating the emergence and recognition of a shared relationship story:
- noting how it clarifies and sustains the values and meanings the partners have in common

An ability to help couples define problems in ways that can limit complaint or criticism, for example by encouraging partners to:

- use specific examples when raising potentially contentious issues
- convey why the problem is important to them
- include clear statements about how the problem makes them feel

An ability to provide a structured and stepped approach to problem-focused discussions, for example by:

- separating the process of sharing thoughts and feelings from discussions about the way in which decision-making and problem-solving will proceed
- developing communication skills before applying them to problem-solving
- starting with low conflict before proceeding to high conflict issues
- addressing one problem at a time

- avoiding being sidetracked
- discouraging disagreements when there is insufficient time to address them

An ability to enable partners to try out different approaches to managing conflict, for example by:

- enacting arguments in the safety of the therapy session
- interrupting enacted arguments to explore alternative approaches
- encouraging pretend or controlled arguments outside sessions

An ability to help couples find a solution to identified specific problems through sequentially: defining problems

- brainstorming potential positive alternatives to current problematic behaviour
- evaluating the pros and cons of those alternatives
- negotiating alternatives
- identifying the components of a contract
- forming an explicit (when appropriate, written) contract
- being able to differentiate between soluble and insoluble problems, and where problems are insoluble maintaining a dialogue round the insoluble problem

Learning Outcomes

Competency in

- using problem-solving techniques in a way that matches the each of the partners' abilities and sensitivities to manage conflict, either actual or feared, at any one time
- enabling the couple to accept and tolerate the insoluble differences between them that usually lead to conflict
- promoting empathic bonding between the couple through the use of techniques that enable an empathic understanding of each other's position in the conflict
- enabling and containing discussions of common conflict-areas of a couple's life such as sex, money, family and parenting, in such a way as to enable the couple to self-regulate more effectively

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Self-reflection questionnaires

Suggested reading

Suggested Reading

Crowe, M. & Ridley, J. 2000. *Therapy with couples. A behavioural-systems approach to couple relationship and sexual problems.* Oxford: Blackwell. 2nd ed.

Jacobson, N. & Christensen, A. 1998. *Acceptance and change in couple therapy. A therapist's guide to transforming relationships.* New York: Norton.

Unit 4b- The Couple Relationship: improving interactions iv

Aims of the Unit – this unit covers the following

The couple therapist needs to be able to further the engagement of the couple in the therapy and in the development of acceptance and tolerance between them by ensuring that the couple are able to clearly and appropriately identify problematic behaviours in the relationship and come to an agreement about what to do with them. This requires the therapist to draw on techniques that promote positive behaviours, whether reciprocated or not, whilst enabling the couple to understanding the meaning and function of the behaviour in the relationship.

The therapist must take account of the negative as well as positive aspects of changing behaviour in the couple relationship consequent to the diagnosis of depression, enabling the couple to develop a sense of what can be changed and what needs to be tolerated for the sake of the relationship.

Couple therapists should ensure that the teaching and development of behavioural exchange skills is in the service of promoting greater awareness and understanding of the experience and needs of each partner in the relationship. The development of behavioural change skills is not an end in itself; like communication skills, it is secondary to the emotional connection and exploration needed to achieve an active state of acceptance and tolerance of each other's particular experience of the relationship.

Changing behaviour

An ability to hold collaborative discussions to establish and assist in achieving agreed upon and specific goals, including:

- helping couples identify and set their own goals for the therapy
- establishing the rules and procedures for achieving these goals
- when appropriate, contracting with either or both partners to refrain from specific behaviour (for instance, behaviour that has been agreed-upon as dangerous)
- exploring why behavioural agreements entered into by the partners have worked or failed to work, and reviewing goals in the light of this

An ability to instigate an increase in reciprocated positive behaviour, for example by:

- noting such behaviour in the couple and:
 - focusing on increasing the frequency of positive exchanges rather than on diminishing negative exchanges
- helping each partner to generate a list of specific, positive, non-controversial things they could do for the partner
- helping the partner to whom the list is directed to develop the list
- conducting a staged approach in which:
 - requests from partners are simple and clear
 - complaints from and about partners become wishes
 - specific, reciprocal, achievable changes are negotiated and worked at together
 - progress is monitored by all participants
- encouraging the reciprocation of positive behaviour

An ability to instigate an increase in positive behaviour that does not depend on reciprocation, for example by:

- enabling partners to identify and achieve specific changes they want to make in themselves irrespective of whether their partner reciprocates, including:
 - changes of a broad nature, such as improving the emotional climate of the relationship through being more available to share time
 - changes with a specific focus, such as the manner in which concerns are raised
- encouraging partners to predict how changes in their own behaviour might have a positively reinforcing effect upon their partner:
 - exploring how this prediction looks to the partner
 - exploring their own and their partner's response to initiating such change
- identifying and articulating relationship themes and meanings for each partner that lie behind specific behaviour

Learning Outcomes

Competency in

- building on the collaborative engagement of the couple in the relationship and in the therapy by encouraging a collaborative approach to behavioural change
- using behavioural-exchange techniques in a way that prioritises the increase in positive behaviours over the reduction of negative ones
- enabling the couple to accept and tolerate their differences between them about reciprocity of wished-for behaviours, so promoting greater trust in the relationship
- promoting empathic bonding between the couple through the use of techniques that enable an empathic understanding of each other's view of the behaviours in question by identifying and articulating the underlying relationship themes and meanings for each partner

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Self-reflection questionnaires

Suggested reading

Suggested Reading

Jacobson, N. & Margolin, G. 1979. Marital therapy: Strategies based on social learning and behavior exchange principles. New York: Brunner-Mazel.

Jacobson, N. & Christensen, A. 1998. Acceptance and change in couple therapy. A therapist's guide to transforming relationships. New York: Norton.

Unit 5a - The Couple Relationship: managing feelings and emotions in the context of Units 3 & 4; and Video Assessment

Aims of the Unit – this unit covers the following

By definition, couple relationships where one partner is experiencing depression have difficulties in the free expression of the full range of emotions normally experienced in committed adult relationships. The emotional impact of depression in a relationship is considerable, making some partners over-compensate by either minimising the expression of affect or by becoming emotionally volatile themselves. Couple therapists have to be active in their engagement with feelings in order to minimise risk to the couple of unbounded or overwhelming emotional states in and outside the therapy sessions.

The couple therapist needs to draw on a range of techniques that promote the optimum expression of feelings and emotions in the couple, depending on what the problems are. Part of this will involve normalising 'difficult' emotions between the couple, as a response to the fact of one partner's depression; part will be the active exploration of the depressed feelings themselves and their origins in past and present experiences including those of loss.

In addition, couple therapists need to help couples see how they each attribute idiosyncratic meanings to the other's emotional expression that have their origins in developmental experiences that have shaped both their emotional repertoire and their characteristic ways of registering and showing or expressing feelings. The safe and empathic exchange of feelings between the couple promotes wellbeing, so reducing depressive states and promoting resilience in the couple.

Managing feelings

An ability to encourage the expression and reformulation of depressive affect, for example by:

- supporting the expression of depressed feelings, and the partner's reactions to depressed feelings, and encouraging acceptance of them
- exploring past and present experiences of loss that may account for these feelings, which provide a framework for acknowledging and understanding them
- facilitating mourning

An ability to work with partners who might minimise expressions of emotion, for example by:

- normalising emotional experience
- describing emotions in language that is both accessible and meaningful to the couple
- validating and promoting acceptance of both existing and newly-experienced feelings of each partner
- using questions, hypotheses, and/or reflections that can evoke emotions within the session in the service of then making them intelligible to each partner
- using pacing and softening techniques to create safety in evoking emotion
- heightening awareness of the link between physiological arousal and emotional states (for example, by using bio-feedback methods)
- teaching individual self-soothing techniques

- when possible, inviting and enabling partners to help each other implement self-soothing techniques
- heightening emotions, in a controlled and safe way within the session by repeating key phrases to intensify their impact

An ability to work with partners who amplify the expression of emotion, for example by:

- bounding the expression of emotion within sessions
- helping partners differentiate between their emotional states:
 - as experienced in themselves
 - as observed by others
- helping them to clarify when unexpressed emotional states might underlie expressed emotion (for instance when unexpressed fear underlies the expression of anger)
- promoting containment of upset in one domain of life to prevent it infiltrating other domains
- curtailing statements of contempt through opening up explorations of its impact and underlying emotions
- helping partners to establish useful boundaries around emotional expression, for example through:
 - scheduling mutually agreed times and places in which to discuss feelings, especially those associated with painful experiences, whether shared or separate
- encouraging partners to accept the importance of other relationships (such as friends and relatives) to provide additional emotional support, and to reduce unmanageable pressure on the relationship, while also:
 - identifying and agreeing upon mutually acceptable boundaries (such as, for example, mutually agreed sexual or financial limits to other relationships)

An ability to work with mismatches between partners' emotional responses and meanings, for example by:

- building awareness between partners of:
 - their different attitudes, histories and experiences with expressing specific emotions
 - their different attitudes towards introspection, self-disclosure and exploration of feelings
- accepting and processing mismatches of emotional expression and responsiveness
- helping translate each partner's respective meanings of the other's behaviours
- helping the couple reach clearer shared understandings of each other's responses and meanings

An ability to provide empathic support, for example by:

- tracking the emotions of each partner, as signalled within sessions through verbal and non-verbal cues
- tuning into and validating emotional experience, for example by responding sensitively and robustly
- focusing on patterns of relating that disrupt emotional connection, and promoting their repair through reprocessing sequences as experienced by each partner
- reframing the emotional experiences of partners to make them intelligible and acceptable to each other

Learning Outcomes

Competency in

- engaging the couple in active and open discussion of their emotional states, both positive and negative, in a way that promotes empathic joining between the couple
- enabling the safe exploration of 'strong' emotions including anger and despair and helping the couple see these as normal in the circumstances of their lives and relationship, whilst assessing the couple's ability to cope with such exploration at any one time

- surfacing hidden emotions, such as ‘soft’ feelings of vulnerability underlying ‘hard’ feelings of anger, in such a way as to enable greater understanding and acceptance of each partner’s emotional worlds (including the ways they perceive and react to feelings)
- widening the range of emotional expression in the couple through techniques designed to make emotional states intelligible as part of each partner’s life experience and history, so promoting empathic understanding

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Video assessment of a role-play using actors

Self-reflection questionnaires

Suggested reading

Suggested Reading

Beach, S., Sandeen, E. & O’Leary, K. 1990. Depression in marriage: A model for etiology and treatment. New York: Guilford.

Gottman, J. 1999. The Marriage Clinic. A scientifically based marital therapy. New York: Norton

Jacobson, N. & Christensen, A. 1998. Acceptance and change in couple therapy. A therapist’s guide to transforming relationships. New York: Norton.

Johnson, S. 2004. The practice of emotionally focused couple therapy. Creating connections. New York: Brunner-Routledge; 2nd edition.

Jones, E. & Asen, E. 2000 Systemic couple therapy and depression. London: Karnac.

Ruszczynski, S. (ed.) 1993. Psychotherapy with Couples. London: Karnac.

Savege Scharff, J & Scharff, D. 2008. Object relations couple therapy. In A. Gurman (ed.) Clinical handbook of couple therapy. New York: Guilford Press, pp 167-195. 4th edition.

Snyder, D. & Mitchell, A. 2008. Affective-reconstructive couple therapy: A pluralistic developmental approach. In A. Gurman (ed.) Clinical handbook of couple therapy. New York: Guilford Press, pp 353-382. 4th edition.

Unit 5b – The Couple Relationship: managing feelings; endings & maintenance and Video Assessment

Aims of the Unit – this unit covers the following

The well conducted ending of a couple therapy is an essential part of the work with the couple, as the end itself can be experienced as another form of loss, so may either be avoided or give rise to a further eruption of symptoms or inter-personal difficulties between the couple as the relationship with the therapist draws to an end. The couple therapist will enable the couple to make the best ending they can, bearing in mind that 'best' may include being open to emotional distress, which can then be understood further. The end of the therapy needs to be discussed from the beginning. Part of understanding the impact of the ending will also be the correct interpretation of any sudden changes in outcome measure scores.

The couple therapist shall work explicitly and collaboratively with the couple to identify potential future difficulties in the relationship and/or in the re-emergence of depression, and to set out a plan to be followed with realistic and specific activities and actions that will enable the couple to manage better what happens. Part of this plan may be the referral to other sources of help and support.

Ability to end couple therapy

An ability to terminate therapy in a planned and considered manner, including being open to revising a planned ending

An ability to act with discretion and awareness that timescales are different for different individuals, and that timetables can be disrupted by events

An ability to review the progress of therapy, for example by identifying what has been achieved, what remains to be achieved and what cannot be achieved

An ability to identify with the couple feelings associated with ending, including the ways these can be expressed indirectly, for example through:

- recurrences of presenting problems, or the emergence of new difficulties within the partnership that call into question the wisdom of ending
- requests from the couple to end early or precipitately, which may serve to avoid difficult feelings associated with ending

An ability to prepare a relapse prevention plan collaboratively with the couple that addresses both individual problems (e.g. depression in one partner) and couple problems (e.g. communication patterns) and sets out realistic interventions for these both to maintain gains and manage potential deterioration

An ability to liaise about the ending appropriately with practitioners who made the referral for couple therapy, and to refer on to other services where required and agreed

Learning Outcomes

Competency in

- working collaboratively with the couple in constructing an idiosyncratic relapse prevention plan or blueprint of therapy to maintain and consolidate gains and identify future stresses that might lead to further distressed feeling
- dealing with the mixed feelings that ending therapy brings, including helping the couple understand the impact of the loss of the therapy relationship on them, and linking this to the characteristic ways that they deal with such events
- judging the interaction between ending therapy and outcome measure scores for any particular couple
- liaising with referring professionals about the ending case in such a way as to increase their understanding of the nature of Couple Therapy for Depression, and of couple relationships, so enabling increasingly appropriate referrals

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Video assessment of a role-play using actors

Self-reflection questionnaires

Suggested reading

Suggested Reading

Beach, S., Sandeen, E. & O'Leary, K. 1990. Depression in marriage: A model for etiology and treatment. New York: Guilford.

Johnson, S. 2004. The practice of emotionally focused couple therapy. Creating connections. New York: Brunner-Routledge; 2nd edition.

Savege Scharff, J & Scharff, D. 2008. Object relations couple therapy. In A. Gurman (ed.) Clinical handbook of couple therapy. New York: Guilford Press, pp 167-195. 4th edition.

Woodhouse, D. and Pengelly, P. (1991). Anxiety and the Dynamics of Collaboration. Aberdeen, Aberdeen University Press

APPENDICES

Couple Therapy for Depression Competency Adherence Scale

This scale is drawn from the 'Specific Couple Therapy Techniques' Competencies.

Raters should make a judgement of the demonstration of the appropriate use of techniques in the observation or recording that they are evaluating on a scale of 0-4 where 0 indicates not present, and 4 indicates extensively present.

Not present	Possibly present	Briefly present	Moderately present	Extensively present
0	1	2	3	4

For each competency area there are examples of 'indicative evidence' that show that the practitioner is functioning within the competency range. Not all examples of indicative evidence need to be observed and there may be other pieces of evidence from the recording or observation that are equally valid. The task of the Rater is to make a professional judgement as to whether the appropriate competencies are being used at the appropriate time and the practitioner is practicing within the range of techniques of Couple Therapy for Depression.

Not all competencies would be expected to be observed in any one instance of the work as some relate to particular stages of the therapy and some are mutually contradictory because of the differences between the therapeutic interventions found in the Evidence Base. However, where there are substantial gaps the practitioner should be alerted so that they can then put forward more appropriate evidence for assessment.

Where the Rater feels that a competency should have been present and that this was a failure of the practitioner, rather than an accident of timing or a conflict of underpinning models, they shall draw this to the practitioner's attention for review in supervision.

It is generally expected that competent practitioners of Couple Therapy for Depression will be achieving a mix of 3s and 4s across the different Techniques, and that the Total Score for all the Techniques shall be at least 126. Scores that are considerably less than this suggest that the practitioner is not functioning as a fully competent IAPT Couple Therapist at the point of assessment. Scores that are borderline will need careful review with the participant as they may mean either a potential lack of competence or a lack of appropriate evidence.

Techniques that engage the couple		
What	Indicative evidence	Score (please circle)
An ability to form and develop a collaborative alliance with each partner and to enlist their support for relationship-focused therapy	<p>responding empathically in order to validate the experience of each partner, especially their emotional experience;</p> <p>accepting and exploring each partner's reservations about engaging in couple therapy;</p> <p>gauging when and whether separate sessions are needed to engage each partner in the therapy, or to overcome an impasse;</p>	0 1 2 3 4
An ability to form and develop an alliance with the couple as a unit	<p>reframing any presentation of individual problems in relationship terms;</p> <p>focusing attention on shared as well as separate concerns;</p> <p>supporting the partners' sense of themselves as being part of a unit as well as two individuals.</p>	0 1 2 3 4
An ability to promote a collaborative alliance between the partners in the couple	<p>using empathic questioning to help the partners explore and reappraise their respective positions;</p> <p>encouraging the partners to address each other directly, rather than the therapist being drawn into a role as mediator or interpreter.</p>	0 1 2 3 4
An ability to engender hope about the therapeutic process	<p>expecting neither too little nor too much about what can be achieved and by when;</p> <p>engaging constructively with problematic issues;</p> <p>encouraging, recognising and reflecting back positive cycles of interaction in the couple; reinforcing achievements by marking and celebrating positive change.</p>	0 1 2 3 4

<p>An ability to instigate therapeutic change</p>	<p>encouraging shared responsibility for the therapy by constructing agendas collaboratively;</p> <p>recapitulating and checking out key communications made during sessions;</p> <p>encouraging couples to describe events and episodes in active rather than passive terms (for example, asking 'how did you make that happen?' rather than 'how did that happen?');</p> <p>creating openings for new relational experiences (for example, through collaboratively setting homework assignments);</p> <p>being clear and sensitive about the rationale for any homework assignment, and following up on how it is experienced as well as whether it has been completed.</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 15 or ABOVE)</p>	

Techniques that focus on relational aspects of depression

What	Indicative evidence	Score (please circle)
<p>an ability to focus on and reduce negative cycles of influence between depression and couple interactions</p>	<p>educating couples about potential links between depression and stressful patterns of relating in the couple;</p> <p>gathering in broader aspects of the couple's relationship and focusing on these (for example, concentrating on their roles as parents as well as partners);</p> <p>inviting the depressed partner to assume the caring role normally occupied by her or his partner;</p> <p>asking the depressed partner to help her or his partner to express feelings;</p> <p>supporting the depressed partner in being assertive;</p> <p>discouraging blaming and denigration;</p> <p>encouraging partners to maintain routines, surroundings and relationships that provide them with a sense of familiarity and security.</p>	<p>0 1 2 3 4</p>
		<p>Cont...</p>

<p>An ability to review interpersonal roles in the couple relationship, especially with regard to care giving and care receiving</p>	<p>using family life-space techniques (such as sculpting or button/stone games) to enable partners to represent how roles are divided between them, including any changes that have taken place;</p> <p>encouraging each partner to depict graphically the amount of time and energy they believe they spend carrying out these roles, including any changes that have taken place;</p> <p>using genograms to investigate family-of-origin roles;</p> <p>reviewing how roles were allocated in previous partnerships;</p> <p>highlighting similarities and differences between each partner in terms of their cultural expectations;</p> <p>investigating how their audit of relationship roles compares with what each partner expects and desires;</p> <p>identifying areas where changes might be achieved.</p>	<p>0 1 2 3 4</p>
<p>An ability to consult with the couple about their interaction</p>	<p>Reflecting back observations about recurring patterns of relating between the partners;</p> <p>reflecting back observations about ways in which each partner and the couple use their therapist;</p> <p>reflecting back observations about any relevance this might have to their relationship concerns.</p>	<p>0 1 2 3 4</p>
<p>An ability to generate and test hypotheses that explain depressive symptoms through the relational contexts in which they occur</p>	<p>offering thoughts about the possible functions of symptomatic behaviour for each partner;</p> <p>highlighting the roles played by each partner and others in creating and maintaining depressive symptoms, and exploring possible reasons for these;</p> <p>describing interactive patterns that may maintain depressive symptoms.</p>	<p>0 1 2 3 4</p>
		<p>Cont...</p>

<p>An ability to challenge repetitive sequences</p>	<p>interrupting monologues, or cycles of accusation, rebuttal and counter-accusation; exploring possible functions performed by such repetitive sequences for each partner and the couple;</p> <p>suggesting alternative behaviours or ways of communicating.</p>	<p>0 1 2 3 4</p>
<p>An ability to offer possibilities for altering interactions</p>	<p>tracking and reflecting back observations about patterns of relating and their possible purposes for each partner and the couple;</p> <p>replaying and highlighting key interactions so they can be more directly be experienced in the session and made available for reflecting on in the therapy;</p> <p>providing opportunities for each partner to imagine what they think might happen if existing roles and relationship patterns were to change;</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 18 or ABOVE)</p>	

**Techniques that reduce stress upon and increase support within the couple 1:
improving communication**

What	Indicative evidence	Score (please circle)
An ability to teach listening skills	<p>encouraging partners to listen actively (clarifying but not debating what is being said) in a manner that supports and validates the speaker;</p> <p>encouraging partners to summarise and reflect back what they have heard, especially in relation to key issues voiced;</p> <p>discouraging either partner (or their therapist) from making unfounded assumptions about communications.</p>	0 1 2 3 4
An ability to teach disclosing skills	<p>encouraging direct rather than ambiguous statements;</p> <p>encouraging the expression of appreciation, especially before raising concerns;</p> <p>softening the way concerns are introduced and voiced;</p> <p>discouraging ending on a criticism when positive statements are made;</p> <p>promoting 'I' statements (rather than 'We' or 'You' statements that attribute meanings and intentions to others);</p> <p>encouraging concise, specific and relevant speech;</p> <p>encouraging expression of information about feelings as well as reports of thoughts and experiences.</p>	0 1 2 3 4
An ability to use exploratory techniques to aid communication	<p>using open-ended questioning;</p> <p>extending the issue being discussed;</p> <p>using silence while actively and supportively listening.</p>	0 1 2 3 4
An ability to use explanatory techniques to aid communication	<p>clarifying what has been said;</p> <p>providing feedback about a communication;</p> <p>reconstructing the content of a message, especially where contradictions may be embedded within it.</p>	0 1 2 3 4
TOTAL SCORE (SHOULD BE 12 or ABOVE)		

**Techniques that reduce stress upon and increase support within the couple 1:
reducing stress**

What	Indicative evidence	Score (please circle)
<p>An ability to help partners cope with their own and each other's stress</p>	<p>enhancing a sense of safety by encouraging each partner to talk first about low-level stressors that are removed from home before going on to talk about higher-level stressors that may be closer to home;</p> <p>encouraging the speaking partner to identify what they might find helpful in coping with the stress;</p> <p>enabling the listening partner to offer empathic support for the speaker in disclosing what they are finding stressful, and any specific needs they may have in order to cope with the stress;</p> <p>encouraging the speaking partner to provide empathic feedback on their experience of being supported;</p> <p>repeating these sequences with the partners changing speaker and listener roles;</p> <p>maintaining fairness and equity in the balance of speaker and listener roles to ensure neither partner is privileged in either role.</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 3 or ABOVE)</p>	

Techniques that reduce stress upon and increase support within the couple 2: managing feelings

What	Indicative evidence	Score (please circle)
<p>An ability to encourage the expression and reformulation of depressive affect</p>	<p>supporting the expression of depressed feelings, and the partner's reactions to depressed feelings, and encouraging acceptance of them;</p> <p>exploring past and present experiences of loss that may account for these feelings, which provide a framework for acknowledging and understanding them;</p> <p>facilitating mourning.</p>	<p>0 1 2 3 4</p>
<p>An ability to work with partners who might minimise expressions of emotion</p>	<p>normalising emotional experience;</p> <p>describing emotions in language that is both accessible and meaningful to the couple;</p> <p>validating and promoting acceptance of both existing and newly-experienced feelings of each partner;</p> <p>using questions, hypotheses, and/or reflections that can evoke emotions within the session in the service of then making them intelligible to each partner;</p> <p>using pacing and softening techniques to create safety in evoking emotion;</p> <p>heightening awareness of the link between physiological arousal and emotional states (for example, by using bio-feedback methods);</p> <p>teaching individual self-soothing techniques and when possible, inviting and enabling partners to help each other implement self-soothing techniques;</p> <p>heightening emotions, in a controlled and safe way within the session by repeating key phrases to intensify their impact.</p>	<p>0 1 2 3 4</p>

<p>An ability to work with partners who amplify the expression of emotion</p>	<p>bounding the expression of emotion within sessions;</p> <p>helping partners differentiate between their emotional states as experienced in themselves and as observed by others;</p> <p>helping them to clarify when unexpressed emotional states might underlie expressed emotion (for instance when unexpressed fear underlies the expression of anger);</p> <p>promoting containment of upset in one domain of life to prevent it infiltrating other domains;</p> <p>curtailing statements of contempt through opening up explorations of its impact and underlying emotions;</p> <p>helping partners to establish useful boundaries around emotional expression, for example through scheduling mutually agreed times and places in which to discuss feelings, especially those associated with painful experiences, whether shared or separate;</p> <p>encouraging partners to accept the importance of other relationships (such as friends and relatives) to provide additional emotional support, and to reduce unmanageable pressure on the relationship, while also identifying and agreeing upon mutually acceptable boundaries (such as, for example, mutually agreed sexual or financial limits to other relationships).</p>	<p>0 1 2 3 4</p>
<p>An ability to work with mismatches between partners' emotional responses and meanings</p>	<p>building awareness between partners of their different attitudes, histories and experiences with expressing specific emotions, and their different attitudes towards introspection, self-disclosure and exploration of feelings;</p> <p>accepting and processing mismatches of emotional expression and responsiveness;</p> <p>helping translate each partner's respective meanings of the other's behaviours;</p> <p>helping the couple reach clearer shared understandings of each other's responses and meanings.</p>	<p>0 1 2 3 4</p>

<p>An ability to provide empathic support</p>	<p>tracking the emotions of each partner, as signalled within sessions through verbal and non-verbal cues;</p> <p>tuning into and validating emotional experience, for example by responding sensitively and robustly;</p> <p>focusing on patterns of relating that disrupt emotional connection, and promoting their repair through reprocessing sequences as experienced by each partner;</p> <p>reframing the emotional experiences of partners to make them intelligible and acceptable to each other.</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 15 or ABOVE)</p>	

**Techniques that reduce stress upon and increase support within the couple 2:
changing behaviour**

What	Indicative evidence	Score (please circle)
<p>An ability to hold collaborative discussions to establish and assist in achieving agreed upon and specific goals</p>	<p>helping couples identify and set their own goals for the therapy;</p> <p>establishing the rules and procedures for achieving these goals;</p> <p>when appropriate, contracting with either or both partners to refrain from specific behaviour (for instance, behaviour that has been agreed-upon as dangerous);</p> <p>exploring why behavioural agreements entered into by the partners have worked or failed to work, and reviewing goals in the light of this.</p>	<p>0 1 2 3 4</p>
<p>An ability to instigate an increase in reciprocated positive behaviour</p>	<p>noting such behaviour in the couple and focusing on increasing the frequency of positive exchanges rather than on diminishing negative exchanges;</p> <p>helping each partner to generate a list of specific, positive, non-controversial things they could do for the partner;</p> <p>helping the partner to whom the list is directed to develop the list;</p> <p>conducting a staged approach in which requests from partners are simple and clear, complaints from and about partners become wishes, specific, reciprocal, achievable changes are negotiated and worked at together, and progress is monitored by all participants;</p> <p>encouraging the reciprocation of positive behaviour.</p>	<p>0 1 2 3 4</p>

<p>An ability to instigate an increase in positive behaviour that does not depend on reciprocation</p>	<p>enabling partners to identify and achieve specific changes they want to make in themselves irrespective of whether their partner reciprocates, including: changes of a broad nature, such as improving the emotional climate of the relationship through being more available to share time; changes with a specific focus, such as the manner in which concerns are raised;</p> <p>encouraging partners to predict how changes in their own behaviour might have a positively reinforcing effect upon their partner and exploring how this prediction looks to the partner, as well as exploring their own and their partner's response to initiating such change;</p> <p>identifying and articulating relationship themes and meanings for each partner that lie behind specific behaviour.</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 12 or ABOVE)</p>	

Techniques that reduce stress upon and increase support within the couple 3: solving problems

What	Indicative evidence	Score (please circle)
<p>An ability to create and nurture shared systems of meaning within the couple as a prelude to addressing problems</p>	<p>encouraging partners to talk to each other about respective hopes and fears they have about their relationship, especially when they feel upset or threatened;</p> <p>establishing and noting, to underline their intentional nature, the partners' daily rituals of connecting with each other (over meal times, shared activities and so on);</p> <p>identifying ways, and noting their intentional nature, in which partners already are supported by each other in their shared roles (parenting, home maintenance and so on);</p> <p>facilitating the emergence and recognition of a shared relationship story and noting how it clarifies and sustains the values and meanings the partners have in common.</p>	<p>0 1 2 3 4</p>
<p>An ability to help couples define problems in ways that can limit complaint or criticism</p>	<p>By encouraging partners to use specific examples when raising potentially contentious issues;</p> <p>to convey why the problem is important to them;</p> <p>to include clear statements about how the problem makes them feel.</p>	<p>0 1 2 3 4</p>
<p>An ability to provide a structured and stepped approach to problem-focused discussions</p>	<p>separating the process of sharing thoughts and feelings from discussions about the way in which decision-making and problem-solving will proceed;</p> <p>developing communication skills before applying them to problem-solving;</p> <p>starting with low conflict before proceeding to high conflict issues;</p> <p>addressing one problem at a time;</p> <p>avoiding being sidetracked;</p> <p>discouraging disagreements when there is insufficient time to address them.</p>	<p>0 1 2 3 4</p>

<p>An ability to enable partners to try out different approaches to managing conflict</p>	<p>enacting arguments in the safety of the therapy session;</p> <p>interrupting enacted arguments to explore alternative approaches;</p> <p>encouraging pretend or controlled arguments outside sessions.</p>	<p>0 1 2 3 4</p>
<p>An ability to help couples find a solution to identified specific problems</p>	<p>Through sequentially defining problems;</p> <p>brainstorming potential positive alternatives to current problematic behaviour;</p> <p>evaluating the pros and cons of those alternatives;</p> <p>negotiating alternatives;</p> <p>identifying the components of a contract;</p> <p>forming an explicit (when appropriate, written) contract.</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 15 or ABOVE)</p>	

**Techniques that reduce stress upon and increase support within the couple 3:
promoting acceptance**

What	Indicative evidence	Score (please circle)
<p>An ability to work with couples in ways that respect each partner's experience of depression</p>	<p>educating the couple about depression by naming and explaining the symptoms of depression, allowing depression to be viewed as an illness, and thereby reducing feelings of guilt or blame associated with the condition;</p> <p>accepting the couple's reality of the depressed partner as patient especially in the early stages of therapy, and simultaneously helping the non-depressed partner play a supportive role;</p> <p>accepting the reality of both partners' depression when this is the case, and the limitations on what each can do for the other in the short term;</p> <p>engaging the supportive abilities of the non-depressed partner, for example by involving him or her in helping the depressed partner prioritise tasks, undertake manageable social activities, be assertive; recognise dysphoric symptoms; seek out situations that can relieve such symptoms;</p> <p>evaluating and managing the patient's depressive symptoms, including the need for either social stimulus and/or medication;</p> <p>relating to the depressed partner as 'more than his or her depression', to help reduce the effects of depression;</p> <p>assisting the depressed partner to manage their condition for themselves.</p>	<p>0 1 2 3 4</p>

<p>An ability to help partners empathically connect with each other around the problem</p>	<p>eliciting vulnerable feelings from each partner that may underlie their emotional reactions to the problem;</p> <p>encouraging them to express and elaborate these feelings;</p> <p>conveying empathy and understanding for such feelings;</p> <p>helping each partner develop empathy for the other's reactions through modelling empathy toward both partners.</p>	<p>0 1 2 3 4</p>
<p>An ability to help the couple empathically connect with each other in distancing themselves from their concerns</p>	<p>Helping partners step back from their problem and take a descriptive rather than evaluative stance towards it;</p> <p>describe the sequence of actions they take during problematic encounters to build awareness of the triggers that activate and escalate their feelings and consider departures from their behaviour and what might account for such variations;</p> <p>generate an agreed name for problematic repetitive encounters to help them call 'time out'.</p>	<p>0 1 2 3 4</p>
<p>An ability to help the couple develop tolerance of responses that the problem can trigger</p>	<p>helping partners identify positive as well as negative functions served by problematic behaviour;</p> <p>using desensitising techniques to reduce the impact of problematic behaviour (such as practising arguments in sessions).</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 12 or ABOVE)</p>	

**Techniques that reduce stress upon and increase support within the couple 4:
revising perceptions**

What	Indicative evidence	Score (please circle)
<p>An ability to observe and reflect back on observations of seemingly distorted cognitive processing</p>	<p>marking selective inattention;</p> <p>encouraging partners to check out the validity of attributions they make about each other;</p> <p>encouraging partners to check out the validity of perceived (as compared with actual) criticism;</p> <p>drawing attention to self-reinforcing problematic predictions and assumptions.</p>	<p>0 1 2 3 4</p>
<p>An ability to reduce blame and stimulate curiosity in the partners about their own and each other's perceptions</p>	<p>'circular' questioning (questioning that highlights the interactive nature of each partner's behaviour on the other);</p> <p>'Socratic' questioning (questioning that re-evaluates the logic behind existing positions in order to create an alternative, more functional logic);</p> <p>Encouraging partners to 'read' what their partner is thinking and feeling through: picking up verbal and non-verbal cues and messages, and listening to feedback about the accuracy of these readings;</p> <p>imagining the effects their behaviour and feelings have on their partner, and to accept and reflect on feedback from their partner about this.</p>	<p>0 1 2 3 4</p>
<p>An ability to use techniques that increase the partners' understanding of their own and each other's vulnerability to cognitive distortion</p>	<p>identify recurring behaviour and feelings that might act as flashpoints for each partner in their relationship;</p> <p>explore the contexts in which they arise; encourage reflection across relationship domains about similar experiences and reactions.</p>	<p>0 1 2 3 4</p>

<p>An ability to engage the curiosity of partners about possible links between their current relationship perceptions and past developmental experiences</p>	<p>taking a thorough family and relationship history for each partner, or facilitating this to emerge in the context of the therapeutic process, that includes attachment patterns, events and themes;</p> <p>using devices such as family genograms to identify cross-generational family meanings, norms, and/or expectations, especially with regard to relationship roles and scripts;</p> <p>allowing embedded roles, scripts, themes, and patterns that might contribute to distortions in the representation of relationships to emerge and be worked with;</p> <p>linking past attachment themes and problematic experiences with current perceptions and predictions.</p>	<p>0 1 2 3 4</p>
<p>An ability to develop shared formulations of central relationship themes</p>	<p>exploring the transference of representations of past attachment patterns, roles and affects into current couple and/or therapy relationships, and helping the couple distinguish between past and present meanings and realities;</p> <p>exploring the therapist's own emotional and behavioural responses, both to each partner and to the couple itself to identify affects and experiences that may reflect and resonate with those of the couple;</p> <p>to make connections between the affective experiences of each partner and their therapist to build understanding from shared experience.</p>	<p>0 1 2 3 4</p>
<p>An ability to identify and make links between specific arguments and central relationship themes</p>	<p>Highlighting: meanings, thoughts and feelings that accompany escalating arguments;</p> <p>recurring tensions over the need for intimacy and autonomy;</p> <p>conflicts that are structured around issues of dominance and submission;</p> <p>roles that rooted in gender or cultural expectations that might be uncomfortable for one or other of the partners;</p> <p>past attachment experiences that might be creating anxieties and fears.</p>	<p>0 1 2 3 4</p>

<p>An ability to reframe events, actions, feelings or interactions to provide alternative, more positive and/or functional meanings to those posited by one or both partners in order to change perceptions of what is going on in the relationship</p>	<p>reconceptualising a partner's perceived negative motivations as misguided or misfired attempts to be supported by and/or supportive of the other;</p> <p>emphasising the desire of partners to enable rather than disable each other.</p>	<p>0 1 2 3 4</p>
<p>An ability to apply developing formulations to achieve changes in perception</p>	<p>working through past attachment difficulties, disappointments and losses;</p> <p>making accessible and accepting feared emotions/experiences, and encouraging new ways that partners can be with each other;</p> <p>providing the context for a corrective emotional experience that encourages each partner to feel secure with each other.</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 24 or ABOVE)</p>	

Adherence Scale Summary Sheet

ID:		
Session #	Segment:	
Rater ID:	Date:	
Specific Couple Therapy Techniques		Scores
Techniques that engage the couple		
Techniques that focus on relational aspects of depression		
Techniques that reduce stress upon and increase support within the couple 1: <i>improving communication</i>		
Techniques that reduce stress upon and increase support within the couple 1: <i>reducing stress</i>		
Techniques that reduce stress upon and increase support within the couple 2: <i>managing feelings</i>		
Techniques that reduce stress upon and increase support within the couple 2: <i>changing behaviour</i>		
Techniques that reduce stress upon and increase support within the couple 3: <i>solving problems</i>		
Techniques that reduce stress upon and increase support within the couple 3: <i>promoting acceptance</i>		
Techniques that reduce stress upon and increase support within the couple 4: <i>revising perception</i>		
Total Score		
Comments:		

Practitioner's Rationale for Technique Selection

Name:

Unit:

Technique Chosen:

What is the fit with your basic Couple Training?

How is this technique is better suited than others to your clinical practice with couples where one partner is depressed?

What are the circumstances when you might decide that this technique is not suitable?

How confident do you feel about using this technique? Please indicate:

1	2	3	4	5
Not at all		Moderately		Very

EXAMPLE TRAINING TIMETABLE

Day 1: Introduction to IAPT, Couple therapy and Depression

9.00 Coffee and registration

9.30 Welcome and introductions. Outline, aims and structure of the course.

10.55 Coffee

11.15 IAPT

12.45 Lunch

1.45 NICE depression; diagnosis, risk assessment, treatment, medication.

2.30 Introduction to the main principles of couple therapy.
Case discussion groups

3.40 Tea

4.00 Plenary. The Plenary should include the opportunity to reflect on the experience of the day – including the interactions between the participants, and between them and the training team – as well as the learning achieved.

4.30 End

Day 2: The Therapeutic Relationship – engagement, balance and involvement

9.00 Coffee

9.30 Aims of the day and learning outcomes

9.45 IBCT overview. Promoting acceptance. Assessment and Formulation.

10.55 Coffee

11.15 Case study focusing on acceptance and formulation.

12.00 Case discussion groups focusing on participants own casework.

12.45 Lunch

1.45 Measures and revising perceptions.

3.40 Tea

4.00 Plenary

Day 3: The Couple Relationship - Improving Interactions I

9.00 Coffee

9.30 Aims of today and tomorrow.

9.45 Communication Skills

10.55 Coffee

11.15 Case discussion groups: role plays

12.45 Lunch

1.45 Coping with stress.

2.45 Case Discussion groups

3.40 Tea

4.00 Plenary

Day 4: The Couple Relationship - Improving Interactions II

9.00 Coffee

9.30 Aims of the day

9.45 Problem solving techniques

10.55 Coffee

11.15 Case discussion groups

12.45 Lunch

1.45 Changing behaviour

2.45 Case Discussion groups.

3.40 Tea

4.00 Plenary

Day 5: Managing Feelings. Managing Endings. Video Assessment

9.00 Coffee

9.30 Aims of the day

9.45 Managing Feelings

10.55 Coffee

11.15 Case discussion groups.

12.45 Lunch

1.45 Endings.

2.30 Case discussion groups. Discussion on endings and managing feelings.

3.40 Tea

4.00 Plenary

COUPLE THERAPY FOR DEPRESSION PRACTITIONER TRAINING COURSE

Course Dates

COURSE EVALUATION

Please circle the number along the continuum which best describes your opinion. On this scale from 1-5, circle (1) for a “poor” evaluation, (5) for an excellent evaluation and (3) for a neutral response.

Evaluation of teaching sessions:

	Poor	Neutral			Excellent
UNIT 1A: Origins of Couple Therapy for Depression	1	2	3	4	5
Overview of IAPT/Medication/Risk	1	2	3	4	5
UNIT 1B: Principles of Couple Therapy	1	2	3	4	5
UNIT 2A: Acceptance & Tolerance	1	2	3	4	5
UNIT 2B: Use of Measures	1	2	3	4	5
Revising Perspectives	1	2	3	4	5
UNIT 3A: Communication Skills	1	2	3	4	5
UNIT 3B: Coping with Stress	1	2	3	4	5
UNIT 4A: Problem-Solving Techniques	1	2	3	4	5
UNIT 4B: Changing Behaviour	1	2	3	4	5
UNIT 5A: Managing Feelings	1	2	3	4	5
UNIT 5B: Endings	1	2	3	4	5
Video Material	1	2	3	4	5
Plenary Sessions	1	2	3	4	5

cont...

Evaluation of other aspects of the course:

	Poor	Neutral			Excellent
	1	2	3	4	5
Please rate your satisfaction with this course as a CPD add-on to your existing Couple Experience	1	2	3	4	5
Please rate the usefulness of the Training Pack & handouts	1	2	3	4	5
Please rate the responsiveness of the Training Team to queries or comments about the course	1	2	3	4	5
Please rate the organization of the course	1	2	3	4	5
Please rate the quality of refreshments/lunch	1	2	3	4	5
Please rate the Training environment (rooms etc)	1	2	3	4	5

Overall, what were the strengths of the course?

Overall, what were the weaknesses of the course?

Please share any suggestions you may have for future Couple Therapy for Depression training courses.

Thank you for your feedback – please feel free to email us with further comments if wanted.

TCCR/IAPT 15 MINUTE FILMED TRAINING SCENARIO

FOR FINAL DAY

George (51), a TV news producer, originally from Leeds, and Annette (48), a teaching assistant at a local secondary school, have been married for 18 years. They have two teenage daughters, Lara, 13, and Katie, 15, and live in London, near to where Annette grew up.

Annette was diagnosed with depression a year ago, apparently triggered by the death of her father. They have been referred to IAPT couples therapy for depression and during the assessment it was revealed that Annette had a termination early on in their relationship, although it hasn't been talked about since.

We meet them session 6, (3 sessions were spent on assessment), where the therapist and couple are familiar with each other.

George

Appearing to support Annette during her depression, George is barely able to contain his frustration at her 'negative' thinking. He feels that his life's work has been spent trying to make her happy and is quick to say that if the relationship is what is getting her down, they should consider separating. He's a bit of a martyr at times, which is very powerful.

George is a 'fixer', a man with a solution to everything. He's used to running news teams. He is always 'on call' and clearly his career is a huge part of who he is. He's abroad a lot and with his charisma, energy and people-pleasing persona, Annette's doubts about his fidelity are probably well-founded, although George denies having an extra-marital affair. These doubts are compounded by the fact the couple have not had sex for a year, 'because of Annette's illness'.

George finds it hard to think about himself and spends much of his time imagining what is going on in Annette's head. He recognises he can't talk about his emotional life and is alarmed at the prospect of any change. As part of an individual assessment session he talked of not sharing any part of his internal world with his violent mother after about the age of 9, "why should I change that now?" As a result, he spends much of the session's time being a 'good client', willing the therapist to acknowledge how hard he is trying and how Annette is clearly going mad.

Annette

Annette talks about what gets her down in her marriage and, once she gets started, finds it hard to stop; issues and events mushrooming up into a huge, insurmountable cloud of despair.

She feels she has a good understanding of her internal life and is always the one urging George to try and talk together. In reality, she very swiftly feels infantilised and powerless in the relationship and is unable to contain herself or her panicked emotions; her extremes of feelings graphically illustrating to George exactly why he doesn't want to talk about their relationship.

She wants the therapist to understand how impossible George is but can often feel that she is being criticised during the session, by both George and the therapist.

The couple's background

Annette's foundations have been shaken by the death of her father. The loss she is experiencing has linked into her resentment and guilt around the termination. She blames George for never talking about it and this then augments her sense of injustice about being the chief child-carer and bottle-washer. She feels stuck in a dead-end job and a lonely marriage with no choice but to carry on; at this point she takes the martyr baton from George.

The termination seems to trigger in both partners a yearning for the life before they met. There's an unspoken fear that the only reason that they stayed together was to protect each other from the painful thought that enduring the trauma of the termination was "all for nothing". Focussing on their relationship's beginning seems to be the way into expressing their fears about their difference; that they have nothing in common. Now the girls are growing up, these differences are becoming overwhelming.

Coming from different parts of England with families from different socio-economic and cultural backgrounds; both have been wondering if they would be better off with someone else. These clashes over difference are often played out in their parenting styles and, with two teenage daughters already pushing their buttons with ease, the rows and sullen silences that follow are now the primary components of their relationship.

Below is an excerpt of the type of exchange they would have in a session but please improvise, it is just to give you a taste of their communication. (Please try and make each role play as similar as is possible, although each therapist will have a different style. Don't worry if you are led down a different path by the therapist, just go with it).

What we are trying to illustrate in this scenario is that when things feel bad, Annette and George tend to feel polarised (he all positive/her all negative etc) and thus isolated and misunderstood.

They are both frightened about their feelings and what is happening and so communication has broken down. They are trying to locate the 'fault' in the other and don't want to think about their own part in it. They think their problems stem from their differences, which can never be resolved.

The therapist needs to try and not be pulled towards one partner or the other but occupy a 'couple' space between them, hopefully encouraging them to do the same. He or she will be trying to encourage more acceptance and tolerance of difference and improve their communication and problem solving skills.

Annette

Of course, it's ironic... that's why I fell for him in the first place. His charm...his passion for his work... and the fact that he wasn't like the chinless wonders I'd gone out with before..

George

What, you mean old Giles the Gormless...

(A BRIEF SMILE BETWEEN THEM...)

Annette

But I didn't realise that work would come before me, always. That I'd always take second place...

(PAUSE)

Actually more like fifth place...

(TO THERAPIST)

Do you know that when I was in labour, with both girls, he spent all his time on the phone to the office.

(SILENCE FOR A MOMENT WHILE BOTH REMEMBER)

Even the midwife was embarrassed and asked him to go outside.

(HER SENSE OF INJUSTICE IS BUILDING)

He never remembers our anniversary but if the BBC news team wins an award, well... it's champagne all round. He says it's because he's from the North and they're not soft like that...but I think.... (doesn't end her sentence, but it would be 'that he doesn't love me'.)

....Just like he says we should leave the girls to make their own rules about what they can do. That no-one knew what *he* got up to after the age of nine. He couldn't care less if they roll in a 2 am, high as kites.

(HER BITTERNESS IS EMERGING)

And, you know, he never talks to them about how they are feeling, what's going on in their world. If there's a hint of trouble, I have to front it out with them on my own and have them loathing me for days. If I leave it to him, he just throws cash at them.

(SARCASTIC, TO GEORGE NOW)

Yes, that'll solve it! A trip to Westfields!

George

(TO THERAPIST)

Are you going to stop her? She can go on like this for hours you know. Can't you, honey?

Annette

Oh, shut up.

George

(TO THERAPIST)

I know it's just the depression, that it's an illness and she can't help it. I've spoken to quite a few people about it, experts... and I know it will pass. She'll get better.

(APPEALING TO THE THERAPIST)

One thing I know would help is if she changed job.

No-one values her enough – and being in that school year in and year out would be enough to drive anyone mad...

Annette

(INTERRUPTING, NOT REGISTERING WHAT HE'S SAYING AT ALL)

If I'd known that I was marrying someone *this* stunted emotionally....You know, I don't think he has an emotion in him – I'd never have gone out with him in the first place. I should have known. I should have seen....

(MUSTERING UP THE COURAGE TO SAY)

How he was ... about the termination. Right at the start.

(PAUSE)

He just threw money at that too. A big present when I got home.

(TO SELF)

I've still got it I think, a beautiful velvet scarf.

(TALKING AS IF SHE'S GEORGE)

'Not cheap that. Like it? That's good. All better now. No need to talk about this again. Let's shove it under the carpet, in the cupboard, under the stairs, where no-one will trip over it. Ever. Again.'

(TO THERAPIST)

Normal people just aren't like that. He's like some sort of robot. It feels like I'm living with an alien from outer space.... And he wonders why I never want to have sex with him...

(TO GEORGE)

Don't look shocked, I'm supposed to be truthful here.

(TO THERAPIST)

Aren't I?

George

Honestly, if you listened to her you'd hardly believe we've got two lovely girls, a lovely house... We go on lovely holidays... We've got friends, family. You'd never believe it....

Video Assessment – Notes and Rating Scale

For Participants

We're aiming particularly for the overall competency around **balance**, but would expect to see others also. This couple is one where we'd be looking for the therapists NOT to treat Annette as the ill person, but to try to see the distress as part of the **couple dynamic**.

Remember to go for the **polarisation** between the couple, and to try to get to something '**empathically joining**'.

Feel free to address the couple as though you have already got a **formulation** (but do remind them of it so that the actors have something to go with).

The Couple

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The Ratings

Have a look through the list, below, to refresh your memory of the kinds of things that could be evidenced in the role play. **YOU ARE NOT EXPECTED TO DO ALL OF THEM** – you might choose which ones you want to focus on, though. To show competence you'll need to get an overall score of more than 30, which should be manageable.

Video Assessment Competency Adherence Scale

This scale is drawn from the ‘Specific Couple Therapy Techniques’ Competencies.

Raters should make a judgement of the demonstration of the appropriate use of techniques in the observation or recording that they are evaluating on a scale of 0-4 where 0 indicates not present, and 4 indicates extensively present.

Not present	Possibly present	Briefly present	Moderately present	Extensively present
0	1	2	3	4

For each competency area there are examples of ‘indicative evidence’ that show that the practitioner is functioning within the competency range. Not all examples of indicative evidence need to be observed and there may be other pieces of evidence from the recording or observation that are equally valid. The task of the Rater is to make a professional judgement as to whether the appropriate competencies are being used at the appropriate time and the practitioner is practicing within the range of techniques of Couple Therapy for Depression.

For the Video Assessment a therapist will not be able to evidence all of these, but different therapists will evidence different competencies, which is why there are 18 different ones. Raters should look for evidence of the first competence in particular.

NAME:

Potential Techniques utilised during the video assessment		
What	Indicative evidence	Score (please circle)
<p>An ability to draw on knowledge that couple therapists focus on establishing and maintaining a balanced position in relation to the couple</p>	<p>focusing attention on their relationship, rather than either partner, as the means of achieving change</p> <p>providing a framework for understanding and managing presenting concerns</p>	<p>0 1 2 3 4</p>
<p>An ability to draw on knowledge that couple therapists focus on understanding the interpersonal factors that shape the dynamics of couple relationships</p>	<p>focusing on the effects of potentially different understandings and levels of awareness between partners about their roles, responsibilities and expected behaviour</p> <p>exploring the degree to which the partners agree on matters such as what constitutes a comfortable distance in their relationship, or how feelings are managed</p>	<p>0 1 2 3 4</p>

	<p>exploring the degree of fit within the couple over the values, beliefs and meanings each partner brings to interpreting events occurring inside and outside their relationship</p> <p>addressing the degree to which each partner is aware of and responsive to the other's feelings, intentions and states of mind, especially in stressful situations</p> <p>acknowledging the couple's communication skills, including their capacity to give, ask for and accept support from each other</p> <p>assessing the rigidity or flexibility with which partners interact together, including their capacity to adapt and change over time</p>	
<p>An ability to draw on knowledge that couple therapists focus on understanding developmental factors that contribute to shaping the dynamics of couple relationships</p>	<p>addressing the effects of family of origin, childhood and earlier partnership experiences on each partner's assumptions about and expectations of their relationship</p> <p>addressing the ways in which couple and family relationships and meanings have been changed by predictable life events (such as the birth of a child)</p> <p>addressing the ways in which couple and family relationships and meanings have been changed by unpredictable life events (such as unemployment, illness, or bereavement)</p> <p>addressing the ways in which new partnerships are affected by past relationship conflicts, and ongoing commitments resulting from them (such as parenting or financial responsibilities)</p>	<p>0 1 2 3 4</p>
<p>An ability to take account of sexual functioning in the couple's relationship</p>	<p>exploring the current state of their sexual relationship</p> <p>identifying any changes that have taken place over time</p> <p>establishing if the couple wants specialist help for any sexual dysfunction</p>	<p>0 1 2 3 4</p>

<p>An ability to consult with the couple about their interaction</p>	<p>reflecting back observations about:</p> <ul style="list-style-type: none"> • recurring patterns of relating between the partners • ways in which each partner and the couple use their therapist • any relevance this might have to their relationship concerns 	<p>0 1 2 3 4</p>
<p>An ability to generate and test hypotheses that explain depressive symptoms through the relational contexts in which they occur</p>	<p>offering thoughts about the possible functions of symptomatic behaviour for each partner;</p> <p>highlighting the roles played by each partner and others in creating and maintaining depressive symptoms, and exploring possible reasons for these;</p> <p>describing interactive patterns that may maintain depressive symptoms.</p>	<p>0 1 2 3 4</p>
<p>An ability to challenge repetitive sequences</p>	<p>interrupting monologues, or cycles of accusation, rebuttal and counter-accusation</p> <p>exploring possible functions performed by such repetitive sequences for each partner and the couple</p> <p>suggesting alternative behaviours or ways of communicating, including specific skills to regulate conflict</p>	<p>0 1 2 3 4</p>
<p>An ability to form and develop a collaborative alliance with each partner and to enlist their support for relationship-focused therapy</p>	<p>responding empathically in order to validate the experience of each partner, especially their emotional experience</p> <p>accepting and exploring each partner's reservations about engaging in couple therapy</p> <p>gauging when and whether separate sessions are needed to engage each partner in the therapy, or to overcome an impasse</p>	<p>0 1 2 3 4</p>
<p>An ability to promote a collaborative alliance between the partners in the couple</p>	<p>using empathic questioning to help the partners explore and reappraise their respective positions</p> <p>encouraging the partners to address each other directly, rather than the therapist being drawn into a role as mediator or interpreter</p>	<p>0 1 2 3 4</p>

<p>An ability to help partners empathically connect with each other around their concerns</p>	<p>eliciting vulnerable feelings from each partner that may underlie their emotional reactions to their concerns</p> <p>encouraging them to express and elaborate these feelings</p> <p>conveying empathy and understanding for such feelings</p> <p>helping each partner develop empathy for the other's reactions through modelling empathy toward both partners</p>	<p>0 1 2 3 4</p>
<p>An ability to reduce blame and stimulate curiosity in the partners about their own and each other's perceptions</p>	<p>'circular' questioning (questioning that highlights the interactive nature of each partner's behaviour on the other)</p> <p>'Socratic' questioning (questioning that re-evaluates the logic behind existing positions in order to create an alternative, more functional logic)</p> <p>encouraging partners to 'read' what their partner is thinking and feeling through:</p> <ul style="list-style-type: none"> • picking up verbal and non-verbal cues and messages • listening to feedback about the accuracy of these readings • minimising unhelpful 'mindreading' • imagining the effects their behaviour and feelings have on their partner, and to accept and reflect on feedback from their partner about this 	<p>0 1 2 3 4</p>
<p>An ability to identify and make links between specific arguments and central relationship themes</p>	<p>highlighting meanings, thoughts and feelings that accompany escalating arguments</p> <p>highlighting recurring tensions over the need for intimacy and autonomy</p> <p>highlighting conflicts that are structured around issues of dominance and submission</p> <p>highlighting roles that rooted in gender or cultural expectations that might be uncomfortable for one or other of the partners</p> <p>highlighting past attachment experiences that might be creating anxieties and fears</p>	<p>0 1 2 3 4</p>
<p>An ability to</p>	<p>reconceptualising a partner's perceived</p>	

<p>reframe events, actions, feelings or interactions to provide alternative, more positive and/or functional meanings to those posited by one or both partners in order to change perceptions of what is going on in the relationship</p>	<p>negative motivations as misguided or misfired attempts to be supported by and/or supportive of the other</p> <p>emphasising the desire of partners to enable rather than disable each other</p>	<p>0 1 2 3 4</p>
<p>An ability to use explanatory techniques to aid communication</p>	<p>clarifying what has been said</p> <p>providing feedback about a communication</p> <p>reconstructing the content of a message, especially where contradictions may be embedded within it</p>	<p>0 1 2 3 4</p>
<p>An ability to encourage the expression and reformulation of depressive affect</p>	<p>supporting the expression of depressed feelings, and the partner's reactions to depressed feelings, and encouraging acceptance of them</p> <p>exploring past and present experiences of loss that may account for these feelings, which provide a framework for acknowledging and understanding them</p> <p>facilitating mourning</p>	<p>0 1 2 3 4</p>
<p>An ability to work with partners who might minimise expressions of emotion</p>	<p>normalising emotional experience</p> <p>describing emotions in language that is both accessible and meaningful to the couple</p> <p>validating and promoting acceptance of both existing and newly-experienced feelings of each partner</p> <p>using questions, hypotheses, and/or reflections that can evoke emotions within the session in the service of then making them intelligible to each partner</p> <p>using pacing and softening techniques to create safety in evoking emotion</p> <p>heightening awareness of the link between</p>	<p>0 1 2 3 4</p>

	<p>physiological arousal and emotional states (for example, by using bio-feedback methods)</p> <p>teaching individual self-soothing techniques when possible, inviting and enabling partners to help each other implement self-soothing techniques</p> <p>heightening emotions, in a controlled and safe way within the session by repeating key phrases to intensify their impact</p>	
<p>An ability to work with partners who amplify the expression of emotion</p>	<p>bounding the expression of emotion within sessions</p> <p>helping partners differentiate between their emotional states:</p> <ul style="list-style-type: none"> • as experienced in themselves • as observed by others <p>helping them to clarify when unexpressed emotional states might underlie expressed emotion (for instance when unexpressed fear underlies the expression of anger)</p> <p>promoting containment of upset in one domain of life to prevent it infiltrating other domains</p> <p>curtailing statements of contempt through opening up explorations of its impact and underlying emotions</p> <p>helping partners to establish useful boundaries around emotional expression, for example through:</p> <ul style="list-style-type: none"> • scheduling mutually agreed times and places in which to discuss feelings, especially those associated with painful experiences, whether shared or separate 	<p>0 1 2 3 4</p>
<p>An ability to provide empathic support</p>	<p>tracking the emotions of each partner, as signalled within sessions through verbal and non-verbal cues</p> <p>tuning into and validating emotional experience, for example by responding sensitively and robustly</p> <p>focusing on patterns of relating that disrupt emotional connection, and promoting their repair through reprocessing sequences as experienced by each partner</p>	<p>0 1 2 3 4</p>

	reframing the emotional experiences of partners to make them intelligible and acceptable to each other	
	TOTAL	
18 competencies	Score should add up to more than 30	

Comments to go back to the participant

Curriculum for Couple Therapy for Depression

**CONTINUING PROFESSIONAL DEVELOPMENT
FOR QUALIFIED THERAPISTS DELIVERING
HIGH INTENSITY INTERVENTIONS**

Dr David Hewison,
Tavistock Centre for Couple Relationships

March 2011

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Curriculum for Couple Therapy for Depression – Participants' Version

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Acknowledgements

This training curriculum draws on the Competency Framework for Couple Therapy for Depression commissioned by the Department of Health from Relate and the Tavistock Centre for Couple Relationship, and written by Dr Christopher Clulow, Senior Fellow of the Tavistock Centre for Couple Relationships, drawing on the work of the Expert Reference Group, Chaired by Nick Turner of Relate. The format of the curriculum draws on the Reach Out training materials for Psychological Wellbeing Practitioners developed by Professor David Richards and Mark Whyte.

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Tavistock Centre for Couple Relationships
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Introduction

Couple Therapy for Depression Training: IAPT National Curriculum

This curriculum is for a training that enables Couple Therapists to provide a depression-specific 20 session therapy in an IAPT setting for couples where there is both relationship distress and depression in one of the partners.

The competences required to deliver effective Couple Therapy for Depression were drawn up using the tried-and-tested methodology developed at the Centre for Outcomes Research & Effectiveness at University College London (www.ucl.ac.uk/CORE). Relate and the Tavistock Centre for Couple Relationships were jointly commissioned to lead this work because of their expertise in couple therapy. An Expert Reference Group was set up with a membership drawn from national experts selected for their experience of developing, evaluating, providing training for and supervising different approaches to couple therapy. The Membership of the ERG was:

Susanna Abse	Chief Executive, Tavistock Centre for Couple Relationships
Peter Bell	Chair, British Association for Sexual & Relationship Therapy
Jeremy Clark	Programme Leader, IAPT
Michael Crowe	Psychiatrist, Maudsley Hospital
Peter Fonagy	Professor, University College London
David Hewison	Head of Research, Tavistock Centre for Couple Relationships
Julian Leff	Professor, Institute of Psychiatry
Alessandra Lemma	Professor, Tavistock & Portman NHS Trust
Viveka Nyberg	Psychotherapist, St Bartholomew's Hospital
Anthony Roth	Professor, University College London
Nick Turner	Director, Relate Institute (CHAIR)
Rebecca Walker	Secretary to the Expert Reference Group
Ben Wright	Psychiatrist, East London NHS Trust

In addition, Janet Reibstein, Professor, University of Exeter, provided advice on systemic couple therapy.

The ERG reviewed the evidence base identified by the National Institute for Health and Clinical Excellence (NICE) for the treatment of depression by couple therapy and felt that, on its own, it was insufficient to enable the development of a coherent set of therapy competencies. Accordingly, the ERG also looked at other Randomised Controlled Trial studies that examined the effectiveness of key couple therapy modalities and integrated competencies from these into the modality. Most of these approaches are based on behavioural principles as developed since the 1970s in the USA. Other evidence-based approaches that have been utilised include: Interpersonal Therapy-Conjoint Marital (IPT-CM); Systemic Therapy; Emotion-focused Therapy (EFT); and Insight-oriented Therapy. As a result the Couple Therapy for Depression competencies include a range of approaches that may not usually sit side-by-side; nonetheless all have been shown to increase relationship satisfaction and so reduce depression in couples.

The resulting Competencies Framework was then peer reviewed and approved by:

Professor Guy Bodenmann	University of Zurich
Professor Steven Beach	University of Georgia
Professor Andrew Christensen	University of California at Los Angeles
Dr David Scharff	International Psychotherapy Institute, Washington

The Competency Framework and the Background documentation are available on the CORE website: http://www.ucl.ac.uk/clinical-psychology/CORE/Couple-Therapy-for-Depression_framework.htm

Couple Therapy for Depression is specifically designed to address presenting symptoms of depression and for delivery within the context of the IAPT programme. It is an add-on skill to existing advanced competence in Couple Therapy. The training to deliver this therapy within the IAPT programme consists of two linked elements: a five-day course; and an additional period of supervised clinical work with an approved supervisor, during which two cases must be satisfactorily completed in order to be accredited as a *Couple Therapy for Depression IAPT Practitioner*. The accrediting body is the British Society of Couple Psychotherapists and Counsellors.

Clinicians treating couples with depression and relationship distress within IAPT Services will be expected to draw on competencies from their existing model of Couple Therapy and integrate these with competencies specified for use with this patient group, as outlined in this training curriculum.

Aims of the Training

4. To develop practical competency in Couple Therapy for Depression as a development of existing Couple Therapy skills.
5. To ensure clinical practice in accordance with Local and National IAPT Service policy including the need to work appropriately with difference.
6. To enable Couple Therapy for Depression practitioners to act as an expert resource to professional colleagues, so ensuring appropriate referrals for Couple Therapy for Depression

Overarching meta-competency for Couple Therapy for Depression:

Capacity to use different therapeutic approaches appropriately and coherently

A capacity to select from, integrate and move between different therapeutic models and techniques to provide a coherent and appropriate therapeutic response to the different and changing needs of couples, for example by:

- applying a graded model of intervention tailored to the nature and severity of the couple's areas of concern
- exploring behavioural contracting, communication and conflict management skills in conjunction with more complex, in-depth work, and determining the appropriate level on which to work
- drawing on other, more complex approaches, such as insight-oriented ones, where the couple can both benefit from and work with a deeper understanding of underlying developmental factors that may be interfering with their relationship
- focusing on accepting limitations for the partnership set by factors within, between and external to the partners as a means of increasing relationship satisfaction

Overarching elements common to the practice of Couple Therapy for Depression:

- knowledge of depression;
- working with difference.

Knowledge of depression

An ability to draw on knowledge of the cluster of symptoms associated with a diagnosis of depression:

- depressed mood most of the day
- marked loss of interest or pleasure in daily activities
- sleep problems
- loss of appetite and significant loss of weight
- fatigue/exhaustion
- difficulties getting to sleep or excessive sleep
- psychomotor agitation (feeling restless or agitated) or psychomotor retardation (feeling slowed down)
- feelings of worthlessness or excessive guilt
- low self-confidence
- difficulties in thinking/ concentrating and/or indecisiveness
- recurrent thoughts of death, suicidal ideation, suicidal intent (with or without a specific plan)

An ability to draw on knowledge:

- that a diagnosis of depression is based on the presence of a subset of these symptoms
- that of these symptoms, depressed mood; loss of interest or pleasure; and fatigue are central
- that symptoms need to be present consistently over time (e.g. DSM-IV-TR criteria specify two weeks, ICD-10 criteria specify one month)

An ability to draw on knowledge of the diagnostic criteria for all mood disorders (including minor depression/dysthmic disorder and bipolar disorder) and to be able to distinguish between these presentations

An ability to draw on knowledge of the incidence and prevalence of depression, and the conditions that are commonly comorbid with depression

An ability to draw on knowledge of the patterns of remission and relapse/ recurrence associated with depression

Ability to work with difference (cultural competence)

An ability to maintain an awareness of the potential significance for practice of social and cultural difference across a range of domains, but including:

- For all clients with whom the therapist works, an ability to draw on knowledge of the relevance and potential impact of social and cultural difference on the effectiveness and acceptability of an intervention
- Where clients from a specific minority culture or group are regularly seen within a service, an ability to draw on knowledge of that culture or area of difference

An ability to draw on knowledge of cultural issues which commonly restrict or reduce access to interventions e.g.:

- An ability for therapists of all cultural backgrounds to draw on an awareness of their own personal/cultural values and how these may influence their perceptions of the couple, the couple's problem, and the therapy relationship
- An ability to take an active interest in the cultural background of couples, and hence to demonstrate a willingness to learn about the couple's cultural perspective(s) and world view
- An ability to work collaboratively with the couple in order to develop an understanding of their culture, worldview, and any culturally-specific expectations for the therapeutic relationship

An ability to take an active interest in the couple's experience of difference:

- An ability to discuss with the couple the ways in which individual and family relationships are represented in their culture(s) (e.g. models of individuality and personal or collective responsibility), and to consider the implications for organisation and delivery of therapy

An ability to ensure that standardised assessments/ measures are employed and interpreted in a manner which is culturally-sensitive e.g.:

- Where there is evidence that social and cultural difference is likely to impact on the accessibility of an intervention, an ability to make appropriate adjustments to the therapy and/or the manner in which therapy is delivered, with the aim of maximising its potential benefit to the couple

An ability to draw on knowledge that culturally-adapted treatments should be judiciously applied, and are warranted:

- Where the therapist does not share the same language as the couple, an ability to identify appropriate strategies to ensure and enable the couple's full participation in the therapy (including the ability to work with an interpreter)

An ability to enable service provision that meets the requirements of the Equality Act 2010

Key Texts relating to Equalities and Difference

Depression-focused texts are listed in the relevant Units, below.

Bhugra, D. & Bahl, V., 1999. Ethnicity: an agenda for mental health. London: Royal College of Psychiatrists/Gaskell.

CCAWI website,
www.lincoln.ac.uk/ccawi/publications/Ten%20Essential%20Shared%20Capabilities.pdf

Department of Health, 2002. A sign of the times: modernising mental health services for people who are deaf. London: HMSO.

Department of Health, 2005. Delivering race equality in mental health care: a summary. London: Department of Health.

Department of Health, 2007. Positive steps: supporting race equality in mental healthcare. London: Department of Health.

Ethnicity Online. Useful web resources and good practice guidelines at www.ethnicityonline.net/resources.htm

Equality Act 2010: http://www.equalities.gov.uk/equality_act_2010.aspx

HM Government Office for Disability Issues: <http://www.officefordisability.gov.uk/index.php>

MIND information on different community groups:
http://www.mind.org.uk/help/people_groups_and_communities/

O'Hagan, K., 2001. Cultural competence in the caring professions. London: Jessica Kingsley.

Prior, P., 1999. Gender and mental health. Basingstoke: Macmillan.

Rogers, A. & Pilgrim, D., 2003. Mental health and inequality. Basingstoke: Palgrave Macmillan.

Royal National Institute for the Blind at <http://www.rnib.org.uk/Pages/Home.aspx>

Ryan, T. & Pritchard, J. eds., 2004. Good practice in adult mental health. London: Jessica Kingsley.

Stokes, G., 2000. Mental health problems in older people. In Bailey, D. (ed.) At the core of mental health: key issues for practitioners, managers and mental health trainers. Brighton: Pavilion Publishing Ltd, p.80-128.

Thornicroft, G., 2006. Shunned: discrimination against people with mental illness. Oxford: OUP.

High Intensity Curriculum - Couple Therapy for Depression

This curriculum aims to develop skills in Couple Therapy for Depression at an advanced level, building on existing proficiency in the fundamental techniques of Couple Therapy and developing competency in the specialist techniques used in the treatment of depression in couples.

The curriculum will comprise the following:

- phenomenology, diagnostic classification and epidemiological characteristics of depression
- common factors linked to predisposition and precipitation, course and outcome of depression
- current evidence-based pharmacological and psychological treatments for depression to include the role of combined treatment
- an overview of the principles of the stepped-care system, knowledge of low-intensity interventions with depression and the role of high-intensity psychological therapy within that framework.
- risk assessment, risk management, suicide risk, mental state examination, personal and medical history
- application and suitability of Couple Therapy for Depression (to include contra-indications such as inter-partner violence and bipolar disorder) and awareness of referral pathways for unsuitable cases
- role of co-morbid disorders such as anxiety, PTSD, plus personality disorders and substance abuse
- theory and application of Couple Therapy models of depression, and the role of the relationship in precipitating, maintaining, and preventing depression
- development of therapeutic competency in the application of integrative Couple Therapy interventions with depression
- the role of the therapeutic relationship in Couple Therapy for Depression
- the importance of practitioners' selection of specific techniques that are congruent with their Couple Therapy training
- use of standard and idiosyncratic clinical measures to monitor Couple Therapy for Depression process and outcome in depression
- relapse prevention and prevention planning
- values, culture and diversity (the need to attend to access, ethical, professional and cultural considerations in a way that promotes Equality and reduces Inequality – Equalities Act 2010)
- effective use of supervision to help practitioners identify their own values and beliefs in working with couples with depression to enhance and regulate good practice
- enabling appropriate referrals for Couple Therapy for Depression so as to maximise the effectiveness of the service

Structure of the Training

The Units & associated competencies

Each Unit is half a day; the training aims at covering all the Specific Technique Competencies for the treatment of depression by couple therapy outlined in the Competencies Framework. It also includes refreshers on basic principles of couple therapy and emphasises the role of feelings and emotional states as well as behavioural interactions between the couple, and the need for rigorous assessment of risk. Each Unit, therefore, has its own associated competencies which link, as follows:

Unit 1a – Introduction to IAPT Context, Couple Therapy, and Depression

Competency: Knowledge and understanding of the basic principles of couple therapy

Competency: Knowledge of depression

Unit 1b – Depression *cont* and Risk *in Couples*

Competency: Knowledge of depression

Competency: Ability to use techniques that focus on relational aspects of depression

Unit 2a – The Therapeutic Relationship – engagement, balance and involvement

Competency: Ability to use techniques that engage the couple

Competency: Promoting acceptance

Unit 2b – The Therapeutic Relationship - engagement, balance and involvement, *cont.*

Competency: Revising perceptions

Competency: Ability to use measures to guide therapy and to monitor outcomes

Unit 3a – The Couple Relationship: improving interactions i

Competency: Improving communication

Unit 3b - The Couple Relationship: improving interactions ii

Competency: Coping with stress

Unit 4a - The Couple Relationship: improving interactions iii

Competency: Solving problems

Unit 4b- The Couple Relationship: improving interactions iv

Competency: Changing behaviour

Unit 5a - The Couple Relationship: managing feelings and emotions and Video Assessment

Competency: Managing feelings

Unit 5b – The Couple Relationship: managing feelings; endings & maintenance and Video Assessment

Competency: Ability to end couple therapy

Method of Training

The 5 day course will be a mix of:

Didactic teaching

Large and small group discussion

Extensive use of case-discussion and role-play

Video assessment of a role-play using actors

Supervised Clinical Work

Back in their local IAPT service practitioners will continue to work with couples. 2 cases have to be brought to supervision to supervisors approved for the Couple Therapy for Depression training where they will be helped to continue developing the skills needed to work with depression. These supervisors may be part of the course training team. 3 taped sessions from each therapy will be assessed by the supervisor to ensure competence in the practitioner. Once this is achieved, the practitioner will be eligible for accreditation. This clinical assessment process may take up to 12 months, based on 20-24 weekly group supervisions of no more than 5 participants for 1.5 hours, or their equivalent pro-rata.

Assessment of competence

There is a self-assessment tool for practitioners to rate themselves against the list of competencies for Couple Therapy for Depression. Trainers and Supervisors will also rate practitioners against these, using the Couple Therapy for Depression Competency Adherence Scale. The videoed role play with actors will be rated against the key competencies it is designed to draw out.

An acceptable standard overall is competence in 80% of the list. This figure has been chosen as some of the competencies come from different (and contrasting) modalities, and it allows lee-way to enable practitioners to continue to work in their original couple training rather than having to adapt too much to what might be an alien methodology. It is the treatment of depression via the treatment of the relationship that is the focus of the training, not any specific therapeutic method, as the training is Continuing Professional Development for couple therapists and not a new clinical modality.

The training is designed, however, to increase the range of relevant techniques available to the practitioner in their work with depressed couples; a further part of the assessment process in the training is the participant's self-reflection on their choice of technique and how these can be integrated into their existing practice.

Accreditation

Successful completion of the training course plus successful assessment of competence in two cases by an approved supervisor of Couple Therapy for Depression enables the practitioner to apply for accreditation as a *Couple Therapy for Depression IAPT Practitioner* with the British Society of Couple Psychotherapists and Counsellors. Their names will be included in the BSCPC's list of accredited practitioners on their website. Therapists are also encouraged to register their advanced skills with their original Registering body (eg BACP; BABCP; BPS; etc) where relevant.

Note to Participants

Practitioners coming on the Couple Therapy for Depression training are all expected to be qualified as Couple Therapists or experienced in clinical work with couples to an equivalent level. They will have different professional and theoretical backgrounds and will be expected to make extensive use of these in assimilating the learning from the training. Each participant will reflect on the overall aims of each Unit and the range of techniques presented, and how these can be integrated with or added to their existing model. Over the course of the training they will develop a critical understanding of their choice of techniques and how these help maintain and promote a balanced engagement with the couple that uses the relationship to promote change.

General learning outcomes

This 5-day Continuing Professional Development training course will provide opportunities for participants to develop and demonstrate knowledge, understanding and skills as follows.

Participants must demonstrate competency in:

- xiii. The knowledge, skills and techniques of Couple Therapy for Depression as a development of their existing Couple Therapy skills as applied to couples with relationship distress and depression.
- xiv. Working clinically in accordance with Local and National IAPT Service policy including working with difference.
- xv. Sensitively adapting the competencies of Couple Therapy for Depression, and ensuring equitable access for people from diverse cultures and with different values
- xvi. Working with co-morbid presentations of depression and taking personal responsibility for clinical decision making in complex and unpredictable situations
- xvii. Acting as an expert resource to professional colleagues, so ensuring appropriate referrals for Couple Therapy for Depression

Specific learning outcomes

- 41. holding a balanced professional position that treats the relationship as the patient, without neglecting the individuals in the couple
- 42. a working knowledge of the principles and practice, and ability to deliver high-intensity psychological therapy for depression in couples within a stepped-care system.
- 43. a critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of depressive disorders
- 44. assessing patients with depression, taking into account clinical manifestations, co-morbidity, past history, present life situation, course and outcome of depression in suitability for Couple Therapy for Depression
- 45. assessing risk factors associated with depression in couples and the integration of risk management within treatment plans
- 46. assessing suicidal risk and implementing practical strategies for managing suicidality in couples
- 47. addressing relational aspects of depression through the appropriate use of depictive, challenging and supportive techniques
- 48. identifying unhelpful cycles of between the couple and enabling the couple to observe and use ways of changing their interactions
- 49. addressing the role of the couple's sexual relationship in their difficulties
- 50. using techniques to establish a collaborative alliance between the couple and between the couple and the therapist
- 51. moving between the concerns and perspective of each partner and their shared relationship in such a way that the relationship itself becomes a resource for them
- 52. developing tolerance in the couple for the exploration of their competing positions and perspectives
- 53. using techniques that focus on the development of empathic acceptance of difference between the couple
- 54. identifying cognitive, perceptual and emotional distortions and misconstruals and using a variety of techniques to enable the couple to change or correct these

55. enabling the couple to see the impact of repetitive patterns between them, and to identify their roots in each of their developmental and relationship histories, so enabling change in appropriate ways
56. consistently using outcome measures in the therapy in a way that promotes balance, curiosity and enables the revision of fixed or problematic perceptions of each partner in the relationship.
57. using measures to provide appropriate feedback to the couple which helps support the couple's own awareness of their emotional state and encourage self-monitoring.
58. using and teaching communication skills including listening and disclosing in such a way as to further the development of acceptance and tolerance in the couple
59. modelling appropriate use of communication, including silence and care in expression, so that the couple's experience of appropriate and helpful communication is reinforced
60. enabling the empathic use of curiosity and receptivity about each other
61. enabling the couple to express and explore things they find stressful in a carefully managed way, ensuring that the exploration itself does not become over-stressful
62. enabling the couple to recognise and accept that some stressors cannot be got rid of, but can be lived with as part of an ordinary relationship
63. maintaining a balance between each of the partners in a way that is not rigidly equal but which matches the emotional needs of the couple at any one time
64. enabling the couple to identify and distance themselves from influential and repetitive family 'scripts' or expectations that arise from their developmental histories so enabling accurate perception of the current interactions between them
65. using problem-solving techniques in a way that matches the each of the partners' abilities and sensitivities to manage conflict, either actual or feared, at any one time
66. enabling the couple to accept and tolerate the insoluble differences between them that usually lead to conflict
67. promoting empathic bonding between the couple through the use of techniques that enable an empathic understanding of each other's position in the conflict
68. enabling and containing discussions of common conflict-areas of a couple's life such as sex, money, family and parenting, in such a way as to enable the couple to self-regulate more effectively
69. building on the collaborative engagement of the couple in the relationship and in the therapy by encouraging a collaborative approach to behavioural change
70. using behavioural-exchange techniques in a way that prioritises the increase in positive behaviours over the reduction of negative ones
71. enabling the couple to accept and tolerate their differences between them about reciprocity of wished-for behaviours, so promoting greater trust in the relationship
72. promoting empathic bonding between the couple through the use of techniques that enable an empathic understanding of each other's view of the behaviours in question through identifying and articulating the underlying relationship themes and meanings for each partner
73. engaging the couple in active and open discussion of their emotional states, both positive and negative, in a way that promotes empathic joining between the couple
74. enabling the safe exploration of 'strong' emotions including anger and despair and helping the couple see these as normal in the circumstances of their lives and relationship, whilst assessing the couple's ability to cope with such exploration at any one time
75. surfacing hidden emotions, such as 'soft' feelings of vulnerability underlying 'hard' feelings of anger, in such a way as to enable greater understanding and acceptance of each partner's emotional worlds (including the ways they perceive and react to feelings)
76. widening the range of emotional expression in the couple through techniques designed to make emotional states intelligible as part of each partner's life experience and history, so promoting empathic understanding
77. working collaboratively with the couple in constructing an idiosyncratic relapse prevention plan or blueprint of therapy to maintain and consolidate gains and identify future stresses that might lead to further distressed feeling

78. dealing with the mixed feelings that ending therapy brings, including helping the couple understand the impact of the loss of the therapy relationship on them, and linking this to the characteristic ways that they deal with such events
79. judging the interaction between ending therapy and outcome measure scores for any particular couple
80. liaising with referring professionals about the ending case in such a way as to increase their understanding of the nature of Couple Therapy for Depression, so enabling better informed referrals

Suggested Pre-course Reading:

Clulow, C. 2010. The Competencies Required to Deliver Effective Couple Therapy for Partners with Depression: Background Document for Clinicians and Commissioners. TCCR: Unpublished. Downloadable from: http://www.ucl.ac.uk/clinical-psychology/CORE/Couple-Therapy-for-Depression_framework.htm

Dimdjian, S., Martell, C. R. and Christensen, A. 2008. Integrative Behavioral Couple Therapy. In: A. S. Gurman (ed). Clinical Handbook of Couple Therapy. New York, Guilford Press: 73-103.

Hewison, D. 2009. "Marital Therapy". In: Basant, P., & Treasaden, I. (eds.) Psychiatry – an evidence-based text for the MRCPsych. London: Hodder Arnold. Chapter 63.

THE UNITS

Each Unit represents half a day's training and has its own Aims and associated competencies, learning outcomes and Suggested Reading. In some respects the divisions between the Units are artificial – the consequence of their underlying competencies – and participants will find that techniques belonging to one competency are also to be found in others. This reflects the ordinary process of therapy, where there is no simple demarcation between competency-use at any one time.

Each competency is indicated by a boxed header: **like this** followed by the text of the competency. The text is identical to that in the Self-Assessment Tool and participants will already have made a judgement as to what degree they feel they already meet the requirements of the Unit. They will be asked to record the techniques they identify as appropriate to add to their existing skills, and to reflect on this selection process.

The Learning Outcomes distil the competencies for each Unit.

The Suggested Reading for each Unit comes from the specific manuals used to generate each competency, as well as indicative reading from the 'Reach Out' materials. Where the manuals are unpublished or not available in English, they have not been listed.

Unit 1a – Introduction to Context, Couple Therapy, and Depression

Aims of the Unit – this unit covers the following

Couple Therapy for Depression is a Level 3 intervention within IAPT Services. Couple therapists need to have a good knowledge of the aim and methods of IAPT Services, including the stepped-care nature of the provision and the role of other mental health workers within it. In addition, they must have knowledge of the administrative and procedural requirements of IAPT Services such as the role of outcome measurement in monitoring and evaluation of couple's depressive symptoms.

This Unit reiterates the knowledge and understanding expected from couple therapists of relational dynamics and contextual processes (including life events) that influence the quality of a couple relationship. In addition, High intensity Therapists working with couples in IAPT Services need to identify the ways in which depression manifests in the diagnosed patient as well as in the couple as a system – in the relationship. This means that they have to have a good understanding of depression in individuals, its causes, course, phenomenology, range, incidence, and prognosis, as well as its impact on the ability to relate to, and get support from, others, and to relate this knowledge to couples.

IAPT Induction Outline

Background to the IAPT Programme: Access; NICE guidelines; Economic Case

Targets

- 900,000 people accessing psychological therapies
- 50% of attendees approaching recovery
- 3600 extra therapists

Model

- Stepped Care, referral criteria and self-referral, triage and assessment
- Low and High Intensity Interventions; medication
- Roles: Psychological Wellbeing Practitioners, High Intensity Therapists, GP Leads, Employment advisors
- Supervision and case management
- Risk and safe-guarding policies
- Return to work
- Choice and personalisation
- Diversity of providers

Education and training

- Competences and training drawn from research trials
- National curricula
- Collaboration between service and education providers
- Service standards and professional accreditation

Monitoring and evaluation

- Session by session monitoring of outcomes

- Prescribed measures
- Data protection issues
- Number of sessions
- Stepping up and stepping down
- When to complete/discontinue treatment based on amount of change in clinical outcomes
- Key Performance Indicators

Modalities based on NICE Guidance

- CBT
- Counselling for Depression
- Couple Therapy for Depression
- DIT
- IPT

Long term sustainability

- Realising the Benefits policy guidance
- Role of SHAs and PCTs
- Equity of access
- Tailoring to special populations and communities
- Workforce planning for the psychological workforce in the future
- New Ways of Working for Psychological Therapists

Knowledge and understanding of the basic principles of couple therapy

An ability to draw on knowledge that couple therapists focus on establishing and maintaining a balanced position in relation to the couple, in order:

- to focus attention on their relationship, rather than either partner, as the means of achieving change
- to provide a framework for understanding and managing presenting concerns

An ability to draw on knowledge that couple therapists focus on understanding the nature of the commitment that underpins a couple's relationship, which contributes to shaping its dynamics, including:

- the feelings the partners may have for each other, their understanding of why they chose each other, and their sense of being (or not being) a couple
- the conscious and unconscious expectations, assumptions, beliefs and standards they may share (or differ about) with regard to their relationship
- the role of external factors (such as religious affiliation, ethnicity and other social grouping) on their choice of partner and support for their partnership

An ability to draw on knowledge that couple therapists focus on understanding the interpersonal factors that shape the dynamics of couple relationships, for example:

- the effects of potentially different understandings and levels of awareness between partners about their roles, responsibilities and expected behaviour
- the degree to which the partners agree on matters such as what constitutes a comfortable distance in their relationship, or how feelings are managed
- the degree of fit within the couple over the values, beliefs and meanings each partner brings to interpreting events occurring inside and outside their relationship
- the degree to which each partner is aware of and responsive to the other's feelings, intentions and states of mind, especially in stressful situations
- the couple's communication skills, including their capacity to give, ask for and accept support from each other

- the rigidity or flexibility with which partners interact together, including their capacity to adapt and change over time

An ability to draw on knowledge that couple therapists focus on understanding developmental factors that contribute to shaping the dynamics of couple relationships, for example:

- the effects of family of origin, childhood and earlier partnership experiences on each partner's assumptions about and expectations of their relationship
- the ways in which couple and family relationships and meanings have been changed by predictable life events (such as the birth of a child)
- the ways in which couple and family relationships and meanings have been changed by unpredictable life events (such as unemployment, illness, or bereavement)
- the ways in which new partnerships are affected by past relationship conflicts, and ongoing commitments resulting from them (such as parenting or financial responsibilities)

An ability to draw on knowledge that couple therapists focus on understanding contextual factors that contribute to shaping the dynamics of couple relationships, for example:

- the influence of culture and ethnicity on each partner's assumptions about and expectations of their relationship
- the potential for social constructions of gender and sexuality to shape assumptions about roles and responsibilities in the couple
- the effects of socio-economic factors such as employment, relocation, and redundancy on couple and family relationships

Learning Outcomes

Competency in:

- holding a balanced professional position that treats the relationship as the patient, without neglecting the individuals in the couple
- a working knowledge of the principles and practice, and ability to deliver high-intensity psychological therapy for depression in couples within a stepped-care system.
- a critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of depressive disorders
- assessing patients with depression, taking into account clinical manifestations, co-morbidity, past history, present life situation, course and outcome of depression in suitability for Couple Therapy for Depression

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Self-reflection questionnaires

Suggested reading

Suggested Reading

American Psychiatric Association, 1994. The diagnostic and statistical manual of mental disorders (DSM) IV. 4th ed. Washington DC.: American Psychiatric Association.

Bazire, S., 2003. Psychotropic drug directory 2003/2004: the professionals' pocket handbook and aide memoire. Salisbury: Fivepin Publishing.

Beach, S., Sandeen, E. & O'Leary, K. 1990. Depression in marriage: A model for etiology and treatment. New York: Guilford.

BMA and RPS. 2010. British National Formulary 60. London: British Medical Association and Royal Pharmaceutical Society of Great Britain.

Care Services Improvement Partnership, 2006. Primary care services for depression – a guide to best practice, appendix 4: asking about risk. Hyde: Care Services Improvement Partnership.

Crowe, M. & Ridley, J. 2000. Therapy with couples. A behavioural-systems approach to couple relationship and sexual problems. Oxford: Blackwell. 2nd ed.

Gurman, A. (ed.) 2008. Clinical handbook of couple therapy. New York: Guilford Press, pp 383-429. 4th edition.

Jacobson, N. & Christensen, A. 1998. Acceptance and change in couple therapy. A therapist's guide to transforming relationships. New York: Norton.

Johnson, S. 2004. The practice of emotionally focused couple therapy. Creating connections. New York: Brunner-Routledge; 2nd edition.

Jones, E. & Asen, E. 2000. Systemic couple therapy and depression. London: Karnac.

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson

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UNIT 1b – Depression *cont* & Risk in Couples

Aims of the Unit – this unit covers the following

In addition to a good understanding of the nature and incidence of depression, couple therapists need to be aware that depression in one partner can have an impact on the other partner's ability or wish to provide the support needed, and will invariably have an impact on children's wellbeing. Tensions and stresses in the relationship associated with depression can make recovery difficult. There are clear patterns of interaction between couples that influence the incidence of depression, and which in turn are affected by it – the couple's sexual relationship is one such important element.

Combined with this is the need to be aware of the level of risk of self- and other-harm associated with depression in couples (including suicide and physical assault), particularly when associated with other psychological, emotional, sexual and environmental stressors. Risk assessments and risk planning should focus on the couple's abilities to help themselves, together with an estimate of what other support might be needed, including other professional interventions. 'Suicide prevention plans' and 'Domestic violence safety plans' will be needed for some couples. Couple therapists will need to have a good working knowledge of their service's Risk Policy and associated procedures.

The particular role of depression in the couple relationship also needs to be addressed to identify precipitating and maintaining factors that may not be immediately apparent in the presentation of the depressed partner to professional services.

Knowledge of depression

An ability to draw on knowledge of the cluster of symptoms associated with a diagnosis of depression:

- depressed mood most of the day
- marked loss of interest or pleasure in daily activities
- sleep problems
- loss of appetite and significant loss of weight
- fatigue/exhaustion
- difficulties getting to sleep or excessive sleep
- psychomotor agitation (feeling restless or agitated) or psychomotor retardation (feeling slowed down)
- feelings of worthlessness or excessive guilt
- low self-confidence
- difficulties in thinking/ concentrating and/or indecisiveness
- recurrent thoughts of death, suicidal ideation, suicidal intent (with or without a specific plan)

An ability to draw on knowledge:

- that a diagnosis of depression is based on the presence of a subset of these symptoms
- that of these symptoms, depressed mood; loss of interest or pleasure; and fatigue are central
- that symptoms need to be present consistently over time (e.g. DSM-IV-TR criteria specify two weeks, ICD-10 criteria specify one month)

An ability to draw on knowledge of the diagnostic criteria for all mood disorders (including minor depression/dysthmic disorder and bipolar disorder) and to be able to distinguish between these presentations

An ability to draw on knowledge of the incidence and prevalence of depression, and the conditions that are commonly comorbid with depression

An ability to draw on knowledge of the patterns of remission and relapse/ recurrence associated with depression

Ability to use techniques that focus on relational aspects of depression

An ability to focus on and reduce negative cycles of influence between depression and couple interactions, for example by:

- educating couples about potential links between depression and stressful patterns of relating in the couple
- gathering in broader aspects of the couple's relationship and focusing on these (for example, concentrating on their roles as parents as well as partners)
- inviting the depressed partner to assume the caring role normally occupied by her or his partner
- asking the depressed partner to help her or his partner to express feelings supporting the depressed partner in being assertive
- discouraging blaming, denigration and contempt
- encouraging partners to maintain routines, surroundings and relationships that provide them with a sense of familiarity and security

An ability to take account of sexual functioning in the couple's relationship, for example by:

- exploring the current state of their sexual relationship
- identifying any changes that have taken place over time
- establishing if the couple wants specialist help for any sexual dysfunction
- making a referral, where appropriate, for specialist help

An ability to review interpersonal roles in the couple relationship, especially with regard to care giving and care receiving, for example by:

- using family life-space techniques (such as sculpting or button/stone games) to enable partners to represent how roles are divided between them, including any changes that have taken place
- encouraging each partner to depict graphically the amount of time and energy they believe they spend carrying out these roles, including any changes that have taken place
- using genograms to investigate family-of-origin roles
- reviewing how roles were allocated in previous partnerships
- highlighting similarities and differences between each partner in terms of their cultural expectations
- investigating how their audit of relationship roles compares with what each partner expects and desires
- identifying areas where changes might be achieved

An ability to consult with the couple about their interaction, for example by reflecting back observations about:

- recurring patterns of relating between the partners
- ways in which each partner and the couple use their therapist
- any relevance this might have to their relationship concerns

An ability to generate and test hypotheses that explain depressive symptoms through the relational contexts in which they occur, for example by:

- offering thoughts about the possible functions of symptomatic behaviour for each partner
- highlighting the roles played by each partner and others in creating and maintaining depressive symptoms, and exploring possible reasons for these describing interactive patterns that may maintain depressive symptoms

An ability to challenge repetitive sequences, for example by:

- interrupting monologues, or cycles of accusation, rebuttal and counter-accusation
- exploring possible functions performed by such repetitive sequences for each partner and the couple
- suggesting alternative behaviours or ways of communicating, including specific skills to regulate conflict

An ability to offer possibilities for altering interactions, for example by:

- tracking and reflecting back observations about patterns of relating and their possible purposes for each partner and the couple
- replaying and highlighting key interactions so they can be:
 - more directly be experienced in the session
 - made available for reflecting on in the therapy
 - providing opportunities for each partner to imagine what they think might happen if existing roles and relationship patterns were to change

Learning Outcomes

Competency in:

- assessing risk factors associated with depression in couples and the integration of risk management within treatment plans
- assessing suicidal risk and implementing practical strategies for managing suicidality in couples
- addressing relational aspects of depression through the appropriate use of depictive, challenging and supportive techniques
- identifying unhelpful cycles of between the couple and enabling the couple to observe and use ways of changing their interactions
- addressing the role of the couple's sexual relationship in their difficulties

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Self-reflection questionnaires

Suggested reading

Suggested Reading

Beach, S., Sandeen, E. & O'Leary, K. 1990. Depression in marriage: A model for etiology and treatment. New York: Guilford.

Crowe, M. & Ridley, J. 2000. Therapy with couples. A behavioural-systems approach to couple relationship and sexual problems. Oxford: Blackwell. 2nd ed.

Gurman, A. (ed.) 2008. Clinical handbook of couple therapy. New York: Guilford Press, pp 383-429. 4th edition.

Jacobson, N. & Christensen, A. 1998. Acceptance and change in couple therapy. A therapist's guide to transforming relationships. New York: Norton.

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Jones, E. & Asen, E. 2000 Systemic couple therapy and depression. London: Karnac.

Ruszczynski, S. (ed.) 1993. Psychotherapy with Couples. London: Karnac.

Unit 2a – The Therapeutic Relationship – engagement, balance and involvement

Aims of the Unit – this unit covers the following

The overarching competency of the couple therapist working with any couple is the ability to successfully engage two people who may well have competing agendas in a therapy that promises to attend to the relationship between them as opposed to either of their individual positions. The skill required is to meet sufficient individual needs whilst enabling the couple to see the value of giving up some of their demands/resentments in the service of the relationship between them.

The fact that one partner has been diagnosed with depression and that the Couple Therapy is part of the treatment for it requires the practitioner to actively promote a balance between attending to the depressed person themselves, their partner, and the couple. Being able to shift focus between the three positions is a key skill of Couple Therapy for Depression.

What also promotes successful engagement is the capacity to use methods and techniques that involve each of the couple in the exploration of difference between them and that further the emotional connection and exploration needed to achieve an active state of acceptance and tolerance of each other's particular experience of the relationship.

Ability to use techniques that engage the couple

An ability to form and develop a collaborative alliance with each partner and to enlist their support for relationship-focused therapy, for example by:

- responding empathically in order to validate the experience of each partner, especially their emotional experience
- accepting and exploring each partner's reservations about engaging in couple therapy
- gauging when and whether separate sessions are needed to engage each partner in the therapy, or to overcome an impasse

An ability to form and develop an alliance with the couple as a unit, for example by:

- reframing any presentation of individual problems in relationship terms focusing attention on shared as well as separate concerns
- supporting the partners' sense of themselves as being part of a unit as well as two individuals

An ability to promote a collaborative alliance between the partners in the couple, for example by:

- using empathic questioning to help the partners explore and reappraise their respective positions
- encouraging the partners to address each other directly, rather than the therapist being drawn into a role as mediator or interpreter

An ability to engender hope about the therapeutic process, for example by:

- expecting neither too little nor too much about what can be achieved and by when engaging constructively with problematic issues

- encouraging, recognising and reflecting back positive cycles of interaction in the couple reinforcing achievements by marking and celebrating positive change

An ability to instigate therapeutic change, for example by:

- encouraging shared responsibility for the therapy by constructing agendas collaboratively;
- recapitulating and checking out key communications made during sessions encouraging couples to describe events and episodes in active rather than passive terms (for example, asking 'how did you make that happen?' rather than 'how did that happen?')
- creating openings for new relational experiences (for example, through collaboratively setting homework assignments)
- being clear and sensitive about the rationale for any homework assignment, and following up on how it is experienced as well as whether it has been completed

Promoting acceptance

An ability to work with couples in ways that respect each partner's experience of depression, for example through:

- educating the couple about depression:
 - naming and explaining the symptoms of depression
 - allowing depression to be viewed as an illness, and thereby:
 - reducing feelings of guilt or blame associated with the condition
- accepting the couple's reality of the depressed partner as patient:
 - especially in the early stages of therapy
 - helping the non-depressed partner play a supportive role (especially early on)
- accepting the reality of both partners' depression when this is the case, and the limitations on what each can do for the other in the short term
- engaging the supportive abilities of the non-depressed partner, for example by involving him or her in:
 - helping the depressed partner:
 - prioritise tasks
 - undertake manageable social activities
 - be assertive
 - recognise dysphoric symptoms
 - seek out situations that can relieve such symptoms
- evaluating and managing the patient's depressive symptoms, including the need for either social stimulus and/or medication
- relating to the depressed partner as 'more than his or her depression', to help reduce the effects of depression
- assisting the depressed partner to manage their condition for themselves

An ability to help partners empathically connect with each other around their concerns by:

- eliciting vulnerable feelings from each partner that may underlie their emotional reactions to their concerns
- encouraging them to express and elaborate these feelings
- conveying empathy and understanding for such feelings
- helping each partner develop empathy for the other's reactions through modelling empathy toward both partners

An ability to help the couple empathically connect with each other in distancing themselves from their concerns, for example by helping partners:

- step back from their concerns and take a descriptive rather than evaluative stance towards it
- describe the sequence of actions they take during problematic encounters to:
 - build awareness of the triggers that activate and escalate their feelings

consider departures from their behaviour and what might account for such variations
generate an agreed name for problematic repetitive encounters to help them call 'time out'

An ability to help the couple develop tolerance of responses that the problem can trigger, for example by:

- helping partners identify positive as well as negative functions served by problematic behaviour
- using desensitising techniques to reduce the impact of problematic behaviour (such as practising arguments in sessions)

Learning Outcomes

Competency in

- using techniques to establish a collaborative alliance between the couple and between the couple and the therapist
- moving between the concerns and perspective of each partner and their shared relationship in such a way that the relationship itself becomes a resource for them
- developing tolerance in the couple for the exploration of their competing positions and perspectives
- using techniques that focus on the development of empathic acceptance of difference between the couple

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Self-reflection questionnaires

Suggested reading

Suggested Reading

Beach, S., Sandeen, E. & O'Leary, K. 1990. Depression in marriage: A model for etiology and treatment. New York: Guilford.

Christensen, A. and Jacobson, N. S. 2000. Reconcilable Differences. New York: Guilford Press.

Jacobson, N. & Christensen, A. 1998. Acceptance and change in couple therapy. A therapist's guide to transforming relationships. New York: Norton.

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Unit 2b – The Therapeutic Relationship - engagement, balance and involvement, *cont.*

Aims of the Unit – this unit covers the following

Couple therapists need to help couples understand that some of their difficulties stem from misunderstanding or misreading each other's intentions towards them. This requires the couple to develop a capacity to stand back from their initial or habitual assumptions about each other, replacing 'closed' assumptions with 'open' inquiry about each other's experience. The couple therapist needs to be able to choose appropriately from a variety of techniques to enable them do this.

In addition, the couple therapist needs to help the couple understand why their initial assumptions and attributions make sense to them given the particular facts of their experience of relationships and relating in their families of origin and their own lives, and how these patterns of relating may be creating some of the difficulties in their current relationship. Some of the evidence for the influence of these patterns will come from the overt behaviour and implicit thinking of the couple, and some will come from the emotional and relational experience in the therapy sessions with them. The couple therapist should promote a sense of curiosity and interest in the couple about these areas of their experience.

Couple therapists must include the measures that form the minimum data set for IAPT therapies, together with those that focus on the quality of the relationship, in the ongoing work with the couple in such a way that promotes balance, curiosity and enables the revision of fixed or problematic perceptions of each partner in the relationship. In addition, the use of measures should help support the couple's own awareness of their emotional state, encouraging self-monitoring.

Revising perceptions

An ability to observe and reflect back on observations of seemingly distorted cognitive processing, for example through:

- marking selective inattention
- encouraging partners to check out the validity of attributions they make about each other
- encouraging partners to check out the validity of perceived (as compared with actual) criticism
- drawing attention to self-reinforcing problematic predictions and assumptions

An ability to reduce blame and stimulate curiosity in the partners about their own and each other's perceptions, for example through:

- 'circular' questioning (questioning that highlights the interactive nature of each partner's behaviour on the other)
- 'Socratic' questioning (questioning that re-evaluates the logic behind existing positions in order to create an alternative, more functional logic)
- encouraging partners to 'read' what their partner is thinking and feeling through:
 - picking up verbal and non-verbal cues and messages
 - listening to feedback about the accuracy of these readings
 - minimising unhelpful 'mindreading'

- imagining the effects their behaviour and feelings have on their partner, and to accept and reflect on feedback from their partner about this

An ability to use techniques that increase the partners' understanding of their own and each other's vulnerability to cognitive distortion, for example by encouraging them to:

- identify recurring behaviour and feelings that might act as flashpoints for each partner in their relationship
- explore the contexts in which they arise
- encourage reflection across relationship domains about similar experiences and reactions

An ability to engage the curiosity of partners about possible links between their current relationship perceptions and past developmental experiences, for example by:

- taking a thorough family and relationship history for each partner, or facilitating this to emerge in the context of the therapeutic process, that includes attachment patterns, events and themes
- using devices such as family genograms to identify cross-generational family meanings, norms, and/or expectations, especially with regard to relationship roles and scripts
- allowing embedded roles, scripts, themes, and patterns that might contribute to distortions in the representation of relationships to emerge and be worked with;
- linking past attachment themes and problematic experiences with current perceptions and predictions

An ability to develop shared formulations of central relationship themes, for example by:

- exploring the transference of representations of past attachment patterns, roles and affects into current couple and/or therapy relationships, and helping the couple distinguish between past and present meanings and realities
- exploring the therapist's own emotional and behavioural responses, both to each partner and to the couple itself:
 - to identify affects and experiences that may reflect and resonate with those of the couple
 - to make connections between the affective experiences of each partner and their therapist to build understanding from shared experience

An ability to identify and make links between specific arguments and central relationship themes, for example by highlighting:

- meanings, thoughts and feelings that accompany escalating arguments
- recurring tensions over the need for intimacy and autonomy
- conflicts that are structured around issues of dominance and submission
- roles that rooted in gender or cultural expectations that might be uncomfortable for one or other of the partners
- past attachment experiences that might be creating anxieties and fears

An ability to reframe events, actions, feelings or interactions to provide alternative, more positive and/or functional meanings to those posited by one or both partners in order to change perceptions of what is going on in the relationship, for example by:

- reconceptualising a partner's perceived negative motivations as misguided or misfired attempts to be supported by and/or supportive of the other
- emphasising the desire of partners to enable rather than disable each other

An ability to apply developing formulations to achieve changes in perception, for example by:

- working through past attachment difficulties, disappointments and losses
- making accessible and accepting feared emotions/experiences, and encouraging new ways that partners can be with each other

providing the context for a corrective emotional experience that encourages each partner to feel secure with each other

Ability to use measures to guide therapy and to monitor outcomes

Knowledge of measures

An ability to draw on knowledge of commonly used questionnaires and rating scales used with people with depression

Ability to interpret measures

An ability to draw on knowledge regarding the interpretation of measures (e.g. basic principles of test construction, norms and clinical cut-offs, reliability, validity, factors which could influence (and potentially invalidate) test results)

An ability to be aware of the ways in which the reactivity of measures and self-monitoring procedures can bias client report

Knowledge of self-monitoring

An ability to draw on knowledge of self-monitoring forms developed for use in specific interventions (as published in articles, textbooks and manuals)

An ability to draw on knowledge of the potential advantages of using self-monitoring

- to gain a more accurate concurrent description of the client's state of mind (rather than relying on recall)
- to help adapt the intervention in relation to client progress
- to provide the client with feedback about their progress

An ability to draw on knowledge of the potential role of self-monitoring:

- as a means of helping the client to become an active, collaborative participant in their own therapy by identifying and appraising how they react to events (in terms of their own reactions, behaviours, feelings and cognitions))

An ability to draw on knowledge of measurement to ensure that procedures for self-monitoring are relevant (i.e. related to the question being asked), valid (measuring what is intended to be measured) and reliable (i.e. reasonably consistent with how things actually are)

Ability to integrate measures into the intervention

An ability to use and to interpret relevant measures at appropriate and regular points throughout the intervention, with the aim of establishing both a baseline and indications of progress

An ability to share information gleaned from measures with the client, with the aim of giving them feedback about progress

An ability to establish an appropriate schedule for the administration of measures, avoiding over-testing, but also aiming to collect data at more than one timepoint

Ability to help clients use self-monitoring procedures

An ability to construct individualised self-monitoring forms, or to adapt 'standard' self-monitoring forms, in order to ensure that monitoring is relevant to the client

An ability to work with the client to ensure that measures of the targeted problem are meaningful to the client (i.e. are chosen to reflect the client's perceptions of the problem or issue)

An ability to ensure that self-monitoring includes targets which are clearly defined and detailed, in order that they can be monitored/recorded reliably

An ability to ensure that the client understands how to use self-monitoring forms (usually by going through a worked example during the session)

Ability to integrate self-monitoring into the intervention

An ability to ensure that self-monitoring is integrated into the therapy, ensuring that sessions include the opportunity for regular and consistent review of self-monitoring forms

An ability to guide and to adapt the therapy in the light of information from self-monitoring

Learning Outcomes

Competency in

- identifying cognitive, perceptual and emotional distortions and misconstruals and using a variety of techniques to enable the couple to change or correct these
- enabling the couple to see the impact of repetitive patterns between them, and to identify their roots in each of their developmental and relationship histories, so enabling change in appropriate ways
- consistently using outcome measures in the therapy in a way that promotes balance, curiosity and enables the revision of fixed or problematic perceptions of each partner in the relationship.
- using measures to provide appropriate feedback to the couple which helps support the couple's own awareness of their emotional state and encourage self-monitoring.

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Self-reflection questionnaires

Suggested reading

Suggested Reading

American Psychiatric Association, 1994. The diagnostic and statistical manual of mental disorders (DSM) IV, 4th edition. Washington DC.: American Psychiatric Association.

Barkham, M., Hardy, G. E. and Mellor-Clark, J., Eds. 2010. Developing and Delivering Practice-Based Evidence. A Guide for the Psychological Therapies. Chichester: Wiley-Blackwell.

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. The Oxford Guide to Low Intensity CBT Interventions. Oxford: Oxford University Press.

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Kroenke, K., Spitzer, R. & Williams, J., 2001. The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16, p.606–613.

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Spitzer, R. et al., 2006. A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, 166, p.1092-1097.

Stratton, P., Bland, J., Janes, E., & Lask, J., (2010) Developing a practicable outcome measure for systemic family therapy: The SCORE. *Journal of Family Therapy*, 32, p.232-258.

World Health Organization, 1992. ICD-10 Classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization.

Note to Participants on Couple Measures:

The basic IAPT outcome measures need to be added to with specific couple relationship measures. The Locke-Wallace Marital Adjustment Test (as amended to make it applicable to unmarried couples) is one option; another is the Relationship Questionnaire developed by Professor Kurt Hahlweg. The disadvantage of the latter is that it is a 31-item measure, compared to the Locke-Wallace's 15 items); neither can really be used as a weekly monitoring tool, but they could have a role in periodic measurement (beginning, middle and end, for example) as they capture something dynamic between the couple. There's also the Relationship Dynamics Scale to consider, and the SCORE 15 for use in families.

Gradually, as more IAPT Services deliver Couple Therapy for Depression, a consensus will emerge as to which measure(s) are most helpful; until then, participants might want to experiment with different measures to discover which ones are effective in ordinary clinical practice.

Unit 3a – The Couple Relationship: improving interactions i

Aims of the Unit – this unit covers the following

The couple therapist needs to further the engagement of the couple in the therapy and in the development of acceptance and tolerance between them by ensuring that the couple clearly and appropriately communicate their thoughts, perceptions and emotional states to each other and to the therapist. This requires the therapist to draw on techniques that promote clear and effective speaking and listening, as well as the accurate interpretation of the unspoken communications between the couple.

The therapist must take account of the negative as well as positive aspects of clear communication in the couple relationship consequent to the diagnosis of depression, enabling the couple to develop a sense of what can be said, when, to each other and its impact on their feelings.

Couple therapists should ensure that the teaching and development of communication skills is in the service of promoting greater awareness and understanding of the experience and needs of each partner in the relationship. The development of communication skills is not an end in itself; it is secondary to the emotional connection and exploration needed to achieve an active state of acceptance and tolerance of each other's particular experience of the relationship.

Improving communication

An ability to teach listening skills, for example by:

- encouraging partners to listen actively (clarifying but not debating what is being said) in a manner that supports and validates the speaker
- encouraging partners to summarise and reflect back what they have heard, especially in relation to key issues voiced
- discouraging either partner (or their therapist) from making unfounded assumptions about communications

An ability to teach disclosing skills, for example by:

- encouraging direct rather than ambiguous statements
- encouraging the expression of appreciation, especially before raising concerns softening the way concerns are introduced and voiced
- discouraging ending on a criticism when positive statements are made
- promoting 'I' statements (rather than 'We' or 'You' statements that attribute meanings and intentions to others)
- encouraging concise, specific and relevant speech
- encouraging expression of information about feelings as well as reports of thoughts and experiences

An ability to use exploratory techniques to aid communication, for example by:

- using open-ended questioning
- extending the issue being discussed
- using silence while actively and supportively listening

An ability to use explanatory techniques to aid communication, for example by:

- clarifying what has been said
- providing feedback about a communication
- reconstructing the content of a message, especially where contradictions may be embedded within it

Learning Outcomes

Competency in

- using and teaching communication skills including listening and disclosing in such a way as to further the development of acceptance and tolerance in the couple
- modelling appropriate use of communication, including silence and care in expression, so that the couple's experience of appropriate and helpful communication is reinforced
- enabling the empathic use of curiosity and receptivity about each other

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Self-reflection questionnaires

Suggested reading

Suggested Reading

Beach, S., Sandeen, E. & O'Leary, K. 1990. Depression in marriage: A model for etiology and treatment. New York: Guilford.

Crowe, M. & Ridley, J. 2000. Therapy with couples. A behavioural-systems approach to couple relationship and sexual problems. Oxford: Blackwell. 2nd ed.

Jacobson, N. & Christensen, A. 1998. Acceptance and change in couple therapy. A therapist's guide to transforming relationships. New York: Norton.

Unit 3b - The Couple Relationship: improving interactions ii

Aims of the Unit – this unit covers the following

High levels of stress in the couple relationship militate against the ability to communicate openly and sensitively together; yet stress is an inevitable part of any relationship and a particular ingredient of relationships where one partner is depressed. The couple therapist must enhance the couple's ability to cope with stress through carefully grading their discussions about stressors in the relationship: enabling a successful discussion of something relatively non-stressful allows the couple to feel safer in moving on to something more highly charged between them.

Care needs to be taken in managing the tension between the need for openness and exploration, and the inevitable feelings of blame and resentment that arise in the couple. The couple therapist needs to ensure that feelings of empathic curiosity about, and interest in, each other are recovered whenever they are lost. Explicit links may need to be made to developmental experiences in each of the partner's backgrounds, particularly those where these suggest a family 'script' of disappointment or criticism, in order to help couples distinguish between past and present experience.

Communication continued...

Coping with stress

An ability to help partners cope with their own and each other's stress, for example by:

- enhancing a sense of safety by encouraging each partner to talk first about low level stressors that are removed from home before going on to talk about higher level stressors that may be closer to home
- encouraging the speaking partner to identify what they might find helpful in coping with the stress
- enabling the listening partner to offer empathic support for the speaker in disclosing what they are finding stressful, and any specific needs they may have in order to cope with the stress
- encouraging the speaking partner to provide empathic feedback on their experience of being supported
- repeating these sequences with the partners changing speaker and listener roles
- maintaining fairness and equity in the balance of speaker and listener roles to ensure neither partner is privileged in either role

Learning Outcomes

Competency in

- enabling the couple to express and explore things they find stressful in a carefully managed way, ensuring that the exploration itself does not become over-stressful
- enabling the couple to recognise and accept that some stressors cannot be got rid of, but can be lived with as part of an ordinary relationship
- maintaining a balance between each of the partners in a way that is not rigidly equal but which matches the emotional needs of the couple at any one time

- enabling the couple to identify and distance themselves from influential and repetitive family 'scripts' or expectations that arise from their developmental histories so enabling accurate perception of the current interactions between them

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Self-reflection questionnaires

Suggested reading

Suggested Reading

Bodenmann, G. 2007. Dyadic coping and the 3-phase-method in working with couples. In L. VandeCreek (ed.), *Innovations in clinical practice: Focus on group and family therapy* (pp. 235-252). Sarasota: Professional Resources Press.

Bodenmann, G. 2010. New themes in couple therapy: The role of stress, coping and social support. In K. Hahlweg, M. Grawe & D. H. Baucom (Eds.), *Enhancing couples. The shape of couple therapy to come.* (pp. 142-156). Cambridge, MA: Hogrefe Publishing.

Unit 4a - The Couple Relationship: improving interactions iii

Aims of the Unit – this unit covers the following

Couple therapists must ensure couples feel safe in discussing problems as without a feeling of safety the discussion can become destructive and encourage a dynamic between them that increases depressive feelings and attributions. The shared experience of identifying and resolving problems enhances the felt sense of the value of the relationship to each partner and of its ability to enhance closeness and act as a resource to either of them. This is particularly true when problems arise from the couple's sexual relationship and other highly emotionally-charged aspects of their experience such as issues around money, parenting, and relationships with extended family which can feel daunting to many couples.

The couple therapist will build on the work done developing acceptance and tolerance of each partner's experience by carefully grading how problems are worked with. There needs to be a clear assessment of the couple's abilities to manage a discussion about a particular problem, as some problems will be more destabilising to the couple than others; some will therefore need a much more structured approach than others will and it should not be automatically assumed that an ability to solve a problem in one area means that all other areas can be similarly resolved. The experience of successful problem solving will add to the quality of the relationship, however.

Solving problems

An ability to create and nurture shared systems of meaning within the couple as a prelude to addressing problems, for example by:

- encouraging partners to talk to each other about respective hopes and fears they have about their relationship, especially when they feel upset or threatened
- establishing and noting, to underline their intentional nature, the partners' daily rituals of connecting with each other (over meal times, shared activities and so on)
- identifying ways, and noting their intentional nature, in which partners already are supported by each other in their shared roles (parenting, home maintenance and so on)
- facilitating the emergence and recognition of a shared relationship story:
- noting how it clarifies and sustains the values and meanings the partners have in common

An ability to help couples define problems in ways that can limit complaint or criticism, for example by encouraging partners to:

- use specific examples when raising potentially contentious issues
- convey why the problem is important to them
- include clear statements about how the problem makes them feel

An ability to provide a structured and stepped approach to problem-focused discussions, for example by:

- separating the process of sharing thoughts and feelings from discussions about the way in which decision-making and problem-solving will proceed
- developing communication skills before applying them to problem-solving
- starting with low conflict before proceeding to high conflict issues
- addressing one problem at a time

- avoiding being sidetracked
- discouraging disagreements when there is insufficient time to address them

An ability to enable partners to try out different approaches to managing conflict, for example by:

- enacting arguments in the safety of the therapy session
- interrupting enacted arguments to explore alternative approaches
- encouraging pretend or controlled arguments outside sessions

An ability to help couples find a solution to identified specific problems through sequentially: defining problems

- brainstorming potential positive alternatives to current problematic behaviour
- evaluating the pros and cons of those alternatives
- negotiating alternatives
- identifying the components of a contract
- forming an explicit (when appropriate, written) contract
- being able to differentiate between soluble and insoluble problems, and where problems are insoluble maintaining a dialogue round the insoluble problem

Learning Outcomes

Competency in

- using problem-solving techniques in a way that matches the each of the partners' abilities and sensitivities to manage conflict, either actual or feared, at any one time
- enabling the couple to accept and tolerate the insoluble differences between them that usually lead to conflict
- promoting empathic bonding between the couple through the use of techniques that enable an empathic understanding of each other's position in the conflict
- enabling and containing discussions of common conflict-areas of a couple's life such as sex, money, family and parenting, in such a way as to enable the couple to self-regulate more effectively

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Self-reflection questionnaires

Suggested reading

Suggested Reading

Crowe, M. & Ridley, J. 2000. *Therapy with couples. A behavioural-systems approach to couple relationship and sexual problems.* Oxford: Blackwell. 2nd ed.

Jacobson, N. & Christensen, A. 1998. *Acceptance and change in couple therapy. A therapist's guide to transforming relationships.* New York: Norton.

Unit 4b- The Couple Relationship: improving interactions iv

Aims of the Unit – this unit covers the following

The couple therapist needs to be able to further the engagement of the couple in the therapy and in the development of acceptance and tolerance between them by ensuring that the couple are able to clearly and appropriately identify problematic behaviours in the relationship and come to an agreement about what to do with them. This requires the therapist to draw on techniques that promote positive behaviours, whether reciprocated or not, whilst enabling the couple to understanding the meaning and function of the behaviour in the relationship.

The therapist must take account of the negative as well as positive aspects of changing behaviour in the couple relationship consequent to the diagnosis of depression, enabling the couple to develop a sense of what can be changed and what needs to be tolerated for the sake of the relationship.

Couple therapists should ensure that the teaching and development of behavioural exchange skills is in the service of promoting greater awareness and understanding of the experience and needs of each partner in the relationship. The development of behavioural change skills is not an end in itself; like communication skills, it is secondary to the emotional connection and exploration needed to achieve an active state of acceptance and tolerance of each other's particular experience of the relationship.

Changing behaviour

An ability to hold collaborative discussions to establish and assist in achieving agreed upon and specific goals, including:

- helping couples identify and set their own goals for the therapy
- establishing the rules and procedures for achieving these goals
- when appropriate, contracting with either or both partners to refrain from specific behaviour (for instance, behaviour that has been agreed-upon as dangerous)
- exploring why behavioural agreements entered into by the partners have worked or failed to work, and reviewing goals in the light of this

An ability to instigate an increase in reciprocated positive behaviour, for example by:

- noting such behaviour in the couple and:
 - focusing on increasing the frequency of positive exchanges rather than on diminishing negative exchanges
- helping each partner to generate a list of specific, positive, non-controversial things they could do for the partner
- helping the partner to whom the list is directed to develop the list
- conducting a staged approach in which:
 - requests from partners are simple and clear
 - complaints from and about partners become wishes
 - specific, reciprocal, achievable changes are negotiated and worked at together
 - progress is monitored by all participants
- encouraging the reciprocation of positive behaviour

An ability to instigate an increase in positive behaviour that does not depend on reciprocation, for example by:

- enabling partners to identify and achieve specific changes they want to make in themselves irrespective of whether their partner reciprocates, including:
 - changes of a broad nature, such as improving the emotional climate of the relationship through being more available to share time
 - changes with a specific focus, such as the manner in which concerns are raised
- encouraging partners to predict how changes in their own behaviour might have a positively reinforcing effect upon their partner:
 - exploring how this prediction looks to the partner
 - exploring their own and their partner's response to initiating such change
- identifying and articulating relationship themes and meanings for each partner that lie behind specific behaviour

Learning Outcomes

Competency in

- building on the collaborative engagement of the couple in the relationship and in the therapy by encouraging a collaborative approach to behavioural change
- using behavioural-exchange techniques in a way that prioritises the increase in positive behaviours over the reduction of negative ones
- enabling the couple to accept and tolerate their differences between them about reciprocity of wished-for behaviours, so promoting greater trust in the relationship
- promoting empathic bonding between the couple through the use of techniques that enable an empathic understanding of each other's view of the behaviours in question by identifying and articulating the underlying relationship themes and meanings for each partner

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Self-reflection questionnaires

Suggested reading

Suggested Reading

Jacobson, N. & Margolin, G. 1979. Marital therapy: Strategies based on social learning and behavior exchange principles. New York: Brunner-Mazel.

Jacobson, N. & Christensen, A. 1998. Acceptance and change in couple therapy. A therapist's guide to transforming relationships. New York: Norton.

Unit 5a - The Couple Relationship: managing feelings and emotions in the context of Units 3 & 4; and Video Assessment

Aims of the Unit – this unit covers the following

By definition, couple relationships where one partner is experiencing depression have difficulties in the free expression of the full range of emotions normally experienced in committed adult relationships. The emotional impact of depression in a relationship is considerable, making some partners over-compensate by either minimising the expression of affect or by becoming emotionally volatile themselves. Couple therapists have to be active in their engagement with feelings in order to minimise risk to the couple of unbounded or overwhelming emotional states in and outside the therapy sessions.

The couple therapist needs to draw on a range of techniques that promote the optimum expression of feelings and emotions in the couple, depending on what the problems are. Part of this will involve normalising 'difficult' emotions between the couple, as a response to the fact of one partner's depression; part will be the active exploration of the depressed feelings themselves and their origins in past and present experiences including those of loss.

In addition, couple therapists need to help couples see how they each attribute idiosyncratic meanings to the other's emotional expression that have their origins in developmental experiences that have shaped both their emotional repertoire and their characteristic ways of registering and showing or expressing feelings. The safe and empathic exchange of feelings between the couple promotes wellbeing, so reducing depressive states and promoting resilience in the couple.

Managing feelings

An ability to encourage the expression and reformulation of depressive affect, for example by:

- supporting the expression of depressed feelings, and the partner's reactions to depressed feelings, and encouraging acceptance of them
- exploring past and present experiences of loss that may account for these feelings, which provide a framework for acknowledging and understanding them
- facilitating mourning

An ability to work with partners who might minimise expressions of emotion, for example by:

- normalising emotional experience
- describing emotions in language that is both accessible and meaningful to the couple
- validating and promoting acceptance of both existing and newly-experienced feelings of each partner
- using questions, hypotheses, and/or reflections that can evoke emotions within the session in the service of then making them intelligible to each partner
- using pacing and softening techniques to create safety in evoking emotion
- heightening awareness of the link between physiological arousal and emotional states (for example, by using bio-feedback methods)
- teaching individual self-soothing techniques

- when possible, inviting and enabling partners to help each other implement self-soothing techniques
- heightening emotions, in a controlled and safe way within the session by repeating key phrases to intensify their impact

An ability to work with partners who amplify the expression of emotion, for example by:

- bounding the expression of emotion within sessions
- helping partners differentiate between their emotional states:
 - as experienced in themselves
 - as observed by others
- helping them to clarify when unexpressed emotional states might underlie expressed emotion (for instance when unexpressed fear underlies the expression of anger)
- promoting containment of upset in one domain of life to prevent it infiltrating other domains
- curtailing statements of contempt through opening up explorations of its impact and underlying emotions
- helping partners to establish useful boundaries around emotional expression, for example through:
 - scheduling mutually agreed times and places in which to discuss feelings, especially those associated with painful experiences, whether shared or separate
- encouraging partners to accept the importance of other relationships (such as friends and relatives) to provide additional emotional support, and to reduce unmanageable pressure on the relationship, while also:
 - identifying and agreeing upon mutually acceptable boundaries (such as, for example, mutually agreed sexual or financial limits to other relationships)

An ability to work with mismatches between partners' emotional responses and meanings, for example by:

- building awareness between partners of:
 - their different attitudes, histories and experiences with expressing specific emotions
 - their different attitudes towards introspection, self-disclosure and exploration of feelings
- accepting and processing mismatches of emotional expression and responsiveness
- helping translate each partner's respective meanings of the other's behaviours
- helping the couple reach clearer shared understandings of each other's responses and meanings

An ability to provide empathic support, for example by:

- tracking the emotions of each partner, as signalled within sessions through verbal and non-verbal cues
- tuning into and validating emotional experience, for example by responding sensitively and robustly
- focusing on patterns of relating that disrupt emotional connection, and promoting their repair through reprocessing sequences as experienced by each partner
- reframing the emotional experiences of partners to make them intelligible and acceptable to each other

Learning Outcomes

Competency in

- engaging the couple in active and open discussion of their emotional states, both positive and negative, in a way that promotes empathic joining between the couple
- enabling the safe exploration of 'strong' emotions including anger and despair and helping the couple see these as normal in the circumstances of their lives and relationship, whilst assessing the couple's ability to cope with such exploration at any one time

- surfacing hidden emotions, such as ‘soft’ feelings of vulnerability underlying ‘hard’ feelings of anger, in such a way as to enable greater understanding and acceptance of each partner’s emotional worlds (including the ways they perceive and react to feelings)
- widening the range of emotional expression in the couple through techniques designed to make emotional states intelligible as part of each partner’s life experience and history, so promoting empathic understanding

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Video assessment of a role-play using actors

Self-reflection questionnaires

Suggested reading

Suggested Reading

Beach, S., Sandeen, E. & O’Leary, K. 1990. Depression in marriage: A model for etiology and treatment. New York: Guilford.

Gottman, J. 1999. The Marriage Clinic. A scientifically based marital therapy. New York: Norton

Jacobson, N. & Christensen, A. 1998. Acceptance and change in couple therapy. A therapist’s guide to transforming relationships. New York: Norton.

Johnson, S. 2004. The practice of emotionally focused couple therapy. Creating connections. New York: Brunner-Routledge; 2nd edition.

Jones, E. & Asen, E. 2000 Systemic couple therapy and depression. London: Karnac.

Ruszczynski, S. (ed.) 1993. Psychotherapy with Couples. London: Karnac.

Savege Scharff, J & Scharff, D. 2008. Object relations couple therapy. In A. Gurman (ed.) Clinical handbook of couple therapy. New York: Guilford Press, pp 167-195. 4th edition.

Snyder, D. & Mitchell, A. 2008. Affective-reconstructive couple therapy: A pluralistic developmental approach. In A. Gurman (ed.) Clinical handbook of couple therapy. New York: Guilford Press, pp 353-382. 4th edition.

Unit 5b – The Couple Relationship: managing feelings; endings & maintenance and Video Assessment

Aims of the Unit – this unit covers the following

The well conducted ending of a couple therapy is an essential part of the work with the couple, as the end itself can be experienced as another form of loss, so may either be avoided or give rise to a further eruption of symptoms or inter-personal difficulties between the couple as the relationship with the therapist draws to an end. The couple therapist will enable the couple to make the best ending they can, bearing in mind that 'best' may include being open to emotional distress, which can then be understood further. The end of the therapy needs to be discussed from the beginning. Part of understanding the impact of the ending will also be the correct interpretation of any sudden changes in outcome measure scores.

The couple therapist shall work explicitly and collaboratively with the couple to identify potential future difficulties in the relationship and/or in the re-emergence of depression, and to set out a plan to be followed with realistic and specific activities and actions that will enable the couple to manage better what happens. Part of this plan may be the referral to other sources of help and support.

Ability to end couple therapy

An ability to terminate therapy in a planned and considered manner, including being open to revising a planned ending

An ability to act with discretion and awareness that timescales are different for different individuals, and that timetables can be disrupted by events

An ability to review the progress of therapy, for example by identifying what has been achieved, what remains to be achieved and what cannot be achieved

An ability to identify with the couple feelings associated with ending, including the ways these can be expressed indirectly, for example through:

- recurrences of presenting problems, or the emergence of new difficulties within the partnership that call into question the wisdom of ending
- requests from the couple to end early or precipitately, which may serve to avoid difficult feelings associated with ending

An ability to prepare a relapse prevention plan collaboratively with the couple that addresses both individual problems (e.g. depression in one partner) and couple problems (e.g. communication patterns) and sets out realistic interventions for these both to maintain gains and manage potential deterioration

An ability to liaise about the ending appropriately with practitioners who made the referral for couple therapy, and to refer on to other services where required and agreed

Learning Outcomes

Competency in

- working collaboratively with the couple in constructing an idiosyncratic relapse prevention plan or blueprint of therapy to maintain and consolidate gains and identify future stresses that might lead to further distressed feeling
- dealing with the mixed feelings that ending therapy brings, including helping the couple understand the impact of the loss of the therapy relationship on them, and linking this to the characteristic ways that they deal with such events
- judging the interaction between ending therapy and outcome measure scores for any particular couple
- liaising with referring professionals about the ending case in such a way as to increase their understanding of the nature of Couple Therapy for Depression, and of couple relationships, so enabling increasingly appropriate referrals

Indicative Learning Methods

Didactic teaching

Large and small group discussion of theory, technique, and case examples

Extensive use of role-play

Video assessment of a role-play using actors

Self-reflection questionnaires

Suggested reading

Suggested Reading

Beach, S., Sandeen, E. & O'Leary, K. 1990. Depression in marriage: A model for etiology and treatment. New York: Guilford.

Johnson, S. 2004. The practice of emotionally focused couple therapy. Creating connections. New York: Brunner-Routledge; 2nd edition.

Savege Scharff, J & Scharff, D. 2008. Object relations couple therapy. In A. Gurman (ed.) Clinical handbook of couple therapy. New York: Guilford Press, pp 167-195. 4th edition.

Woodhouse, D. and Pengelly, P. (1991). Anxiety and the Dynamics of Collaboration. Aberdeen, Aberdeen University Press

APPENDICES

Couple Therapy for Depression Competency Adherence Scale

This scale is drawn from the ‘Specific Couple Therapy Techniques’ Competencies.

Raters should make a judgement of the demonstration of the appropriate use of techniques in the observation or recording that they are evaluating on a scale of 0-4 where 0 indicates not present, and 4 indicates extensively present.

Not present	Possibly present	Briefly present	Moderately present	Extensively present
0	1	2	3	4

For each competency area there are examples of ‘indicative evidence’ that show that the practitioner is functioning within the competency range. Not all examples of indicative evidence need to be observed and there may be other pieces of evidence from the recording or observation that are equally valid. The task of the Rater is to make a professional judgement as to whether the appropriate competencies are being used at the appropriate time and the practitioner is practicing within the range of techniques of Couple Therapy for Depression.

Not all competencies would be expected to be observed in any one instance of the work as some relate to particular stages of the therapy and some are mutually contradictory because of the differences between the therapeutic interventions found in the Evidence Base. However, where there are substantial gaps the practitioner should be alerted so that they can then put forward more appropriate evidence for assessment.

Where the Rater feels that a competency should have been present and that this was a failure of the practitioner, rather than an accident of timing or a conflict of underpinning models, they shall draw this to the practitioner’s attention for review in supervision.

It is generally expected that competent practitioners of Couple Therapy for Depression will be achieving a mix of 3s and 4s across the different Techniques, and that the Total Score for all the Techniques shall be at least 126. Scores that are considerably less than this suggest that the practitioner is not functioning as a fully competent IAPT Couple Therapist at the point of assessment. Scores that are borderline will need careful review with the participant as they may mean either a potential lack of competence or a lack of appropriate evidence.

Techniques that engage the couple		
What	Indicative evidence	Score (please circle)
An ability to form and develop a collaborative alliance with each partner and to enlist their support for relationship-focused therapy	<p>responding empathically in order to validate the experience of each partner, especially their emotional experience;</p> <p>accepting and exploring each partner's reservations about engaging in couple therapy;</p> <p>gauging when and whether separate sessions are needed to engage each partner in the therapy, or to overcome an impasse;</p>	0 1 2 3 4
An ability to form and develop an alliance with the couple as a unit	<p>reframing any presentation of individual problems in relationship terms;</p> <p>focusing attention on shared as well as separate concerns;</p> <p>supporting the partners' sense of themselves as being part of a unit as well as two individuals.</p>	0 1 2 3 4
An ability to promote a collaborative alliance between the partners in the couple	<p>using empathic questioning to help the partners explore and reappraise their respective positions;</p> <p>encouraging the partners to address each other directly, rather than the therapist being drawn into a role as mediator or interpreter.</p>	0 1 2 3 4
An ability to engender hope about the therapeutic process	<p>expecting neither too little nor too much about what can be achieved and by when;</p> <p>engaging constructively with problematic issues;</p> <p>encouraging, recognising and reflecting back positive cycles of interaction in the couple; reinforcing achievements by marking and celebrating positive change.</p>	0 1 2 3 4

<p>An ability to instigate therapeutic change</p>	<p>encouraging shared responsibility for the therapy by constructing agendas collaboratively;</p> <p>recapitulating and checking out key communications made during sessions;</p> <p>encouraging couples to describe events and episodes in active rather than passive terms (for example, asking 'how did you make that happen?' rather than 'how did that happen?');</p> <p>creating openings for new relational experiences (for example, through collaboratively setting homework assignments);</p> <p>being clear and sensitive about the rationale for any homework assignment, and following up on how it is experienced as well as whether it has been completed.</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 15 or ABOVE)</p>	

Techniques that focus on relational aspects of depression		
What	Indicative evidence	Score (please circle)
<p>an ability to focus on and reduce negative cycles of influence between depression and couple interactions</p>	<p>educating couples about potential links between depression and stressful patterns of relating in the couple;</p> <p>gathering in broader aspects of the couple's relationship and focusing on these (for example, concentrating on their roles as parents as well as partners);</p> <p>inviting the depressed partner to assume the caring role normally occupied by her or his partner;</p> <p>asking the depressed partner to help her or his partner to express feelings;</p> <p>supporting the depressed partner in being assertive;</p> <p>discouraging blaming and denigration;</p> <p>encouraging partners to maintain routines, surroundings and relationships that provide them with a sense of familiarity and security.</p>	<p>0 1 2 3 4</p>
		Cont...

<p>An ability to review interpersonal roles in the couple relationship, especially with regard to care giving and care receiving</p>	<p>using family life-space techniques (such as sculpting or button/stone games) to enable partners to represent how roles are divided between them, including any changes that have taken place;</p> <p>encouraging each partner to depict graphically the amount of time and energy they believe they spend carrying out these roles, including any changes that have taken place;</p> <p>using genograms to investigate family-of-origin roles;</p> <p>reviewing how roles were allocated in previous partnerships;</p> <p>highlighting similarities and differences between each partner in terms of their cultural expectations;</p> <p>investigating how their audit of relationship roles compares with what each partner expects and desires;</p> <p>identifying areas where changes might be achieved.</p>	<p>0 1 2 3 4</p>
<p>An ability to consult with the couple about their interaction</p>	<p>Reflecting back observations about recurring patterns of relating between the partners;</p> <p>reflecting back observations about ways in which each partner and the couple use their therapist;</p> <p>reflecting back observations about any relevance this might have to their relationship concerns.</p>	<p>0 1 2 3 4</p>
<p>An ability to generate and test hypotheses that explain depressive symptoms through the relational contexts in which they occur</p>	<p>offering thoughts about the possible functions of symptomatic behaviour for each partner;</p> <p>highlighting the roles played by each partner and others in creating and maintaining depressive symptoms, and exploring possible reasons for these;</p> <p>describing interactive patterns that may maintain depressive symptoms.</p>	<p>0 1 2 3 4</p>
		<p>Cont...</p>

<p>An ability to challenge repetitive sequences</p>	<p>interrupting monologues, or cycles of accusation, rebuttal and counter-accusation; exploring possible functions performed by such repetitive sequences for each partner and the couple;</p> <p>suggesting alternative behaviours or ways of communicating.</p>	<p>0 1 2 3 4</p>
<p>An ability to offer possibilities for altering interactions</p>	<p>tracking and reflecting back observations about patterns of relating and their possible purposes for each partner and the couple;</p> <p>replaying and highlighting key interactions so they can be more directly be experienced in the session and made available for reflecting on in the therapy;</p> <p>providing opportunities for each partner to imagine what they think might happen if existing roles and relationship patterns were to change;</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 18 or ABOVE)</p>	

**Techniques that reduce stress upon and increase support within the couple 1:
improving communication**

What	Indicative evidence	Score (please circle)
An ability to teach listening skills	<p>encouraging partners to listen actively (clarifying but not debating what is being said) in a manner that supports and validates the speaker;</p> <p>encouraging partners to summarise and reflect back what they have heard, especially in relation to key issues voiced;</p> <p>discouraging either partner (or their therapist) from making unfounded assumptions about communications.</p>	0 1 2 3 4
An ability to teach disclosing skills	<p>encouraging direct rather than ambiguous statements;</p> <p>encouraging the expression of appreciation, especially before raising concerns;</p> <p>softening the way concerns are introduced and voiced;</p> <p>discouraging ending on a criticism when positive statements are made;</p> <p>promoting 'I' statements (rather than 'We' or 'You' statements that attribute meanings and intentions to others);</p> <p>encouraging concise, specific and relevant speech;</p> <p>encouraging expression of information about feelings as well as reports of thoughts and experiences.</p>	0 1 2 3 4
An ability to use exploratory techniques to aid communication	<p>using open-ended questioning;</p> <p>extending the issue being discussed;</p> <p>using silence while actively and supportively listening.</p>	0 1 2 3 4
An ability to use explanatory techniques to aid communication	<p>clarifying what has been said;</p> <p>providing feedback about a communication;</p> <p>reconstructing the content of a message, especially where contradictions may be embedded within it.</p>	0 1 2 3 4
TOTAL SCORE (SHOULD BE 12 or ABOVE)		

**Techniques that reduce stress upon and increase support within the couple 1:
reducing stress**

What	Indicative evidence	Score (please circle)
<p>An ability to help partners cope with their own and each other's stress</p>	<p>enhancing a sense of safety by encouraging each partner to talk first about low-level stressors that are removed from home before going on to talk about higher-level stressors that may be closer to home;</p> <p>encouraging the speaking partner to identify what they might find helpful in coping with the stress;</p> <p>enabling the listening partner to offer empathic support for the speaker in disclosing what they are finding stressful, and any specific needs they may have in order to cope with the stress;</p> <p>encouraging the speaking partner to provide empathic feedback on their experience of being supported;</p> <p>repeating these sequences with the partners changing speaker and listener roles;</p> <p>maintaining fairness and equity in the balance of speaker and listener roles to ensure neither partner is privileged in either role.</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 3 or ABOVE)</p>	

Techniques that reduce stress upon and increase support within the couple 2: managing feelings

What	Indicative evidence	Score (please circle)
<p>An ability to encourage the expression and reformulation of depressive affect</p>	<p>supporting the expression of depressed feelings, and the partner's reactions to depressed feelings, and encouraging acceptance of them;</p> <p>exploring past and present experiences of loss that may account for these feelings, which provide a framework for acknowledging and understanding them;</p> <p>facilitating mourning.</p>	<p>0 1 2 3 4</p>
<p>An ability to work with partners who might minimise expressions of emotion</p>	<p>normalising emotional experience;</p> <p>describing emotions in language that is both accessible and meaningful to the couple;</p> <p>validating and promoting acceptance of both existing and newly-experienced feelings of each partner;</p> <p>using questions, hypotheses, and/or reflections that can evoke emotions within the session in the service of then making them intelligible to each partner;</p> <p>using pacing and softening techniques to create safety in evoking emotion;</p> <p>heightening awareness of the link between physiological arousal and emotional states (for example, by using bio-feedback methods);</p> <p>teaching individual self-soothing techniques and when possible, inviting and enabling partners to help each other implement self-soothing techniques;</p> <p>heightening emotions, in a controlled and safe way within the session by repeating key phrases to intensify their impact.</p>	<p>0 1 2 3 4</p>

<p>An ability to work with partners who amplify the expression of emotion</p>	<p>bounding the expression of emotion within sessions;</p> <p>helping partners differentiate between their emotional states as experienced in themselves and as observed by others;</p> <p>helping them to clarify when unexpressed emotional states might underlie expressed emotion (for instance when unexpressed fear underlies the expression of anger);</p> <p>promoting containment of upset in one domain of life to prevent it infiltrating other domains;</p> <p>curtailing statements of contempt through opening up explorations of its impact and underlying emotions;</p> <p>helping partners to establish useful boundaries around emotional expression, for example through scheduling mutually agreed times and places in which to discuss feelings, especially those associated with painful experiences, whether shared or separate;</p> <p>encouraging partners to accept the importance of other relationships (such as friends and relatives) to provide additional emotional support, and to reduce unmanageable pressure on the relationship, while also identifying and agreeing upon mutually acceptable boundaries (such as, for example, mutually agreed sexual or financial limits to other relationships).</p>	<p>0 1 2 3 4</p>
<p>An ability to work with mismatches between partners' emotional responses and meanings</p>	<p>building awareness between partners of their different attitudes, histories and experiences with expressing specific emotions, and their different attitudes towards introspection, self-disclosure and exploration of feelings;</p> <p>accepting and processing mismatches of emotional expression and responsiveness;</p> <p>helping translate each partner's respective meanings of the other's behaviours;</p> <p>helping the couple reach clearer shared understandings of each other's responses and meanings.</p>	<p>0 1 2 3 4</p>

<p>An ability to provide empathic support</p>	<p>tracking the emotions of each partner, as signalled within sessions through verbal and non-verbal cues;</p> <p>tuning into and validating emotional experience, for example by responding sensitively and robustly;</p> <p>focusing on patterns of relating that disrupt emotional connection, and promoting their repair through reprocessing sequences as experienced by each partner;</p> <p>reframing the emotional experiences of partners to make them intelligible and acceptable to each other.</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 15 or ABOVE)</p>	

**Techniques that reduce stress upon and increase support within the couple 2:
changing behaviour**

What	Indicative evidence	Score (please circle)
<p>An ability to hold collaborative discussions to establish and assist in achieving agreed upon and specific goals</p>	<p>helping couples identify and set their own goals for the therapy;</p> <p>establishing the rules and procedures for achieving these goals;</p> <p>when appropriate, contracting with either or both partners to refrain from specific behaviour (for instance, behaviour that has been agreed-upon as dangerous);</p> <p>exploring why behavioural agreements entered into by the partners have worked or failed to work, and reviewing goals in the light of this.</p>	<p>0 1 2 3 4</p>
<p>An ability to instigate an increase in reciprocated positive behaviour</p>	<p>noting such behaviour in the couple and focusing on increasing the frequency of positive exchanges rather than on diminishing negative exchanges;</p> <p>helping each partner to generate a list of specific, positive, non-controversial things they could do for the partner;</p> <p>helping the partner to whom the list is directed to develop the list;</p> <p>conducting a staged approach in which requests from partners are simple and clear, complaints from and about partners become wishes, specific, reciprocal, achievable changes are negotiated and worked at together, and progress is monitored by all participants;</p> <p>encouraging the reciprocation of positive behaviour.</p>	<p>0 1 2 3 4</p>

<p>An ability to instigate an increase in positive behaviour that does not depend on reciprocation</p>	<p>enabling partners to identify and achieve specific changes they want to make in themselves irrespective of whether their partner reciprocates, including: changes of a broad nature, such as improving the emotional climate of the relationship through being more available to share time; changes with a specific focus, such as the manner in which concerns are raised;</p> <p>encouraging partners to predict how changes in their own behaviour might have a positively reinforcing effect upon their partner and exploring how this prediction looks to the partner, as well as exploring their own and their partner's response to initiating such change;</p> <p>identifying and articulating relationship themes and meanings for each partner that lie behind specific behaviour.</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 12 or ABOVE)</p>	

Techniques that reduce stress upon and increase support within the couple 3: solving problems

What	Indicative evidence	Score (please circle)
<p>An ability to create and nurture shared systems of meaning within the couple as a prelude to addressing problems</p>	<p>encouraging partners to talk to each other about respective hopes and fears they have about their relationship, especially when they feel upset or threatened;</p> <p>establishing and noting, to underline their intentional nature, the partners' daily rituals of connecting with each other (over meal times, shared activities and so on);</p> <p>identifying ways, and noting their intentional nature, in which partners already are supported by each other in their shared roles (parenting, home maintenance and so on);</p> <p>facilitating the emergence and recognition of a shared relationship story and noting how it clarifies and sustains the values and meanings the partners have in common.</p>	<p>0 1 2 3 4</p>
<p>An ability to help couples define problems in ways that can limit complaint or criticism</p>	<p>By encouraging partners to use specific examples when raising potentially contentious issues;</p> <p>to convey why the problem is important to them;</p> <p>to include clear statements about how the problem makes them feel.</p>	<p>0 1 2 3 4</p>
<p>An ability to provide a structured and stepped approach to problem-focused discussions</p>	<p>separating the process of sharing thoughts and feelings from discussions about the way in which decision-making and problem-solving will proceed;</p> <p>developing communication skills before applying them to problem-solving;</p> <p>starting with low conflict before proceeding to high conflict issues;</p> <p>addressing one problem at a time;</p> <p>avoiding being sidetracked;</p> <p>discouraging disagreements when there is insufficient time to address them.</p>	<p>0 1 2 3 4</p>

<p>An ability to enable partners to try out different approaches to managing conflict</p>	<p>enacting arguments in the safety of the therapy session;</p> <p>interrupting enacted arguments to explore alternative approaches;</p> <p>encouraging pretend or controlled arguments outside sessions.</p>	<p>0 1 2 3 4</p>
<p>An ability to help couples find a solution to identified specific problems</p>	<p>Through sequentially defining problems;</p> <p>brainstorming potential positive alternatives to current problematic behaviour;</p> <p>evaluating the pros and cons of those alternatives;</p> <p>negotiating alternatives;</p> <p>identifying the components of a contract;</p> <p>forming an explicit (when appropriate, written) contract.</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 15 or ABOVE)</p>	

**Techniques that reduce stress upon and increase support within the couple 3:
promoting acceptance**

What	Indicative evidence	Score (please circle)
<p>An ability to work with couples in ways that respect each partner's experience of depression</p>	<p>educating the couple about depression by naming and explaining the symptoms of depression, allowing depression to be viewed as an illness, and thereby reducing feelings of guilt or blame associated with the condition;</p> <p>accepting the couple's reality of the depressed partner as patient especially in the early stages of therapy, and simultaneously helping the non-depressed partner play a supportive role;</p> <p>accepting the reality of both partners' depression when this is the case, and the limitations on what each can do for the other in the short term;</p> <p>engaging the supportive abilities of the non-depressed partner, for example by involving him or her in helping the depressed partner prioritise tasks, undertake manageable social activities, be assertive; recognise dysphoric symptoms; seek out situations that can relieve such symptoms;</p> <p>evaluating and managing the patient's depressive symptoms, including the need for either social stimulus and/or medication;</p> <p>relating to the depressed partner as 'more than his or her depression', to help reduce the effects of depression;</p> <p>assisting the depressed partner to manage their condition for themselves.</p>	<p>0 1 2 3 4</p>

<p>An ability to help partners empathically connect with each other around the problem</p>	<p>eliciting vulnerable feelings from each partner that may underlie their emotional reactions to the problem;</p> <p>encouraging them to express and elaborate these feelings;</p> <p>conveying empathy and understanding for such feelings;</p> <p>helping each partner develop empathy for the other's reactions through modelling empathy toward both partners.</p>	<p>0 1 2 3 4</p>
<p>An ability to help the couple empathically connect with each other in distancing themselves from their concerns</p>	<p>Helping partners step back from their problem and take a descriptive rather than evaluative stance towards it;</p> <p>describe the sequence of actions they take during problematic encounters to build awareness of the triggers that activate and escalate their feelings and consider departures from their behaviour and what might account for such variations;</p> <p>generate an agreed name for problematic repetitive encounters to help them call 'time out'.</p>	<p>0 1 2 3 4</p>
<p>An ability to help the couple develop tolerance of responses that the problem can trigger</p>	<p>helping partners identify positive as well as negative functions served by problematic behaviour;</p> <p>using desensitising techniques to reduce the impact of problematic behaviour (such as practising arguments in sessions).</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 12 or ABOVE)</p>	

**Techniques that reduce stress upon and increase support within the couple 4:
revising perceptions**

What	Indicative evidence	Score (please circle)
<p>An ability to observe and reflect back on observations of seemingly distorted cognitive processing</p>	<p>marking selective inattention;</p> <p>encouraging partners to check out the validity of attributions they make about each other;</p> <p>encouraging partners to check out the validity of perceived (as compared with actual) criticism;</p> <p>drawing attention to self-reinforcing problematic predictions and assumptions.</p>	<p>0 1 2 3 4</p>
<p>An ability to reduce blame and stimulate curiosity in the partners about their own and each other's perceptions</p>	<p>'circular' questioning (questioning that highlights the interactive nature of each partner's behaviour on the other);</p> <p>'Socratic' questioning (questioning that re-evaluates the logic behind existing positions in order to create an alternative, more functional logic);</p> <p>Encouraging partners to 'read' what their partner is thinking and feeling through: picking up verbal and non-verbal cues and messages, and listening to feedback about the accuracy of these readings;</p> <p>imagining the effects their behaviour and feelings have on their partner, and to accept and reflect on feedback from their partner about this.</p>	<p>0 1 2 3 4</p>
<p>An ability to use techniques that increase the partners' understanding of their own and each other's vulnerability to cognitive distortion</p>	<p>identify recurring behaviour and feelings that might act as flashpoints for each partner in their relationship;</p> <p>explore the contexts in which they arise; encourage reflection across relationship domains about similar experiences and reactions.</p>	<p>0 1 2 3 4</p>

<p>An ability to engage the curiosity of partners about possible links between their current relationship perceptions and past developmental experiences</p>	<p>taking a thorough family and relationship history for each partner, or facilitating this to emerge in the context of the therapeutic process, that includes attachment patterns, events and themes;</p> <p>using devices such as family genograms to identify cross-generational family meanings, norms, and/or expectations, especially with regard to relationship roles and scripts;</p> <p>allowing embedded roles, scripts, themes, and patterns that might contribute to distortions in the representation of relationships to emerge and be worked with;</p> <p>linking past attachment themes and problematic experiences with current perceptions and predictions.</p>	<p>0 1 2 3 4</p>
<p>An ability to develop shared formulations of central relationship themes</p>	<p>exploring the transference of representations of past attachment patterns, roles and affects into current couple and/or therapy relationships, and helping the couple distinguish between past and present meanings and realities;</p> <p>exploring the therapist's own emotional and behavioural responses, both to each partner and to the couple itself to identify affects and experiences that may reflect and resonate with those of the couple;</p> <p>to make connections between the affective experiences of each partner and their therapist to build understanding from shared experience.</p>	<p>0 1 2 3 4</p>
<p>An ability to identify and make links between specific arguments and central relationship themes</p>	<p>Highlighting: meanings, thoughts and feelings that accompany escalating arguments;</p> <p>recurring tensions over the need for intimacy and autonomy;</p> <p>conflicts that are structured around issues of dominance and submission;</p> <p>roles that rooted in gender or cultural expectations that might be uncomfortable for one or other of the partners;</p> <p>past attachment experiences that might be creating anxieties and fears.</p>	<p>0 1 2 3 4</p>

<p>An ability to reframe events, actions, feelings or interactions to provide alternative, more positive and/or functional meanings to those posited by one or both partners in order to change perceptions of what is going on in the relationship</p>	<p>reconceptualising a partner's perceived negative motivations as misguided or misfired attempts to be supported by and/or supportive of the other;</p> <p>emphasising the desire of partners to enable rather than disable each other.</p>	<p>0 1 2 3 4</p>
<p>An ability to apply developing formulations to achieve changes in perception</p>	<p>working through past attachment difficulties, disappointments and losses;</p> <p>making accessible and accepting feared emotions/experiences, and encouraging new ways that partners can be with each other;</p> <p>providing the context for a corrective emotional experience that encourages each partner to feel secure with each other.</p>	<p>0 1 2 3 4</p>
	<p>TOTAL SCORE (SHOULD BE 24 or ABOVE)</p>	

Adherence Scale Summary Sheet		
ID:		
Session #	Segment:	
Rater ID:	Date:	
Specific Couple Therapy Techniques		Scores
Techniques that engage the couple		
Techniques that focus on relational aspects of depression		
Techniques that reduce stress upon and increase support within the couple 1: <i>improving communication</i>		
Techniques that reduce stress upon and increase support within the couple 1: <i>reducing stress</i>		
Techniques that reduce stress upon and increase support within the couple 2: <i>managing feelings</i>		
Techniques that reduce stress upon and increase support within the couple 2: <i>changing behaviour</i>		
Techniques that reduce stress upon and increase support within the couple 3: <i>solving problems</i>		
Techniques that reduce stress upon and increase support within the couple 3: <i>promoting acceptance</i>		
Techniques that reduce stress upon and increase support within the couple 4: <i>revising perception</i>		
	Total Score	
Comments:		

Practitioner's Rationale for Technique Selection

Name:

Unit:

Technique Chosen:

What is the fit with your basic Couple Training?

How is this technique is better suited than others to your clinical practice with couples where one partner is depressed?

What are the circumstances when you might decide that this technique is not suitable?

How confident do you feel about using this technique? Please indicate:

1	2	3	4	5
Not at all		Moderately		Very