National Curriculum for High Intensity Cognitive Behavioural Therapy Courses

Fourth edition (updated and revised July 2022)

Key Changes to the Fourth Edition:

1. Greater emphasis on anti-discriminatory and anti-racist practice *
2. Requirement to have meaningful involvement of experts by experience in all programmes
3. Requirement for all programmes to develop and offer an adapted route for part-time trainees
4. Extension of the minimum course teaching days to 72 days of synchronous interactive learning (24 per module, including intensive blocks) to enable a higher level of competence to be reached
5. Specification of a minimum of 36 days (12 days per module or 50% of total university days) of in-person teaching time (when safe to offer this), with an emphasis on specific skills practice.
6. Increased focus on core therapeutic skills including:
    a. Intensive face-to-face minimum 4-8 day (adapted if part-time) starter module focusing on generic therapeutic competences, including an emphasis on experiential role play learning, introduction to patient reported outcome measures and the involvement of Experts by Experience (EBE)
    b. Active listening and guided discovery
    c. Making perceptive links between beliefs, emotion and behaviour
    d. Working within a range of affect that maximises forward progress
    e. Using emotional content of the sessions to guide assessment and intervention
    f. Learning how to understand a person's experience in the context of their idiosyncratic beliefs
7. Increased focus on assessing, formulating, conceptualising and intervening effectively in the context of co-morbidity
8. Exclusion of treatments that are not NICE-recommended from being taught
9. Specification that at least 4 days teaching should be devoted to PTSD/CPTSD, and 3 days to social anxiety disorder
10. Specification that one of the course supervised cases should be treated for social anxiety disorder
11. Specification that two of the course supervised cases should be treated for depression
12. Further emphasises that only one model per anxiety disorder should be taught
13. Clarity that interventions not recommended by NICE should not be taught
14. Move of body dysmorphic disorder from depression to anxiety disorders module
15. Requirement to gain knowledge of the evidence base for the delivery of group CBT where this is NICE recommended, including knowledge of which clinical conditions NICE does and does not recommend group treatments, and demonstrate an ability to determine appropriate cases for group therapy where appropriate.
16. Requirement to develop competence in both in-person and digital delivery
17. Requirement to develop understanding and adherence to professional and ethical guidelines.
18. Increased emphasis on effective use of patient reported outcome measures (including disorder specific measures) to select and guide interventions
19. Requirement for trainees to understand the purpose and meaning of IAPT metrics
20. Requirement for trainees to know how to develop appropriate relapse prevention interventions.
21. Requirement that recordings of practice submitted for summative assessment should not be previewed by course staff
22. Reference to the post-qualification preceptorship guidance
23. Reference to the need to complete Long Term Conditions top-up training after qualification
24. Addition to practice portfolio of observation of / co-working with supervisor, and course supervisor reports

Introduction

Cognitive Behavioural Therapy (CBT) is known to be an effective treatment option for many problems. In the National Institute of Clinical Excellence (NICE) guidelines for anxiety disorders and depression CBT is strongly recommended. Historically, CBT has emphasised the importance of evidence-based practice and sought to promote a philosophy of on-going evaluation of its models and methods. The evidence base, short-term nature and economical use of resources has made it attractive to patients, practitioners and commissioners. Many clinicians have had some exposure to CBT, few have had the opportunity to develop competency.

Courses for high intensity CBT therapists will aim to provide a post-qualification training in evidence based cognitive behavioural therapy for adults with depression and/or any of the anxiety disorders, where these can benefit from a standalone psychological therapy. The courses will be at post-graduate diploma level.

Recruitment for the courses will be aimed at post-graduates with trainees drawn from clinical psychologists, psychotherapists, counsellors, mental health nurses, occupational therapists, social workers and others who can demonstrate professional and academic equivalence (including psychological wellbeing practitioners after a minimum of two years post-qualification).

The training should ensure that all trainees reach a level of competence that would enable them to obtain the outcomes reported in the relevant NICE Guidelines for anxiety and depression. It will also be necessary for trainees to be familiar with the management of issues that are commonly co-morbid with depression and anxiety (such as substance abuse).

The trainees work in IAPT services providing the high intensity CBT component through a range of modes of delivery linked to patient choice (in-person and video consultation.

NICE recommends a stepped care approach to the management of many cases of mild to moderate depression and to some, but not all, anxiety and trauma-related disorders (e.g. post-traumatic stress disorder (PTSD), complex post-traumatic stress disorder (CPTSD) and social anxiety disorder should only be treated with NICE-recommended high intensity therapy). For more severe cases, NICE generally recommends high intensity therapy as the first intervention. IAPT services are organised around these principles. For the services to work efficiently, it is important that the high intensity trainees are also familiar with the low intensity work provided by psychological well- being practitioners (PWPs; see the IAPT Manual) that many patients may have received before being “stepped-up” to high intensity treatment, plus the alternative modalities of therapy recommended by NICE guidance (see IAPT Manual). The trainees will also need to understand the patient benefits of the IAPT metrics and be able to use the IAPT national outcomes monitoring system (which includes session-by-session symptom and disability measures). CBT and linked interventions aim to have a meaningful impact on patients’ lives, improving social inclusion, employment and productivity as well as symptoms. Trainees will therefore need to be able to assess employment and develop close working relationships with

employment advisors in order to maximise the chance that patients will be able to return to work where appropriate. Training providers need to work in close liaison with the service providers and this needs to be built into the course structure. For example, through integrated plans for supervision, liaison between courses and services to facilitate familiarisation of clinical supervisors with the models taught by the course, placement visits by course staff, etc. Quality standards for services offering training to IAPT trainees are available as a download from the NHS website (see guidance as set out in the IAPT Manual).

1. Course Aims and Objectives:

The courses will have a cognitive behavioural theoretical base with preference for approaches with the soundest evidence and where cognitive and behavioural techniques are integrated in therapy. In addition to providing practical intensive and detailed skills training to facilitate skill development to a defined standard of competency, a course will aim to increase trainees' knowledge of theory and research in CBT and promote a critical approach to the subject. It will aim to equip trainees to become skilled and creative independent CBT practitioners, in accordance with BABCP Practice Guidance and contribute to the further development of CBT.

The course will provide opportunities for trainees to develop and demonstrate knowledge, understanding and skills in the following areas:

1. To develop practical competency in Cognitive Behavioural Therapy for depression and anxiety disorders
2. To develop critical knowledge of the theoretical and research literature relating to CBT.

At the end of the course trainees will be able to:

i. construct maintenance and developmental CBT conceptualisations for depression, anxiety and trauma-related disorders (PTSD/CPTSD), for their co-occurrence and for other common forms of comorbidity.
ii. develop CBT specific treatment plans
iii. practice CBT with depression, anxiety and trauma-related disorders systematically, creatively and with good clinical outcome
iv. deal with complex issues arising in CBT practice
v. take personal responsibility for clinical decision making in straightforward and more complex situations
vi. demonstrate self-direction and originality in tackling and solving therapeutic problems
vii. practice as "scientist practitioners" advancing their knowledge and understanding and develop new skills to a high level
viii. demonstrate a systematic knowledge of the principles of CBT and the evidence base for the application of CBT techniques
ix. demonstrate a systematic knowledge of CBT for depression and anxiety disorders

x. demonstrate a critical understanding of the theoretical and research evidence for cognitive behavioural models and an ability to evaluate the evidence
xi. demonstrate an ability to sensitively adapt CBT, and actively address disparities in equity of access and outcomes across all protected characteristics, taking into account cultural and social differences and values
xii. demonstrate an ability to select and use recommended patient reported outcome measures including anxiety disorder specific measures to assess outcome and guide treatment.
xiii. demonstrate an ability to deliver CBT via a range of delivery modes including in-person and video consultation
xiv. demonstrate knowledge of the evidence base for the delivery of group CBT[1] for clinical conditions where this is NICE recommended, including knowledge of which clinical conditions NICE does and does not recommend group treatments, and demonstrate an ability to determine for whom group therapy may be appropriate.

2. Competencies

All competencies outlined in this document, both general and specific, are integral to the CBT competency framework. Supervision will be delivered in line with the IAPT Manual and the UCL competence framework for the supervision of psychological therapies according to the IAPT Good Practice Guide on Supervision). Each module also contains general and specific learning outcomes. It is anticipated that the learning outcomes and competencies will accumulate as trainees' progress through the modules. For more information on competencies, please refer to:

Roth and Pilling (2007) UCL Competences for Cognitive and Behavioural Therapy.

Digital competencies:
In working digitally with patients, it is important that trainees adhere to the usual professional and ethical guidelines that guide their practice. Trainees should pay particular attention to issues of client consent and participation, equity of access and choice. HEE's Health and Care Digital capabilities framework and Digital Health Skills digital competency framework, which is specific to psychological professionals, should be consulted.

3. Course Structure

Most courses are likely to be provided by, or affiliated to, a university, and run as a one-year course (if full time) or up to two years (if part-time).

The post-graduate diploma will require 120 credits at M level. The allocation of credits can be determined by the individual Higher Education Institution. The

[1] Group CBT - post-qualification training in group therapy is required to obtain specific competencies and skills in the delivery of group therapy

curriculum outlined below is notionally divided into 3 academic terms, one for each of the modules with the practice portfolio being accumulated over the whole year. Modules and credit ratings can be adapted by Institutions and training providers to comply with their academic timetable and tailored to suit local needs.

For most weeks it is anticipated that trainees will attend lectures, workshops and supervision 2 days a week, with the remainder of their working week being spent working the IAPT service where they are employed. However, we would recommend that courses schedule intensive workshops at the beginning of each module. For example, a course could start with an intensive minimum 4-8 day[2] in person workshop which aims to provide trainees with key assessment skills, an overview of the model and therapeutic methods of CBT, experiential learning through role plays and the involvement of Experts by Experience (EBE) in teaching, in order to equip them with the basic skills to begin working with patients. The specific organisation of training days may vary between training providers but there should be *at least* 24 days of synchronous interactive[3] teaching/supervision per module, including intensive teaching blocks (excluding time accessing recorded content with no synchronous interactive learning and excluding self-directed study time). This requirement, which equates to a minimum of 72 taught days, is based on:

a. the need for trainees to develop skills in line with those deployed in the randomized controlled trials that established the NICE guidance;
b. experience in running and examining on courses that have fewer training days; and
c. experience in training for and delivering therapy in RCTs that figure prominently in the NICE database.
d. developments in workforce flows that mean a larger number of entrants to the training need to gain foundational therapeutic competences at the start.

The training provider and IAPT clinical sites need to work closely together to ensure an integrated learning experience and to facilitate generalisation of skills into practice. This includes the need for transparent information sharing between course and employer. Regular placement reviews will be carried out between members of the course team, trainees and relevant staff on the clinical site. On-site supervisors will provide placement reports outlining student competencies in relation to course learning outcomes. Trainees on the course who have a full-time contract with their service will be expected to carry out an average of 2 to 3 days of related clinical application of CBT in their workplace to ensure generalisation of skills into routine work and a source of patients for the course. For trainees with a part-time contract the number of clinical days will be less. Trainees' managers will agree to an adaptation of the student's workload to allow them to study for the course. This includes some time during university terms *and* vacations to review videotapes, complete written assignments and revise. The two days during all university holidays should be retained as study days, when not on annual leave.

The trainees' place of work is the setting for direct clinical work (in-person and video consultation). Fifty percent of the trainee's clinical supervision is likely to be provided

[2] For full-time, may be adapted for part-time delivery, for example, three days per week across two weeks.
[3]Synchronous interactive content means there is contact with a teacher or lecturer across the session and active engagement and interaction with the teacher or lecturer and other students

by the training course, in order to ensure close integration of the content of lectures, workshops and supervision. The remaining supervision will be provided by the service provider, in a synergistic manner (see the IAPT Manual for more detail).

Trainees are required to assess and treat at least 8 cases under course supervision over the duration of the Programme. The cases should include patients with depression and a range of anxiety disorders as the primary presenting problem. At least one of the course supervised cases must involve delivering trauma-focused CBT for PTSD/CPTSD, another individual CBT for social anxiety disorder, and two others depression.

They will complete informal and formal audio/video recorded therapy sessions and written assignments. Competency will be assessed by the Cognitive Therapy Scale – Revised (CTS-R) (Blackburn et. al. 2000), written assignments, and therapy outcome (through IAPT national outcomes monitoring system and standard outcome measures). Social anxiety disorder, PTSD/CPTSD and panic disorder specific versions of the CTS-R may also be used as part of formative assessment of these specific interventions (available from www.oxacadatresources.com).Trainees will also keep a clinical logbook detailing their clinical work (see Practice Portfolio).

4. Learning and Teaching Strategy:

The specific Learning and Teaching Strategy can be decided by the training provider, but should incorporate the following:

i. Experiential and skills-based workshops providing trainees with a strong foundation in the clinical procedures of CBT, and addressing the most up- to-date research developments. Particular emphasis should be placed in understanding the way in which idiosyncratic beliefs, attentional deployment, memory processes and behaviours interact to maintain an emotional disorder within a given individual, as well as more broadly in individuals with a similar clinical condition.
ii. Skills based competencies will be developed through small group experiential work and role plays in workshops, group supervision by course members and individual/group supervision in the place of work.
iii. On-going clinical supervision provided by members of the course team and at the place of work, including completion of several courses of therapy as a co-therapist with an experienced therapist/supervisor in their service leading.
iv. Self-directed study to include general reading for each module and preparatory reading for each session. Video library and web-based resources will be available in order that trainees can access and study examples of clinical therapy sessions and clinical demonstrations of specific techniques.
v. Case management and problem-based learning will be facilitated through a combination of course and work-based supervision.
vi. Personal practice in setting up and conducting the type of out-of-office behavioural experiments that figure prominently in anxiety disorder treatments. Trainees should do the experiments themselves, either alone or with other trainees.
vii. Personal experience in completing the IAPT measures of symptoms (including disorder specific measures) and disability for themselves on several occasions

during the course.

viii. Supportive viewing and discussion of trainees' own therapy recordings with peers on the course

ix. Training and supervision through a mixture of in person attendance[4], and remote synchronous interactive components. The in-person attendance should comprise a minimum of 36 days (at least 12 days for each module or 50% of total university days), and should include:

- The development of skills for in person therapy methods through live role play feedback;
- Practice of therapy methods that particularly benefit from in person delivery (e.g. accompanied behavioural experiments that feature in many anxiety disorder treatments);
- Peer and tutor support

5. Assessment

Course modules should be examined with a range of procedures. The following is an example of assessment strategies for a module:

- 1 Formative audio/video recording of a CBT assessment session (student and supervisor rated)
- 1 Formative audio/video recording of a CBT therapy session (trainee and supervisor rated)
- 1 Summative[5] audio/video recording of a CBT therapy session rated by course team members. This summative recording will also be self-rated by trainees and will include a 1,000 word reflective analysis on therapy skills. Summative recordings should not be previewed by course staff ahead of formal marking.
- 1 Related case report 3-4,000 words (rated by course team members)
- 8 IAPT Patient experience questionnaires across the 3 modules to assess patient feedback on the service/therapy delivered by trainee

Other assessment strategies to consider include:

- Objective Structured Clinical Examinations (OSCE) involving role play assessments focusing on particular problems/skills.
- Written examination
- Theoretical essays/ literature review

6. Equality, Diversity and Inclusion

Courses must align their programmes to statutory duties under the Equality Act 2010, requiring public authorities who exercise public functions, and organisations carrying out public functions on behalf of a public authority, to advance equality of opportunity, eliminate unlawful discrimination and foster good relations between people of all protected characteristics.

[4] Where this is permitted and assessed as safe under prevailing public health advice

[5] Formative submissions should not be resubmitted as summative submissions

Trainees need to be equipped with understanding of equality and diversity in a broader sense too, in that individuals can experience disadvantage due to a wide range of factors, such as geographic location, educational opportunities and economic factors. Structural and organisational practice needs actively to address inequity of access and strive for equality and cultural competence[6].

Teaching should include supporting trainees to develop an understanding of the different needs of patients and how to identify what adaptations are required to assess and intervene effectively in the context of protected characteristics. Experiential learning approaches should include examples of working with people from different backgrounds, diversity in role plays, and education and reflection on working with people that have different appearances or backgrounds to the trainee.

Key teaching resources should include the Positive Practice Guides (e.g. IAPT Black Asian and Minority Ethnic Service User Positive Practice Guide, Learning Disability, Older Adults) and recorded workshop content on equality, diversity and inclusion published by Health Education England.

Courses should ensure education of tutors and teaching staff on the delivery and presentation of equality, diversity and inclusion course material. Courses and service providers should also provide information and access to sources of support for minoritised trainees.

Courses should include equality, diversity and inclusion issues within all teaching, with a specific focus on:

i. Reducing inequity of access and outcomes among those from minoritised groups accessing mental health services
ii. Seeking to eliminate all forms of discrimination from the experience of the mental health service users and staff
iii. Achieving cultural competence

Achieving cultural competence is a lifelong learning process. Cultural competence for HI Intensity CBT Therapists means developing the student's ability to recognise their own reaction to people who are perceived to be different and their own values and belief about the issue of difference. The assessment criteria for cultural competence should include:

i. Developing an ability to recognise one's own reaction to people who are perceived to be different and one's own values, and beliefs about the issue of difference. Awareness of one's own bias, prejudice and assumptions, making good use of supervision and reflective spaces to examine these.
ii. Developing an ability to recognise the different needs of people and the ability to identify and apply adaptations required to assess and treat each individual across protected characteristics.
iii. 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

[6] See the IAPT Black, Asian and Minority Ethnic Service User Positive Practice Guide for more detail

or belief.

iv. Being capable of taking responsibility for responses and actions taken with people who are different or are perceived to be different.

v. Developing ability to accept ambiguity of not knowing what to expect or what to do initially during an interaction impacted by perceived difference.

vi. Risk taking in order to communicate effectively with people from diverse cultures.

vii. Working effectively with interpreters, establishing ways of working together and considering clinical implications.

viii. Having raised awareness of one's reaction to people who are different and the implications of these reactions during sessions.

ix. Commitment to learning about anti-discriminatory (including anti-racist) clinical practice and implementing and reviewing learning in supervision.

x. Knowledge of research on CBT within different minoritised groups, with specific reference to evidence on cultural adaptations both broadly and clinical implications for working with the specific disorder.

xi. Understanding of limitations on generalisability of research to the population where there may be small sample sizes of minoritised groups.

7. Ethics and Professionalism

All courses should ensure that teaching includes supporting trainees to understand and adhere to the UCL CBT Competency Framework, specifically in relation to the 'Knowledge of, and ability to operate within, professional and ethical guidelines' within the Generic Therapeutic Competences section on p.2.

8. Digital Literacy

Digital technology is integrated into our lives. As technology is evolving rapidly, the IAPT workforce needs to be fully competent, confident and capable in its use in the workplace.

Excellent digital capabilities are not just about technical skills but include a positive attitude towards technology and innovation and its potential to improve care and outcomes.

HEE's Health and Care Digital Capabilities Framework was developed to support the improvement of the digital capabilities of everyone working in health and care. It is intended as a developmental and supportive tool that can empower and enable all staff.

The Psychological Practitioners Digital Competence Framework specifically aims to support the development of digital practice skills for all applied psychologists and psychological practitioners such as IAPT clinicians. They may be used by practitioners and trainers to monitor competences and for curriculum design and the definition of learning outcomes in relation to digital practice.

Courses should include digital literacy issues within all teaching, with a specific focus on:

i. **Clinical Information Governance** e.g., ability to obtain the client's informed consent to digital work throughout the course of their contact
ii. **Assessment & Formulation** e.g., Knowledge of clinical safety issues (risk) associated with digital/remote therapeutic work
iii. **Psychological Intervention e.g.,** Ability to conduct therapy in individual format using digital technologies
iv. **Evaluation and Research** e.g., Ability to manage outcome data collected digitally and integrate this into treatment planning
v. **Communication and Teaching** e.g., Ability to discuss the pros and cons of the digital modality with patients
vi. **Leadership, Supervision & Consultation** e.g., Ability to engage in remote supervision through a digital platform.

9. Expert by Experience Involvement in Training

People with lived experience make a positive contribution to the learning, practice and work of mental health professionals. The involvement of those with lived experience highlights to professionals the importance of placing the goals, needs and strengths of service users, families, carers and the wider community at the centre of all they do.

The inclusion of people with lived experience in training programmes improves trainees understanding of the way in which patients, families and carers experience and understand their situation. Trainees should be equipped to provide compassionate, empathetic and effective care and understand the networks and systems in which patients live.

In addition to the lived experience of members of the public, it is also important that trainees have the opportunity to explore the relevance of their own lived experiences to their clinical practice.

Programmes should incorporate lived experience into the training. Informing, collaborating and co-production are all valuable contributions. Courses should attend to:

- How the involvement of those with lived experience is coordinated.
- How lived experience contributors are selected to be representative of all backgrounds, cultures and ethnicities.
- How people with lived experience are rewarded for their contribution.
- Involvement in:
  - Course development
  - Student selection and interview panels
  - Teaching and learning
  - Assessment

- Student mentoring
- Recruitment of staff
- Planning of programmes and quality assurance

10. Individual Modules

Module 1: The Fundamentals of CBT - The Fundamentals Module

The Fundamentals Module will focus on delivering a systematic knowledge of the fundamental principles of CBT. Trainees will be encouraged to develop a critical understanding of the theoretical and research evidence for cognitive models and an ability to evaluate the evidence. The module will aim to enable trainees to have an understanding of how the scientific principles inform CBT clinical practice

This Module will focus on core clinical competencies (skills) necessary in undertaking CBT. This covers cognitive behavioural models, comprehensive training in therapeutic engagement skills and processes, comprehensive training in developing maintenance and developmental conceptualisations of cases, and the core aspects of the cognitive and behavioural process of therapy. Clinical workshops will address the most up- to-date evidence for the effectiveness of CBT via a range of delivery methods and provide direct training in applying CBT via these methods. Workshops will consist of information giving, tutor demonstrations, role-play, skills practice, experiential exercises, comparative video illustration and case demonstrations. Experiential exercises will encourage self-reflection, increase in self- awareness and skill acquisition. Sessions will also incorporate a focus on therapists' beliefs and the ways in which these may interfere with therapy.

The curriculum will comprise the following:

- A foundation intensive module of 4-8 days of face-to-face teaching[7] that develops the following generic therapeutic competences and generic meta-competences (further detail in the UCL CBT Competence Framework):
    - Ability to engage client - using both in-person and video consultation)
    - Ability to foster and maintain a good therapeutic alliance, and to grasp the client's perspective and 'world view'
    - Ability to manage emotional content of sessions
    - Ability to manage endings
    - Capacity to use clinical judgment when implementing treatment
    - Capacity to adapt interventions in response to client feedback

    and

    - Understanding of session-by-session outcome measures, the benefits and purposes of IAPT metrics and how to utilise these in sessions with patients.

[7] For full-time, may be adapted for part-time delivery, for example, three days per week across two weeks.

        - Ability to apply effective therapeutic engagement skills such as active listening, guided discovery, and becoming highly perceptive in understanding the patient's perspective.
- Ability to assess a patient's idiosyncratic beliefs and to make the mental shift that allows one to see how those beliefs make the patient's emotional and behavioural responses understandable
- Enabling patients to work within the range of affect intensity which allows new understanding to be gained and progress made.
- Learning how to use the emotional content of sessions as a guide - so that patients are enabled to discover maintaining cognitions and behaviours through pursuing connections with key emotions experienced in the session.
- Identifying counterproductive therapist beliefs and behaviours that might get in the way of successful therapy and how to overcome them.
- Phenomenology, diagnostic classification and epidemiological characteristics of common mental health disorders
- CBT theory and development
- CBT assessment and formulation, placing a particular emphasis on understanding the way in which idiosyncratic beliefs, attentional deployment, memory processes and behaviours interact to maintain an emotional disorder within a given individual, as well as more broadly in individuals with a similar clinical condition. A significant component should also include being able to formulate the development of the client's problems within a broad cognitive - behavioural framework taking into account life events, individual vulnerabilities, and social context, as appropriate.
- Risk assessment (as set out in the IAPT Manual) personal and medical history
- Knowledge of relevant pharmacological interventions and how withdrawal should be managed in collaboration with medical practitioners, when relevant.
- Suitability for short-term CBT within an IAPT setting: guidelines, case applications and contra-indications (see the IAPT Manual).
- Fundamental principles of Cognitive Behavioural Therapy:
    - collaborative empiricism and socratic questioning,
    - clinical process – formulation, rationale giving, measurement, active treatment, relapse prevention
    - structuring sessions – agenda setting, summarising, setting homework
- Use of standard and idiosyncratic clinical measurement to monitor CBT process and outcome
- Use of appropriate clinical measures (including disorder specific measures) to identify presenting issues.
- The role and effective development of the therapeutic relationship in CBT, including the management and repair of ruptures in the alliance
- Assessment methodology: clinical and research: clinical trials; outcome studies
- Theories and experimental studies of process.
- Application of theory and method to the individual case
- Demonstrates correct identification of presenting problems across a range of problem descriptors
- Application of CBT with more complex presentations, deriving CBT driven formulations in cases of co-morbidity
- Demonstrates ability to identify and prioritise the appropriate primary

problem(s) in the context of comorbidity.

- Scope and effectiveness of reasonable adjustments available to deliver therapy in the context of autism, some neurological conditions and cognitive impairment
- The purpose and meaning of IAPT metrics, and how these can be used to improve overall service quality
- Develops fundamental competences across both in-person and digital delivery-based assessments. For digital delivery-based assessments, or any other digital platforms, develops digital literacy per the HEE digital competency framework.
- Develops an understanding of the evidence base for NICE-recommended group CBT for specific clinical conditions and an understanding of when group therapy would be NICE-recommended.
- Experiential learning illustrating how cognitive behavioural methods can be applied to the trainees' own lives, such as:
    - Understanding and addressing therapist's beliefs that might impede treatment.
    - Personal practice in setting up and conducting the type of out-of-office behavioural experiments that figure prominently in anxiety disorder treatments. Trainees should do the experiments themselves, either alone or with other trainees.
    - Personal experience in completing the IAPT measures of symptoms (including ADSMs) and disability for themselves on several occasions during the course.
- The role of outcome-focused supervision (how to make best use of supervision during the course and after training, aligned to the requirements of the IAPT Manual).
- Effective use of supervision to help trainees identify their own values and beliefs in working with CBT to enhance and regulate good practice.
- Values, culture and social differences (access, ethical, professional and cultural considerations)
- An overview of the principles of the stepped care system and the roles of CBT and the other high intensity psychological therapy modalities within that framework (see IAPT Manual for more detail)

Aims:

1. To develop practical competency in the fundamentals of Cognitive Behavioural Therapy
2. To develop critical knowledge of the theoretical and research literature of CBT.

Learning Outcomes:

This module will provide opportunities for trainees to develop and demonstrate knowledge, understanding and skills in the following:

Specific Learning Outcomes:

Demonstrate competency in:

i. diagnostic classification and key characteristics of common mental health disorders to allow accurate allocation of a problem descriptor.
ii. assessing patients for suitability for short-term CBT within an IAPT setting.
iii. use of session-by-session outcome measures (including disorder specific measures) and demonstrating understanding of the benefits and purposes of IAPT metrics to inform a session, and how these drive quality for the patient
iv. how apply effective core therapeutic skills (generic therapeutic competences and generic meta-competences - further detail in the UCL CBT Competence Framework), such as active listening, guided discovery, and becoming highly perceptive in understanding the patient's perspective.
v. Learning how to assess a patient's idiosyncratic beliefs and to make the mental shift that allows one to see how those beliefs make the patient's emotional and behavioural responses understandable
vi. Enabling patients to work within the range of affect intensity which allows new understanding to be gained and progress made.
vii. Learning how to use the emotional content of sessions as a guide - so that patients are enabled to discover maintaining cognitions and behaviours through pursuing connections with key emotions experienced in the session.
viii. CBT assessment and formulation, placing a particular emphasis on understanding the way in which idiosyncratic beliefs, attentional deployment, memory processes and behaviours interact to maintain an emotional disorder within a given individual,
ix. assessing patients with co-morbidities, ability to identify and understand the distinction between primary and secondary diagnoses, and the ability to develop appropriate conceptualisations and treatment goals in the context of comorbidities
x. delivering a clear CBT treatment rationale derived collaboratively and appropriate to the individual patient
xi. constructing collaborative maintenance and developmental CBT conceptualisations as essential foundations that guide CBT
xii. agenda setting, pacing and structuring of CBT sessions
xiii. setting agreed goals for treatment which are specific, measurable, achievable, realistic and timely (SMART)
xiv. working with patients using guided discovery, adopting an open and inquisitive style within the cognitive behavioural model,
xv. identifying and evaluating key cognitions, working with automatic thoughts and helping the patient develop an alternative perspective.
xvi. identifying and conceptualising common thinking errors and processing biases
xvii. identifying and evaluating underlying assumptions, attitudes and rules
xviii. employing a range of change techniques such as pie charts, advantages and disadvantages, continuums, positive data logs
xix. identifying and evaluating core beliefs, employing a range of change techniques
xx. eliciting cognitions associated with upsetting emotion with skillful use of empathy
xxi. identifying problematic cognitions, related behaviours, and constructing,

carrying out and evaluating behavioural experiments

xxii. on-going critical evaluation of the CBT conceptualisation with evidence of a clear treatment plan.

xxiii. developing CBT treatment plans for straightforward cases of anxiety and depression

xxiv. developing CBT treatment plans for more complex presentations, including a range of depression and anxiety disorders and cases of co- morbidity

xxv. ability to form effective therapeutic relationship with evidence of teamwork, collaboration and joint summarising of sessions

xxvi. ability to deal with ending therapy and planning for long term maintenance of gains with evidence of a relapse prevention plan.

General Learning Outcomes:

Demonstrate competency in:

i. using theoretical, evidence-based interventions integrated within and guiding therapy.

ii. implementing and critically evaluating a range of CBT interventions (such as setting goals, eliciting and evaluating thoughts, identifying and working with safety behaviours, problem solving)

iii. taking personal responsibility for clinical decision making in complex and unpredictable situations

iv. demonstrating insightful knowledge of CBT and an ability to identify own values and beliefs and CBT's application to their own lives

v. making best use of supervision on the course and evidence of making use of, and continuing to learn from, on-going continuing professional development

vi. adapting CBT sensitively, and ensuring equitable access to diverse cultures, values and all protected characteristics

vii. delivering high intensity psychological therapy within a stepped care system.

viii. Use and understanding of what outcome measures mean to the patient and the ability to explain to the patient how the measures can help to inform sessions

ix. Understanding of how to work ethically, safely and effectively – attending to professional and clinical boundary issues specific to online practice.

Module 2: CBT for Anxiety Disorders

This module aims to develop skills in CBT for anxiety disorders to an advanced level, improving proficiency in the fundamental techniques of CBT, and developing competency in the specialist techniques applied to anxiety disorders and trauma-related disorders. Specific models, evidence base, assessment and specialist treatment strategies will be covered in workshops on Specific Phobia, Panic Disorder, Agoraphobia, Social Anxiety Disorder, Obsessive Compulsive Disorder, Body Dysmorphic Disorder, Post-Traumatic Stress Disorder / Complex Post-Traumatic Stress Disorder, Generalised Anxiety Disorder and Health Anxiety. Approaches that are not recommended by NICE should not be taught.

Trauma-focused CBT for PTSD/CPTSD requires the development of significant additional and unique treatment competences it is expected that a minimum of 4 days will be spent on TF-CBT. Experience shows that greater time is also required to learn the unique procedures involved in individual CBT for social anxiety disorder. It is expected that a minimum of 3 days will be devoted to CBT for social anxiety.

The clinical workshops will also provide trainees with a strong foundation in the evidence base for working with CBT and anxiety disorders and address the most up-to-date research developments. Teaching should include in depth training on assessment for CBT with anxiety disorders and PTSD/CPTSD, including co-morbidities, assessment of which traumas to work on (if applicable), experiential exercises, including out-of-office behavioural experiments and example outcomes measures to test the beliefs of trainees.

It should also include how to select and use the IAPT recommended anxiety disorder specific measures to guide therapy and assess outcomes on a session-by-session basis. Trainees should also be taught how to select and use process measures (beliefs, safety behaviours, attentional focus etc.) that are relevant for guiding CBT for particular anxiety disorders.

The curriculum will comprise the following:

- Phenomenology, diagnostic classification and epidemiological characteristics of anxiety disorders
- Assessment for CBT with anxiety disorders and PTSD/CPTSD, including in the context of co-morbidity, identifying a primary problem and adapting treatment appropriately in line with the evidence
- Constructing collaborative disorder-specific formulations as key guides to therapy
- Risk assessment (see IAPT Manual), personal and medical history relevant to anxiety disorders
- Application and suitability of CBT with anxiety disorders and PTSD/CPTSD: contra-indications for treatment, the role of pharmacological interventions and substance misuse, how to refer on to other agencies if unsuitable for IAPT
- Clinical process for anxiety disorders – formulation, rationale giving, active treatment, relapse prevention

- Sessional use of clinical measurement with specific anxiety disorders to monitor CBT process and outcome, as a key guide to what to do in therapy
- The role of the therapeutic relationship and continued application of therapeutic engagement skills in CBT with anxiety disorders
- Anxiety Disorders and PTSD/CPTSD: clinical and research: clinical trials; outcome studies
- Theories and experimental studies of process in anxiety disorders
- Application of theory and method to the individual case in anxiety disorders
- Experiential learning: illustrating how cognitive behavioural methods with anxiety can be applied to the trainees' own lives, such as:
    - Personal practice in setting up and conducting the type of out-of-office behavioural experiments that figure prominently in anxiety disorder treatments. Trainees should do the experiments themselves, either alone or with other trainees.
    - Personal experience in completing the IAPT measures of symptoms (including ADSMs) and disability for themselves on several occasions during the course.
- Values, culture and social differences (access, ethical, professional and cultural considerations)
- Effective use of supervision in working with people with anxiety disorders to enhance and regulate good practice.
- An overview of the principles of the stepped care system, knowledge of low intensity interventions with anxiety disorders and the role of high intensity psychological therapy within that framework. Clarity about which disorders should not be treated in a stepped care model and should instead go straight to high intensity therapy (e.g. PTSD/CPTSD and Social Anxiety Disorder).
- Socialisation to high intensity therapy that might be required for patients who have previously been treated with low intensity therapy.

Aims:

1. To develop practical competency in Cognitive Behaviour Therapy for anxiety disorders
2. To develop critical knowledge of the theoretical and research literature of CBT with anxiety disorders.

General Learning Outcomes:

Demonstrate competency in:

i. a critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of anxiety disorders
ii. assessing patients for suitability for CBT with anxiety disorders
iii. use of session-by-session outcome measures (including disorder specific measures) and demonstrating understanding of the benefits and purposes of IAPT metrics to inform a session, and how these drive quality for the patient
iv. constructing collaborative disorder-specific maintenance and developmental conceptualisations as key guides to therapy with people with anxiety disorders,
v. developing CBT treatment plans for a range of anxiety disorders

vi. critical evaluation of theoretical evidence based interventions integrated within, and guiding, therapy with anxiety disorders
vii. eliciting and evaluating key cognitions and I images in anxiety disorders
viii. constructing, carrying out and evaluating behavioural experiments
ix. self-direction and originality in tackling and solving basic therapeutic problems with anxiety disorders
x. self-direction and originality in working with co-morbidity and solving more complex therapeutic problems
xi. dealing with ending therapy and planning for long term maintenance of gains with evidence of relapse prevention plan including: 1) developing summaries of what has been learned in therapy and action plans to reactivate these skills in response to early signs of relapse, and 2) How to schedule and use booster sessions
xii. practicing as "scientist practitioners", continuing to advance their knowledge and understanding to develop new skills with anxiety to a high level
xiii. insightful knowledge of CBT and an ability to identify own values and beliefs in working with anxiety and CBT's application to their own lives
xiv. making best use of supervision with anxiety disorders on the course and making use of, and continuing to learn from, on-going continuing professional development.
xv. effective use of out-of-office behavioural experiments and example outcomes measures to test beliefs.
xvi. an ability sensitively to adapt CBT for anxiety disorders, and ensure equitable access of CBT, taking into account cultural and social differences and values
xvii. a working knowledge of the principles and practice, and competency in delivering high intensity psychological therapy within a stepped care system
xviii. selecting and using anxiety disorder specific measures and process measures (beliefs, attentional focus etc) to assess outcomes and guide treatment of relevant conditions in collaboration with the patient.

Competencies:

NICE guidelines indicate that the strongest evidence for effectiveness of CBT with anxiety disorders lies with disorder-specific CBT protocols. With this in mind, it will be crucial that trainees develop competency in at least one of the specific programmes related to the anxiety disorders listed in the UCL Cognitive and Behavioural Therapy competence framework (Roth and Pilling 2007) or recommended by NICE for the specific condition. Approaches that are not recommended by NICE should not be taught. One model per condition should be taught, rather than spreading teaching / learning across multiple models per condition.

Below is an example of competencies relevant for a CBT programme for each anxiety disorder. For illustrative purposes we have chosen CBT programmes developed in the UK. It would, however, be perfectly reasonable to teach other validated treatments. These competencies are delivered in addition to, and enhance, competencies already covered in the Fundamentals Module.

CBT for Specific Phobia:

Demonstrate competency in:

i. a critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of a specific phobia
ii. a critical understanding of the current, evidence based pharmacological and psychological treatment for specific phobia
iii. assessing specific phobia to determine specific symptoms, severity and impact on daily life and to include the role of medication, substance use and previous treatment
iv. identifying triggers, patterns of avoidance, and safety seeking behaviours
v. deriving a shared understanding of the cognitive behavioural conceptualisation of specific phobia and delivering a rationale for treatment with a patient using a recent example
vi. the use of standard and idiosyncratic measures to evaluate outcome with CBT for specific phobia
vii. identifying the role of cognitions in maintaining the phobia and generating an alternative perspective through discussion techniques, cognitive re-structuring and behavioural experiments
viii. drawing up a graded hierarchy to guide exposure interventions
ix. carrying out exposure using key principles of graded, repeated, focused and prolonged exposure, working with difficulties competently as they arise modelling non-phobic behaviour
x. deriving, conducting and evaluating behavioural experiments in and out of sessions
xi. deriving related specific homework tasks and evaluating these in the next session
xii. ending therapy, deriving a relapse prevention plan utilising an idiosyncratic blueprint of therapy and planning for long term maintenance of gains.

CBT for Panic Disorder

Demonstrate competency in:

i. a critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of panic disorder
ii. critical understanding of the current, evidence based pharmacological and psychological treatment for panic disorder
iii. assessing panic disorder to include the role of medication, substance use and previous treatment
iv. identifying triggers, patterns of avoidance, and safety seeking behaviours
v. deriving a shared understanding of the cognitive behavioural conceptualisation of panic disorder and delivering a rationale for treatment with a patient using a recent example
vi. the use of standard and idiosyncratic measures to guide treatment and evaluate outcome with CBT for panic
vii. identifying catastrophic interpretations of bodily sensations, generating alternative non-catastrophic interpretations, testing the validity of these through discussion techniques and behavioural experiments
viii. deriving, conducting and evaluating behavioural experiments in and out of sessions
ix. deriving related specific homework tasks and evaluating these in the next session

x. ending therapy, deriving a relapse prevention plan utilising an idiosyncratic blueprint of therapy and planning for long term maintenance of gains.

CBT for Social Anxiety Disorder

Demonstrate competency in:

i. a critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of social anxiety disorder
ii. a critical understanding of the current, evidence based pharmacological and psychological treatment for social anxiety disorder
iii. assessing social phobia to include the role of medication, substance use and previous treatment
iv. identifying problematic situations, patterns of avoidance, self-focus of attention, processing of self, safety seeking behaviours and images
v. deriving a shared understanding of the cognitive behavioural conceptualisation of social anxiety disorder and delivering a rationale for treatment with a patient using a recent example
vi. developing a therapeutic relationship with evidence of an awareness of key inter-personal difficulties
vii. the use of standard and idiosyncratic measures to evaluate outcome with CBT for social anxiety disorder
viii. working with self-focused attention/ external focus exercises both within and out of session
ix. setting up in-session experiential exercises working on self- focused attention and safety behaviours
x. using video/audio feedback, plus use of other people to reality test the patient's self-perception
xi. demonstrate originality and creativity in deriving, conducting and evaluating behavioural experiments in and out of sessions
xii. demonstrate competency in use of surveys to obtain alternative information
xiii. working with anticipatory anxiety and post-event processing in social anxiety disorder
xiv. identifying and working with specific childhood memories and images through discussion techniques, cognitive restructuring, stimulus discrimination and imagery rescripting
xv. deriving related specific homework tasks and evaluating these in the next session
xvi. ending therapy, deriving a relapse prevention plan utilising an idiosyncratic blueprint of therapy and planning for long term maintenance of gains.

CBT for Obsessive Compulsive Disorder

Demonstrate competency in:

i. a critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of OCD
ii. a critical understanding of the current, evidence based pharmacological and psychological treatment for OCD
iii. assessing OCD to include the role of medication, substance use, previous treatment and the role of key family members, partners or friends

iv. identifying triggers, patterns of avoidance, safety seeking behaviours, rituals and reassurance seeking
v. deriving a shared understanding of the cognitive behavioural conceptualisation of OCD and delivering a rationale for treatment with a patient using a recent example
vi. the use of standard and idiosyncratic measures to evaluate outcome with CBT for OCD
vii. identifying intrusive thoughts, obsessional fears and related rituals
viii. the use of exposure and response prevention to include therapist modelling as appropriate
ix. working with issues of responsibility and probability in OCD
x. deriving, conducting and evaluating behavioural experiments in and out of sessions
xi. eliciting and re-evaluating intrusive images
xii. working with obsessional rumination, identifying mental rituals and implementing strategies to reduce them
xiii. deriving related specific homework tasks and evaluating these in the next session
xiv. ending therapy, deriving a relapse prevention plan, utilising an idiosyncratic blueprint of therapy and planning for long term maintenance of gains

CBT for Body Dysmorphic Disorder

Overall aim is to decrease preoccupation, distress and interference in life by focusing on building an alternative understanding of the problem and reducing self-focused attention and rumination.

Assessment

i. Identify possible developmental factors for BDD and how these may be used in an alternative understanding of the problem to be tested in therapy
ii. Use standard and idiosyncratic measures (including a self-portrait) to evaluate processes during therapy and outcomes with treatment
iii. Identify imagery, appraisals, emotion, and processing of the self-related to the perceived defect(s)
iv. Develop functional understanding of the various responses (for example the motivation for comparing; self-focused attention; ruminating; camouflaging one's features; mirror checking; avoiding social situations) and their unintended consequences
v. Develop a shared understanding of the cognitive behavioural conceptualisation and the way the responses serve to maintain the preoccupation and distress.
vi. Develop a rationale for treatment using Theory A/ B and a developmental history
vii. Identify plans and expectations of outcome of cosmetic procedures

Intervention

i. Use imagery rescripting to update aversive memories of being humiliated or rejected

ii. Use behavioural experiments to test out fears and expectations
iii. Work with self-focused attention and external focus exercises both in and out of sessions
iv. Use behavioural experiments for avoidance behaviour, dropping of safety seeking behaviours in and out of sessions
v. Identify and work with specific childhood memories and images through the use of imagery rescripting and stimulus discrimination
vi. Use of disengagement from ruminations, comparing and self-criticism
vii. Use of photo or video feedback to reality test the patients' self-perception
viii. Use of habit reversal for skin-picking
ix. Develop and review specific homework tasks
x. Use other approaches such as behavioural activation for depression in parallel with CBT for BDD
xi. End intervention with a relapse prevention plan, utilizing an idiosyncratic blueprint of therapy and planning for long term maintenance of gains.

Trauma-focused CBT for Post-Traumatic Stress Disorder

Demonstrate competency in:

i. a critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of PTSD/CPTSD
ii. a critical understanding of the current, evidence based pharmacological and psychological treatments for PTSD/CPTSD
iii. assessing PTSD/CPTSD to include the role of medication, substance use, previous treatment, presence of on-going threat, enabling the patient to share a brief account of the trauma, main intrusions, identify triggers, patterns of avoidance, and safety seeking behaviours, current coping mechanisms
iv. deriving a shared understanding of the cognitive behavioural conceptualisation of PTSD/CPTSD,
v. Establishing treatment plans including which trauma(s) to work on
vi. delivering a rationale for revisiting the trauma memories with a patient in reliving or narrative writing
vii. the use of standard and idiosyncratic measures to evaluate outcome with trauma-focused CBT for PTSD/CPTSD
viii. identifying key appraisals, cognitive themes and ”hot spots" and key coping behaviours (hypervigilance, substance use, thought suppression)
ix. carrying out imaginal reliving or narrative writing in a safe therapeutic environment, tracking distress levels, prompting for thoughts, feelings, sensations
x. identifying the worst moments or hot spots of the traumatic event and related idiosyncratic meaning for the patient
xi. re-processing and updating the trauma memory through discussion, further reliving, cognitive restructuring and site visits
xii. identifying and discriminating triggers for intrusive memories
xiii. deriving, conducting and evaluating behavioural experiments in and out of sessions (e.g. for hypervigilance/ over-estimation of danger)
xiv. deriving related specific homework tasks and evaluating these in the next session

xv. deriving an idiosyncratic relapse prevention plan to enable patient to be able to deal with future unexpected events.
xvi. Therapist resilience: identifying and coping with vicarious trauma during work with people with PTSD/CPTSD, including welfare self-check techniques

CBT for Generalised Anxiety Disorder

Demonstrate competency in:

i. a critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of GAD
ii. a critical understanding of the current, evidence based pharmacological and psychological treatment for GAD
iii. assessing GAD to include the role of medication, substance use and previous treatment
iv. identifying triggers, patterns of avoidance, and safety seeking behaviours in GAD
v. deriving a shared understanding of the cognitive behavioural conceptualisation of GAD and delivering a rationale for treatment with a patient drawing on knowledge of the Self-control Desensitisation (SCD) and Cognitive Therapy (CT) methods
vi. explaining the rationale for CBT, specifically the relationship between anxiety, perception of threat and perception of coping
vii. the use of standard and idiosyncratic measures to evaluate outcome with CBT for GAD
viii. explaining the contribution of internal and external cues to the patient's anxiety
ix. explaining the role of self-monitoring techniques through in-session practice using imagery to help identify relevant internal and external cues
x. applying progressive and applied relaxation techniques
xi. developing a hierarchy for self-control de-sensitisation, and imaginal desensitisation in and out of session
xii. shifting attentional focus, with extensive use of in-session practice
xiii. identifying anxiety-arousing cognitions, cognitive distortions and helping the patient examine the evidence and generate alternative beliefs
xiv. appraising and re-appraising worries using decatastrophisation techniques
xv. deriving worry free periods and helping the patient maintain a worry outcome diary
xvi. deriving, conducting and evaluating behavioural experiments in and out of sessions
xvii. deriving related specific homework tasks and evaluating these in the next session
xviii. ending therapy, deriving a relapse prevention plan utilising an idiosyncratic blueprint of therapy and planning for long term maintenance of gains.

CBT for Health Anxiety

Demonstrate competency in:

i. a critical understanding of the phenomenology, diagnostic classifications and

epidemiological characteristics of health anxiety

ii. a critical understanding of the current, evidence based pharmacological and psychological treatment for health anxiety

iii. assessing health anxiety to include the role of medication, substance use and previous treatment

iv. identifying internal and external triggers, patterns of avoidance, and safety seeking behaviours

v. deriving a shared understanding of the cognitive behavioural conceptualisation of health anxiety and delivering a rationale for treatment with a patient using a recent example

vi. the use of standard and idiosyncratic measures to evaluate outcome with CBT for Health Anxiety

vii. identifying catastrophic interpretations of bodily sensations and physical symptoms, and related information supporting health concerns

viii. generating alternative non-catastrophic interpretations, testing the validity of these through discussion techniques and behavioural experiments

ix. working with underlying assumptions, rules and attitudes and using a range of cognitive and behavioural strategies to effect change (pie charts, advantages and disadvantages, exposure and response prevention, continuums)

x. deriving, conducting and evaluating behavioural experiments in and out of sessions

xi. deriving related specific homework tasks and evaluating these in the next session

xii. ending therapy, deriving a relapse prevention plan, utilising an idiosyncratic blueprint of therapy and planning for long term maintenance of gains

Module 3: CBT for Depression

This module will develop skills in CBT for depression to an advanced level, improving proficiency in the fundamental techniques of CBT, developing competency in the specialist techniques used in the treatment of depression. Specific cognitive and behavioural models of depression, empirical evidence, and assessment and specialist cognitive and behavioural treatment strategies will be covered in workshops. The clinical workshops will provide trainees with a strong foundation in the evidence base for CBT with depression, and address the most up to date research methods. Approaches that are not recommended by NICE should not be taught.

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 role of combined treatment.
- Theory and development of cognitive and behavioural models for depression
- Assessment for CBT with depression, including specific associated problems
- constructing collaborative maintenance and developmental conceptualisations as key guides to therapy with people with depression
- Risk assessment, risk management, suicide risk, mental state examination, personal and medical history
- Application and suitability for CBT with depression (to include contra- indications) and awareness of referral pathways for cases unsuitable for IAPT
- Role of co-morbid disorders such as anxiety, PTSD/CPTSD, plus personality disorders and substance abuse
- Clinical process for CBT with depression using a cognitive therapy and behavioural activation models (formulation, rationale, frequency of sessions, active treatment, and relapse prevention)
- Clinical process for CBT with chronic, recurrent depression
- Use of standard and idiosyncratic clinical measures to monitor CBT process and outcome in depression
- The role of the therapeutic relationship in CBT with depression
- Use of specific methods to support relapse prevention including:
    1) developing summaries of what has been learned in therapy and action plans to reactivating these skills in response to early signs of relapse, and
    2) How to schedule and use booster sessions
- Linking theory with practice, clinical trials and outcome studies
- Application of theory to practice in individual cases
- Theories and experimental studies of process in depression
- Development of therapeutic competency in the application of cognitive and behavioural interventions with depression
- Experiential learning illustrating how both cognitive and behavioural strategies with depression can be applied to trainees' own experiences
- Specific CBT interventions for sleep disturbance in the context of depression or anxiety
- Values, culture and social differences (access, ethical, professional and cultural

considerations)

- Effective use of supervision to help trainees identify own values and beliefs in working with people with depression to enhance and regulate good practice.
- 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
- Socialisation to high intensity therapy that might be required for patients who have previously been treated with low intensity interventions.

Aims

1. To develop practical competency in Cognitive Behavioural Therapy for depression
2. To develop critical knowledge in the theoretical and research literature for cognitive and behavioural models with depression.

Learning Outcomes

This module will provide an opportunity for trainees to develop and demonstrate knowledge, understanding and skills in the following:

General Learning Outcomes:

Demonstrate competency in:

i. a critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of depressive disorders
ii. assessing patients with depression, considering clinical manifestations, co-morbidity, history, present life situation, course and outcome of depression in determining suitability for CBT
iii. assessing risk factors associated with depression and the integration of risk management within treatment plans
iv. ability to assess suicidal risk and self-harming behaviours and implement practical strategies for managing suicidality and self-harm (see IAPT Manual)
v. use of session-by-session outcome measures (including disorder specific measures) and demonstrating understanding of the benefits and purposes of IAPT metrics to inform a session, and how these drive quality for the patient
vi. prioritising problem areas, problem solving and identifying solutions
vii. constructing both cognitive and behavioural development and maintenance formulations in cases of depression
viii. developing cognitive and behavioural treatment plans for depression
ix. ability to critically evaluate a range of evidence based interventions in depression
x. deriving cognitive or behavioural models with patients considering individual needs and preferences
xi. working with co-morbid presentations of depression and taking personal responsibility for clinical decision making in complex and unpredictable situations
xii. demonstrate self-direction and originality in tackling and solving therapeutic problems with depression including use of patient support networks
xiii. ability to deal with ending therapy and planning for long term maintenance of gains with evidence of a relapse prevention plan including booster sessions
xiv. practising as “scientist practitioners”, continuing to advance their knowledge and

understanding to develop new skills with depression to a high level

xv. insightful knowledge of CBT and an ability to identify own values and beliefs in working with depression and CBT's application to their own lives

xvi. making best use of supervision with depressive disorders on the course and evidence of making use of and continuing to learn from on- going continuing professional development

xvii. sensitively adapting CBT for depression, taking into account cultural and social differences and values, and ensuring equitable access to, and outcomes of, CBT

xviii. delivering high intensity psychological therapy for depression within a stepped care system

xix. using standardized and idiosyncratic patient reported outcome measures (including disorder specific measures) to assess outcomes and guide treatment of depression.

Cognitive Therapy for Depression

Demonstrate competency in:

i. applying the cognitive triad (self, others and future) with depression

ii. conceptualising common processing biases such as arbitrary inference, andselective abstraction.

iii. working with severe depression in working initially on behavioural rather than cognitive approaches in the early phase of therapy

iv. monitoring and scheduling activity, rating mastery and pleasure

v. an awareness of the patient's idiosyncratic depressive beliefs, maintenance factors and coping strategies

vi. delivering a rationale for treatment using a recent example collaboratively

vii. defining the role of cognitions and the concept of negative automatic thoughts and images

viii. identifying depressive rumination and to make links with this and under activity

ix. identifying the different forms of common cognitive information biases or "cognitive distortions" used to support the patient's thinking

x. enabling a patient successfully to re-appraise their own thoughts using the Daily Record of Dysfunctional Thoughts

xi. helping the patient find alternatives by examining the accuracy of specific thoughts working with themes of guilt and self-blame

xii. identifying and working to effect change with underlying assumptions using a range of specific change techniques such as pie charts, advantages and disadvantages, continuums

xiii. identifying and implementing strategies working with depressive rumination on a process and content level

xiv. constructing and carrying out behavioural experiments both in and out of session to modify their assumptions

xv. identifying core beliefs using downward arrow techniques, looking for common themes and use cognitive techniques to re-evaluate core beliefs and strengthen new beliefs

xvi. constructing appropriate homework tasks using a rationale and anticipating difficulties

xvii. constructing an idiosyncratic relapse prevention plan or "blueprint" of therapy to maintain and consolidate gains and identify future stressors

Behavioral Activation for Depression

Demonstrate competency in:

i. knowledge of the behavioural activation model, behavioural theory and the role of behaviour in the development and maintenance of depression
ii. working collaboratively with a patient developing a functional analysis (linking antecedents, behaviours and consequences) and focusing on contingencies that are maintaining the depression
iii. explaining the rationale for a focus on behavioural activation and socialising the patient to the model
iv. helping the patient engage in activities despite feeling low or lacking in motivation
v. identifying secondary coping behaviours (such as avoidance, inactivity or rumination)
vi. enabling the patient to focus on external environmental cues (act from outside in, rather than inside out) introducing and implementing the TRAP and ACTION tools
vii. helping patients use activity charts, rate mastery and pleasure, monitor patterns of avoidance, developing manageable short-term goals and re- establishing routine
viii. utilising distraction from unpleasant events or “behavioural stopping”
ix. developing a functional analysis of triggers for rumination and alternative activity-focused strategies
x. constructing appropriate homework tasks using a rationale and anticipating difficulties
xi. constructing an idiosyncratic relapse prevention plan or “blueprint” of
xii. therapy to maintain and consolidate gains and identify future stressors. The use of booster sessions to support relapse-prevention

Sleep disturbance

The knowledge and skills described in this unit address the understanding and treatment of sleep disturbance which arises in the context of anxiety disorders, depression and LTCs. Interventions should either be integrated into ongoing treatment for these conditions or offered in parallel. They should not be offered as a substitute for the treatment of anxiety disorders or depression,

Although this module is applicable to the training of both PWPs and High Intensity (HI) CBT therapists, the formulation of a maintenance cycle and the modification of unhelpful beliefs will draw on skills associated with the background training of HI CBT therapists; as such PWPs will usually focus on offering guided self-help rather than this aspect of an intervention.

Aims

1. knowledge of the prevalence and presentation of sleep disorders and their impact and association with depression and anxiety
2. common reasons for insomnia or other sleep disturbance, including common psychological and physical reasons for disturbed sleep
3. evidence-based psychological interventions for insomnia or a disrupted sleep pattern.

Competencies:

Knowledge

i. A knowledge of the prevalence and presentation of primary sleep disorders including obstructive sleep apnoea, insomnia disorder, restless legs and circadian rhythm disturbance, their impact and their association with depression and anxiety

ii. An ability to draw on knowledge of the impact of the patient's age, medical and physical condition on sleep, and strategies for improving sleep commonly used to ameliorate or manage these impacts (e.g. changing the timing of medication, adapting posture and support in bed)
iii. Ability to liaise with physical healthcare staff to ensure that all phases of the intervention take into account the patient's medical condition

Assessment

i. Ability to conduct a comprehensive sleep assessment including current sleep patterns and associated behaviours (such as bed times, 'up times' and time spent sleeping versus time spent in bed), as well as current medication prescribed for sleep
ii. An ability to draw on knowledge of the impact of psychotropic medication on sleep

Intervention

i. Ability to assess the patient's beliefs and potential fears about their sleep patterns
ii. Ability to draw on knowledge of psychological interventions for insomnia
iii. Ability to derive a shared understanding of the factors associated with poor sleep routine
iv. Ability to introduce the rationale for interventions likely to improve sleep quality
v. Ability to collaboratively formulate current sleep difficulties, emotion, beliefs and behaviours within a maintenance cycle of a disrupted sleep pattern
vi. Ability to help the patient introduce new behaviours such as sleep hygiene, a specific 'up time', bed or sleep restriction, stimulus control
vii. Ability to use problem solving when appropriate (usually where there are obstacles to self-management)
viii. Ability to help the patient to identify unhelpful beliefs about sleep and to test out new beliefs, through discussion and behavioural experiments
ix. Ability to use idiosyncratic measures to evaluate progress and outcomes in people with insomnia such as the insomnia severity index.

11. Registration after Qualification

On qualification, graduates of BABCP Level 2 Accredited IAPT High Intensity CBT training will meet all of the Minimum Training Standards to achieve Level 2 Provisional Accreditation with BABCP. Graduates must be in CBT practice, meet all criteria stated and can apply for Full Accreditation 12 months after the awarded Provisional Accreditation. All BABCP members must agree to abide by the BABCP Standards of Conduct, Performance and Ethics.

All qualified CBT Therapists working within IAPT services are required to be accredited with BABCP and listed on the CBT Register.

12. Preceptorship Guidance

After CBT Therapists have completed their BABCP Level 2 accredited training programme there is an expectation for them to complete a structured preceptorship year. This provides a coordinated approach to support, sustain and develop CBT Therapists during their first year after qualifying. Specific Preceptorship Guidance will be published in the IAPT Manual.

13. Long Term Conditions Top-up Training

Approximately 40% of entrants into IAPT have a long term health condition[8]. Considering such a high proportion of those being seen by IAPT services will have a long term condition, it is important that CBT therapists have a good understanding of long term conditions and how these should be considered at assessment and intervention. The training provides CBT therapists with knowledge of the adverse impact of the LTC, key issues the practitioner should look to identify at assessment, specific CBT treatments for Long Term Conditions and adaptations depression and anxiety disorder treatments in the context of a long term condition or persistent physical symptoms.

This is a compulsory top up module that all CBT therapists will normally be expected to complete within two years of qualification.

This training is synchronous and interactive but accompanied by e-learning materials available on the e-learning for healthcare webpage.

[8] improving-access-to-psychological-therapies-long-term-conditions-pathway.pdf (england.nhs.uk)

Practice Module

The practice module runs across all three taught modules over the whole academic year. In order to pass the practice element trainees need to have passed all practice requirements for all modules and demonstrate the following:

- Delivered at least 200 hours of individual CBT assessment and treatment.
- Completed treatment with a minimum of 8 training cases, with at least one being treated for PTSD/CPTSD, one for social anxiety and two for depression.
- Demonstrated disorder specific competence in assessment, formulation, use of measures and delivery of treatment with the 8 training cases.
- Regular ongoing clinical supervision with a CBT therapist who is BABCP accredited
- Received a minimum of 70 hours of clinical supervision.
- On-site supervisor placement reviews and final report
- Self-rated 6 sessions using CTS-R (or equivalent). To include a brief reflective analysis of session
- Reflected on at least 5 samples of CBT literature and its application to practice with individual patients
- 8 IAPT Patient experience questionnaires across the 3 modules to assess patient feedback on the service/therapy delivered by trainee
- Submitted within the Portfolio a reflective analysis of a treatment session including a session recording which is integrated within a case discussion.
- Completion of several courses of therapy as a co-therapist with an experienced therapist/supervisor in their service leading.
- Demonstrated learning for any teaching sessions by completing a ‘catch up form’ signed by relevant member of the course team
- For KSA students, a KSA portfolio must have been submitted and passed.
- For all students' evidence of BABCP membership is required

This will ensure that by the end of the training, successful trainees will meet eligibility requirements for BABCP accreditation. Clinical hours and supervision hours are based on a 3-day clinical practice week. For part-time trainees, whose clinical days are 1.5-2.5 days per week Practice Portfolio documents can be adjusted accordingly and continuing practice following successful completion of other course requirements can be used to increase hours up to accreditation requirements.

Guidelines for Practice Portfolio

The portfolio comprises 11 items, which should be completed according to the guidelines below:

1. Front Cover Sheet

The student completes the number which refers to the relevant practice period, their name, and the practice area (name and type of clinical setting/service) where their CBT work is undertaken along with their supervisor for that practice area.

2. Case Flow Charts

This is an overview of all patients who were contacted as part of the student's CBT work; it includes patients who were referred to the service and were sent an invitation but did not attend. The student records each patient's initials and presenting problem, the number, amount and dates of their assessment sessions, the number, amount and time-frame of their treatment sessions, the type of interventions, and the status of the patient at the time of PORTFOLIO completion (e.g. awaiting assessment, in treatment, discharged, lapsed etc.)

3. Samples of Assessment Reports / end of treatment reports

The student gives their best samples of assessment reports, formulation diagrams and treatment summaries.

4. Patient Summaries

This is a summary for each patient's information in disguised and unidentifiable form (pseudonym, demographics, presenting problem, main treatment, etc.), problems-and-goals statements and ratings, and standardised session-by-session patient reported outcome measures. It should include 8 IAPT Patient experience questionnaires across the 3 modules to assess patient feedback on the service/therapy delivered by trainee.

5. CBT Supervision Logs

The student uses this weekly to record each clinical supervision session.

6. Session recordings and completed Cognitive Therapy Rating Scales

The supervisor and tutors will use the CTS-R to rate the student's skills and competence in delivering CBT assessment and treatment, by reviewing student-led session video/audio recordings. This should include assessing competence in therapeutic engagement skills, such as interpersonal listening skills and self-reflection techniques. The student also uses the CTS-R to self-rate the same sessions but blind to the supervisor's or course tutor's ratings. Therapy recordings submitted for summative assessment should not be subject to preview by course staff or supervisors.

7. CBT literature in practice

The trainee summarises the focal points of papers and book chapters and describes how these have been used to substantially shape, support or change their working practice with individual patients. Knowledge of CBT theory and the ability to link literature to practice is demonstrated.

8. Record of jointly delivered therapy

Ideally trainees should complete several courses of therapy as a co-therapist with an experienced therapist/supervisor in their service leading. At least one of these cases should be during the fundamental's module. Trainees do not need to be a co-therapist for every session of the treatment being conducted by the experienced therapist /supervisor but they should join at least 3 sessions that are close together. Each session should be followed by a reflective

discussion with the experienced/ therapist. The practice portfolio should include a reflective account of trainee learning from the co-therapy experience.

9. Signed 'catch up' forms

Evidencing that any missed teaching has been covered through self-study.

10. Course and Site Supervisor Reports

Supervisor reports indicating trainee clinical practice at appropriate level of competence for stage of training.

11. Progress Reviews

A course tutor reviews this in liaison with the student at mid-point of each practice period and formally completes it as “passed or “failed” at the end of each practice period.

Acknowledgments

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