Cohort 17 Programme Handbook

PG Diploma in High Intensity Psychological Therapy

University of Exeter | Cedar

Contents

Welcome

Welcome to the University of Exeter's PG Dip in High Intensity Psychological Therapy. We are really excited to be able to bring you this training programme which is the culmination of several years' development. The training spearheads the NHS Talking Therapies for Anxiety and Depression (previously known as IAPT) service delivery model within which the High Intensity worker role is of fundamental importance.

The PG Dip is designed to increase participant's knowledge and understanding of clinical theory and evidence-based practice of High Intensity Psychological Therapy for anxiety and depression. The programme is heavily rooted within the development of clinical skills associated with a patient-centred approach and on the skills required to support a range of evidence-based high intensity psychological therapies. The continued development of these skills is embedded within a strong focus on practice-based supervision, which is a fundamental component of the training. As such, your training should not just be seen as being the time you spend being taught within the University, but full time, based also around your clinical work undertaken within your work setting supplemented by your practice based supervision (or part time over two years for part-time trainees).

Successful completion of clinical and written assignments and appropriate participation in tutorials and workshops will lead to the awarding of a PG Diploma. We hope that graduates will be able to act as 'product champions' for CBT practice and be available as teachers and consultants, in the various settings in which they work.

A major contributing resource to the programme is the knowledge and experiences that programme members bring with them. We intend to draw upon and honour this knowledge and experience in order to develop clinical skills and increase awareness and theoretical understanding. It is important, however, that understanding and use of theory is integrated with clinical application in a rigorous and constructively critical manner.

We hope you enjoy the training and look forward to meeting you over the coming months.

Diversity and Inclusivity

Respect for Diversity

Cedar Equity, Diversity & Inclusion Statement

It is our intention within Cedar that trainees from all diverse backgrounds and perspectives be well served by our training courses, that trainees' learning needs be addressed both in and out of teaching sessions, and that the diversity that trainees bring to their learning environment be viewed as a resource, strength and benefit. It is our intention to present materials and activities that are respectful of diversity. This includes, but is not limited to, gender and gender identify, sexuality, disability, age, socioeconomic status, ethnicity, religion, race, and culture. Your suggestions are at all times invited, encouraged and appreciated. We encourage you to let us know ways to improve the effectiveness of the course for you personally or for other trainees or student groups. In addition, if any of our training sessions conflict with your religious events, or if you have a disability or other condition necessitating accommodation, please let us know so that we can make the necessary arrangements for you in line with your professional body/ national curriculum requirements.

Our goal within Cedar as a learning community is to create a safe learning environment that fosters open and honest dialogue. We are all expected to contribute to creating a respectful, welcoming, and inclusive environment within which any form of discrimination will not be tolerated. To this end, classroom discussions should always be conducted in a way that shows respect and dignity to all members of the class. Moreover, disagreements should be pursued without personal attack and aggression, and instead, should be handled with care, consideration and a non-judgmental stance. This will allow for rigorous intellectual engagement and a deeper learning experience for all.

(Statement adapted from the University of Iowa, College of Education and Yale University - Dr. Carolyn Roberts, Assistant Professor, History of Science & History of Medicine, and African American Studies)

At Cedar, in our training of psychological professionals, we are committed to progressing and embedding the principles of equity, diversity and inclusion into all areas of our training courses, and are active in our endorsement of the Psychological Professions Network Equity, Diversity, and Inclusion Position Statement which can be read here: **https://www.ppn.nhs.uk/resources/ppn-publications/462-ppn-equity-diversity-and-inclusion-position-statement-v1-0-october-2023/file**.

Accessibility, Engagement, and Wellbeing

We aim for this course to be inclusive and accessible to all. Please let the course team know if you are having difficulty engaging with any aspect of the course. Information regarding support related to accessibility can be found here: **https://www.exeter.ac.uk/wellbeing/accessability/support/**

A copy of the University's accessibility statement is available on ELE.

A personal tutor is assigned to all trainees on the course. The personal tutor will make contact with each trainee by email during the course and meet with each trainee at least once per term (more often if required).

The university is committed to supporting trainees through their studies and recognises the importance of trainee wellbeing. As well as their personal tutor, trainees can contact hub staff or the Wellbeing service if they have questions or need support.

Course Team

Director of Portfolio for HI CBT Programmes:
Dr Nicole Jamani - **N.Jamani@exeter.ac.uk**

HI CBT Programme Lead:
Karen Tate - **K.Tate@exeter.ac.uk**

HI CBT Clinical Leads:
Shane FitzGerald - **S.J.Fitzgerald@exeter.ac.uk**
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HI CBT Academic Leads:
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KSA Assessor:
Alan Bee – **HI-KSA@exeter.ac.uk**

Experts by Experience:
Nigel Reed
Kelly Betts
Gemma Edworthy (after March 2024)

Programme Tutors:
Kate Hannay - **K.Hannay@exeter.ac.uk**
Adele Holder – **A.Holder@exeter.ac.uk**
Anna Hutchinson
Alison Windsor – **A.D.Windsor@exeter.ac.uk**

Clinical Skills Tutors:
Shane Fitzgerald - **S.J.Fitzgerald@exeter.ac.uk**
Kate Hannay - **K.Hannay@exeter.ac.uk**
Alison Windsor – **A.D.Windsor@exeter.ac.uk**
James Thomas – **J.Thomas6@exeter.ac.uk**

Individual Tutors:

Liz Benson - **E.Benson@exeter.ac.uk**
Shane Fitzgerald - **S.J.Fitzgerald@exeter.ac.uk**
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Supervisors:

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Administration Team:

Harriet Keers-Stribley - Programme Administrator: **HI-CBT@exeter.ac.uk**
CEDAR PGT Support Team: **CEDAR-PGTadmin@exeter.ac.uk**

Main Aims of the Programme

This programme is designed to prepare mental health workers employed as High Intensity trainees within the NHS Talking Therapies service delivery model. The course is BABCP level 2 accredited. Successful completion of the course will provide programme members with all the necessary academic and training requirements to meet BABCP accreditation as a Cognitive Behavioural Therapist.

Specific Programme Aims

On completion of the programme, we hope that members will be able to:

- Evidence practical competency in Cognitive Behaviour Therapy for depression and anxiety and be familiar with the recognition and management of common co-morbid conditions
- Understand and work within an NHS Talking Therapies service model, understanding stepped care and the role of low intensity workers
- Evidence critical knowledge of the theoretical and research literature relating to CBT
- Integrate theoretical understanding with their clinical practice in CBT practice
- Be familiar with the classic CBT literature, its context and its relevance or otherwise to contemporary CBT practice
- Assess patients for CBT, to know when it is indicated and contra-indicated, and to have an awareness of other forms of potentially appropriate therapies
- Develop an ethical approach to the clinical practice of CBT practice, and an understanding of the issues of confidentiality and ethics in relation to CBT theory and practice
- Understand the social context in which CBT ideas developed and consider ways in which sexism, racism, sectarianism, ageism, and other forms of discrimination may affect practice of psychotherapy
- Engage in career-long reflective practice for the ongoing development of clinical skills

CBT Competencies and the Curriculum

CBT Competencies Framework

The University of Exeter High Intensity Training Programme has been designed in line with CBT Competencies Framework (Roth & Pilling, 2007) and the NHS Talking Therapies High Intensity CBT Curriculum.

For further information on CBT Competencies, please visit: **Cognitive and Behavioural Therapy | UCL Psychology and Language Sciences - UCL – University College London**

NHS Talking Therapies disorder specific models are those referred to within the CBT competencies framework – references for these models are available by accessing this framework online (see link above).

On the University of Exeter HI CBT course, we ensure that we teach one of the approved models for each disorder.

The NHS Talking Therapies High Intensity Curriculum is available on the Health Education England website: **https://www.hee.nhs.uk/our-work/mental-health/improving-access-psychological-therapies**

The evidence base for CBT is constantly being added to. In addition to the NHS Talking Therapies specific models, it is recognised that there are other evidenced based models that may be appropriate to use and so we may also teach the following models:

Disorder	Author
Specific Phobia	Kirk & Rouf or Ost
OCD	Salkovskis
Health Anxiety	Salkovskis et al.

NHS Talking Therapies High Intensity Curriculum Mapping

Download the document: CBT Competence Framework for Depression and Anxiety Disorders

Programme Structure

The Structure & Timing of Days:

University sessions will be delivered in-person and remotely. There will be three block weeks of in-person teaching each term (Monday-Thursday).

Lunch will be 12:30 - 1:30pm on all remote days and 1pm – 2pm on a 10am - 5pm day.

Mondays: 9:30am - 4:30pm (when remote). Teaching hours = 6

Tuesdays: 9:30am - 4:30pm. Teaching hours = 5 (for trainees who have 2 hours of university supervision weekly)

First day of a block of in-person teaching days: 10am – 5pm

Term Dates 2023/4	
Induction days:	Monday 4th and Tuesday 5th December 2023
Term 1:	8th January – 28th March 2024 (half-term: w/c 12th February)
Term 2:	22nd April – 9th July 2024 (half-term: w/c 27th May)
Term 3:	2nd September – 19th November 2024 (half-term: w/c 28th October)

Timetables can be located on the HI CBT ELE page.

Study Time

The updated national HIT curriculum states that 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 term time and vacations to review videotapes, complete written assignments and revise teaching materials. In addition, Mondays and Tuesdays during all university holidays should be retained as study days, when trainees are not on annual leave. We have timetabled in five study days during the half-term breaks and the remaining 23+ days can be spread throughout the training period (including year 2 for part-time trainees), with an arrangement that works best for the trainee and the service and taking submission dates of coursework into consideration. Trainees should have a minimum of 28 days of study time during their training period. Although part-time trainees will only be working 1.5-2.5

days in service in year 1, they should still be encouraged to take study days/half-days where needed, both during term time and in the university holiday periods.

Information sent to Workplace Service Leads, Clinical Leads & Supervisors

The information sent to Workplace Service Leads, Clinical Leads and Supervisors can be found on your ELE page.

Assessments – Cohort 17

Academic honesty

Please read the above document about academic honesty before submitting any assignments. The mandatory academic honesty and plagiarism module and quiz canbe found on ELE. You will not receive your results of your first summative assignment untilyou have completed completing this.

Assessment Overview by Module – Cohort 17

Please note for submissions that require a consent form, the consent form must also be submitted by the submission deadline.

If you believe you have grounds for an extension, please see the Cedar PGT Handbook for further information: **https://ele.exeter.ac.uk/course/view.php?id=8259&section=1**

Module Code	Module Name	Assessments	% Marks	Deadline Dates
PYCM040	CBT Clinical Practice	KSA portfolio for KSA Trainees	Pass/ Fail	8th January 2024, by 1pm
PYCM038	CBT Depression	Essay	33%	4th March 2024, by 1pm
PYCM040	CBT Clinical Practice	Case Presentation	50%	22nd April 2024, by 9am
PYCM038	CBT Depression	Case Report	33%	Full-time trainees: 3rd June 2024, by 1pm Part-time trainees: 24th June 2024, by 1pm

PYCM038	CBT Depression	Competency Tape and Reflective Summary	34%	Full-time trainees: 2nd July 2024, by 1pm Part-time trainees: 24th September 2024, by 1pm
PYCM039	CBT for Anxiety Disorders	Case Report	50%	Full-time trainees: 2nd September 2024, by 1pm Part-time trainees: 24th February 2025, by 1pm
PYCM039	CBT for Anxiety Disorders	Competency Tape and Reflective Summary	50%	Full-time trainees: 24th September 2024, by 1pm Part-time trainees: 1st April 2025, by 1pm
PYCM037	Fundamentals of CBT	Self-Practice Self-Reflection (SP/SR) Summary	10%	Full-time trainees: 14th October 2024, by 1pm Part-time trainees: 16th June 2025, by 1pm
PYCM037	Fundamentals of CBT	Extended Case Report	90%	Full-time trainees: 4th November 2024, by 1pm Part-time trainees: 15th September 2025, by 1pm
PYCM040	CBT Clinical Practice	Competency Tape and Reflective Summary	50%	Full-time trainees: 12th November 2024, by 1pm Part-time trainees: 23rd September 2025, by 1pm
PYCM040	CBT Clinical Practice	Clinical portfolio including Supervisors Reports	Pass/ Fail	Full-time trainees: 28th January 2025, by 1pm

				Part-time trainees: 18th November 2025, by 1pm

For more information on the postgraduate marking scheme/criteria, please see the link below:
https://as.exeter.ac.uk/academic-policy-standards/tqa-manual/lts/genericassessment/#seven

Receiving Results for Summative Assessments

For academic assessments (essay, case presentation, case reports, SP/SR summary) and the clinical portfolio, there is a 15 working day marking turnaround time.

For the PYCM038 competency assessment, there is a 4 week marking turnaround.

For the PYCM039 and PYCM040 competency assessments, there is a 6 week marking turnaround.

University closure days will extend the marking turnaround time accordingly.

Results will be sent via your University email and your workplace supervisor/lead will be copied in. If results are due back on a day you have University teaching/supervision, these will usually be returned at the end of the working day. You are welcome to also share your results with your 1:1 tutor, if you wish to.

If you have not received your results by the end of the day you are expecting to receive them, please contact the programme administrator.

Formative and Summative Assessments/Submissions in Chronological Order

Summative assessments contribute to your final mark for a module. They are marked according to the assessment criteria and intended learning outcomes of a module.

Formative assessments do not contribute to your final mark given for a module, but provide feedback that is an integral part of your learning.

Full-Time Students:

Term	Assessment	Formative or Summative	Submission Date	Submission Instructions
1	PYCM040 KSA portfolio (KSA trainees only)	Summative	8th January 2024, by 1pm	Electronic copy via OneDrive.
	CTS-R, self-rating and reflective summary within supervision	Formative	To be agreed with supervisor	Competency tape via secure sharing method within supervision. Reflection emailed to supervisor.
	PYCM038 Depression Essay	Summative	4th March 2024, by 1pm	Through submission portal on ELE (found on course page or on your ELE dashboard).
	Formative group case presentation	Formative	19th March 2024	1 client consent form per group submitted by **9am** via MS Forms link (found on ELE). Presentations will be delivered live within tutorial groups.
	Self-Rated CBT Competency (CTS-R & Reflection)	Formative	19th March 2024, by 1pm	Recording and consent form via MS Forms link (found on ELE). Cover sheet with student signature, formulation, CTSR scale and reflective summary via submission portal on ELE.
	Portfolio progress review form	Formative	2nd April 2024, by 1pm	Through submission portal on ELE (found on course page or on your ELE dashboard).
	Supervisors' reports	Formative	2nd April 2024, by 11am	Through submission portal on ELE (found on course page or on your ELE dashboard).

2	PYCM040 Assessment & Formulation Case Presentation	Summative	22nd April 2024	Presentations delivered live. Client consent form and slides to be submitted by **9am** via MS Forms link (found on ELE).
	CTS-R, self-rating and reflective summary within supervision	Formative	To be agreed with supervisor	Competency tape via secure sharing method within supervision. Reflection emailed to supervisor.
	PYCM038 Depression Case Report	Summative	3rd June 2024, by 1pm	Client consent form via MS Forms link, found on ELE. Case Report via submission portal on ELE.
	PYCM038 CompetencyTape & Reflective Summary *(also known as PYCM038 CTSR)*	Summative	2nd July 2024, by 1pm	Recording and consent form via MS Forms link (found on ELE). Cover sheet with student signature, formulation, CTSR scale and reflective summary via submission portal on ELE.
	Portfolio progress review	Formative	10th July 2024, by 1pm	Through submission portal on ELE (found on course page or on your ELE dashboard).
	Supervisors' reports	Formative	10th July 2024, by 11am	Through submission portal on ELE (found on course page or on your ELE dashboard).
3	PYCM039 Anxiety Case Report	Summative	2nd September 2024, by 1pm	Client consent form via MS Forms link, found on ELE.

				Case Report via submission portal on ELE.
	CTS-R, full self-rating and reflective summary of excerpt of therapy session within supervision	Formative	To be agreed with supervisor	Competency tape via secure sharing method within supervision. Reflection emailed to supervisor.
	PYCM039 Competency Tape & Reflective Summary *(also known as PYCM039 CTSR)*	Summative	24th September 2024, by 1pm	Recording and consent form via MS Forms link (found on ELE). Cover sheet with student signature, formulation, CTSR scale and reflective summary via submission portal on ELE.
	PYCM037 Self Practice Self Reflection (SP/SR) Summary (including 10 SP/SR blogs)	Summative	14th October 2024, by 1pm	Through submission portal on ELE (found on course page or on your ELE dashboard).
	PYCM037 Extended Case Report	Summative	4th November 2024, by 1pm	Client consent form via MS Forms link, found on ELE. Case Report via submission portal on ELE.
	PYCM040 Competency Tape & Reflective Summary	Summative	12th November 2024, by 1pm	Recording and consent form via MS Forms link (found on ELE). Cover sheet with student signature, formulation, CTSR scale and reflective summary via submission portal on ELE.

	Supervisors' reports	Summative	20th November 2024, by 11am	Through submission portal on ELE (found on course page or on your ELE dashboard).
	PYCM040 Clinical Portfolio (including Supervisors' reports)	Summative	28th January 2025, by 1pm	Electronic copy via SharePoint (links will be shared directly with students via email).

Part-Time Students:

Term	Assessment	Formative or Summative	Submission Date	Submission Instructions
1	PYCM040 KSA portfolio (KSA trainees only)	Summative	8th January 2024, by 1pm	Electronic copy via OneDrive.
	PYCM038 Depression Essay	Summative	4th March 2024, by 1pm	Through submission portal on ELE (found on course page or on your ELE dashboard).
	CTS-R, self-rating and reflective summary within supervision (or in term 2 for some part-time trainees)	Formative	To be agreed with supervisor	Competency tape via secure sharing method within supervision. Reflection emailed to supervisor.
	Formative group case presentation	Formative	19th March 2024	1 client consent form per group submitted by **9am.** Presentations will be delivered live within tutorial groups.
	Self-Rated CBT Competency (CTS-R & Reflection)	Formative	19th March 2024	Recording and consent form via MS Forms link (found on ELE). Cover sheet with student signature, formulation, CTSR scale and reflective

				summary via submission portal on ELE.
2	PYCM040 Assessment & Formulation Case Presentation	Summative	22nd April 2024	Presentations delivered live. Client consent form and slides to be submitted by **9am** via MS Forms link (found on ELE).
	CTS-R, self-rating and reflective summary within supervision (if not done in term 1)	Formative	To be agreed with supervisor	Competency tape via secure sharing method within supervision. Reflection emailed to supervisor.
	PYCM038 Depression Case Report	Summative	24th June 2024, by 1pm	Client consent form via MS Forms link, found on ELE. Case Report via submission portal on ELE.
	Portfolio progress review	Formative	10th July 2024	Through submission portal on ELE (found on course page or on your ELE dashboard).
	Supervisors' reports	Formative	10th July 2024	Through submission portal on ELE (found on course page or on your ELE dashboard).
3	PYCM038 Competency Tape & Reflective Summary *(also known as PYCM038 CTSR)*	Summative	24th September 2024, by 1pm	Recording and consent form via MS Forms link (found on ELE). Cover sheet with student signature, formulation, CTSR scale and reflective summary via submission portal on ELE.

	CTS-R, self-rating and reflective summary within supervision (or in 1st term of year 2 for some part-time trainees)	Formative	To be agreed with supervisor	Competency tape via secure sharing method within supervision. Reflection emailed to supervisor.
Year 2				
1	CTS-R, full self-rating and reflective summary within supervision (if not done in term 3 of year 1)	Formative	To be agreed with supervisor	Competency tape via secure sharing method within supervision. Reflection emailed to supervisor.
	PYCM039 Anxiety Case Report	Summative	24th February 2025, by 1pm	Client consent form via MS Forms link, found on ELE. Case Report via submission portal on ELE.
	PYCM039 Competency Tape & Reflective Summary *(also known as PYCM039 CTSR)*	Summative	1st April 2025, by 1pm	Recording and consent form via MS Forms link (found on ELE). Cover sheet with student signature, formulation, CTSR scale and reflective summary via submission portal on ELE.
	Portfolio progress review	Formative	2nd April 2025	Through submission portal on ELE (found on course page or on your ELE dashboard).
	Supervisors' reports	Formative	2nd April 2025, by 11am	Through submission portal on ELE (found on course page or on your ELE dashboard).
2	CTS-R, full self-rating and reflective summary of excerpt of therapy	Formative	To be agreed with supervisor	Competency tape via secure sharing

	session within supervision (or in term 3 of year 2 for some part-time trainees)			method within supervision. Reflection emailed to supervisor.
	PYCM037 Self Practice Self Reflection (SP/SR) Summary (including 10 SP/SR blogs)	Summative	16th June 2025, by 1pm	Through submission portal on ELE (found on course page or on your ELE dashboard).
3	PYCM037 Extended Case Report	Summative	15th September 2025, by 1pm	Client consent form via MS Forms link, found on ELE. Case Report via submission portal on ELE.
	PYCM040 Competency Tape & Reflective Summary *(also known as PYCM040 CTSR)*	Summative	23rd September 2025, by 1pm	Recording and consent form via MS Forms link (found on ELE). Cover sheet with student signature, formulation, CTSR scale and reflective summary via submission portal on ELE.
	CTS-R, full self-rating and reflective summary of excerpt of therapy sessionwithin supervision (if not done in term 2 of year 2)	Formative	To be agreed with supervisor	Competency tape via secure sharing method within supervision. Reflection emailed to supervisor.
	Supervisor Reports	Summative	12th November 2025	Through submission portal on ELE (found on course page or on your ELE dashboard).
	PYCM040 Clinical Portfolio (including Supervisors' reports)	Summative	18th November 2025, by 1pm	Electronic copy via SharePoint (links will be shared directly with students via email).

Supervisors' Reports

Over the course, you will be required to hand in three supervisor reports by both your University and Workplace Supervisors. For full-time trainees this will be one in term 1, one in term 2 and one in term 3. For part-time trainees this will be at the end of term 2, by Easter of year 2 and at the end of year 2. The first two reports are formative reports. The University and Workplace supervisors reports handed in in term 3 (full-time trainees)/end of year 2 (part-time trainees) are summative and a copy must also be included in your PYCM040 Clinical Portfolio when this is submitted.

Name of Assessment	Deadline Dates
Formative University & Workplace Supervisors Report 1	For full-time trainees: 2nd April 2024 For part-time trainees: 10th July 2024
Formative University & Workplace Supervisors Report 2	For full-time trainees: 10th July 2024 For part-time trainees: 2nd April 2025
Summative University & Workplace Supervisors Report	For full-time trainees: 20th November 2024 For part-time trainees: 12th November 2025

You must submit all of your supervisors reports (six in total) via ELE. We do not need hard copies of these reports. You should keep the original copies.

Please note that all supervisor reports must be hand-signed. Digital signatures are also accepted. If a signature cannot be provided or is typed, the supervisor must email the report to the Programme Administrator as confirmation of their signature, and copy you in so that you can provide evidence of this in your clinical portfolio.

Resubmissions

If you receive a mark below 50%, this is classed as a fail and you will need to resubmit your assignment. You will have four weeks to resubmit your assignment (up to 12 weeks for competency assessment resubmissions).

Please note that if you have a resubmission, the whole module must be capped at 50%.

Resubmitted work should be submitted alongside:

1. A copy of the previous marking feedback
2. A resubmission cover sheet that shows how you have addressed the issues identified.

You can find all the forms on your ELE page. Please contact HI-CBT@exeter.ac.uk if you have any questions.

Assessment Information

For details on late submission policies, please see the Cedar PGT Handbook: **https://ele.exeter.ac.uk/course/view.php?id=8259&section=1**

Forms

There are cover sheets for the competency assessment submissions as well as forms for supervision, portfolio progress reviews, attendance and mitigation requests. These can be found on the ELE page. If you are having difficulties locating any of these, please contact **HI-CBT@exeter.ac.uk**.

Essay

You will need to submit one essay during the course. For details of how to submit this piece of work, please refer to the tables above or email **HI-CBT@exeter.ac.uk**.

CBT for Depression PYCM038

Submission date: Monday 4th March 2024
Word limit: 3,750
NB marking will stop at this word limit and work exceeding this limit will therefore not receive credit

Essay Title:

'Critically appraise Beck's model and protocol for CBT for depression, considering specifically factors around diversity and inclusion'.

In this essay you should firstly describe the Beck model and protocol for depression. You should then go on to critique this model and protocol in terms of its strengths and limitations specifically around diversity and inclusion, with reference to empirical literature. The research should also be critiqued in terms of strengths and limitations. You may wish to focus on one or two of the protected characteristics for your critique. Finally, you need to consider the implications of your findings for clinical practice and/or research.

Essay Guidelines

You will be assessed on the following dimensions:

***Interpretation of Title**

Marks will be awarded for your ability to answer the essay question posed. Therefore, ensure you read the essay question clearly and that you understand it; if not, ask. In order to pass this section, you will need to clearly address all elements of the essay question.

The markers would expect the following to be included:

- Definition of key terms
- Outline of how the author intends to address the question
- Theory, empirical evidence and implications relevant to the question all addressed

***Understanding of Theory**

Marks will be awarded where you demonstrate a clear understanding of relevant theory and the ability to apply this understanding to answer the essay question.

The markers would expect the following to be included:

- An accurate description of the CBT model/s relevant to the essay question
- Using theory in a way that supports the argument
- Demonstrating an understanding of sources
- Sources are used appropriately in a way that demonstrates that theory is understood

***Critical Analysis**

Marks will be awarded where you demonstrate an ability to not only pull together relevant information, but also to analyse this critically, for example, weighing it against evidence that does not fit with the point you are making and demonstrating a thoughtful, reflective approach or commenting on the rigor of the evidence cited. You should clearly differentiate your own opinions from those critiques reported from the work of other authors.

The markers would expect the following to be included:

- Demonstration of your understanding of evidence from research studies/ policy documents, explaining what the studies were investigating and how these fit with the points being made in the essay
- Identifying strengths and possible limitations of research / theory cited and how these relate to your arguments or own practice/context
- Different viewpoints/ perspectives/ evidence on the topic/question and how these relate to each other
- Showing reasoning and conclusions from your reading
- Explain things in sufficient detail / depth and address why things might be happening and what this means for the question being addressed
- Take account of different contexts and how they might affect viewpoints and research outcomes, e.g. social, cultural, historical, geographical, political contexts

***Summary of Arguments and Implications**

Marks will be awarded where you demonstrate an ability to summarise your arguments and comment on the implications they may have for clinical practice and or future research. The essay should not be a purely theoretical exercise and it is important that you demonstrate your ability to apply your conclusions to the broader context within which you are working.

The markers would expect the following to be included:

- Summaries of key points and arguments with direct linking back to the essay question when relevant
- Implications of findings/conclusions of the arguments/evidence presented in the essay forclinical practice (for CBT more generally and NHS Talking Therapies services specifically) and/or future research
- The implications should follow logically from the arguments/evidence previously discussed in the essay

Use of Sources

You need to ensure that the points you make are backed up by relevant literature. We would expect you to use a wide source of references e.g. journals, books and reliable websites. An absolute minimum of 10 references would be the norm.

The markers would expect the following to be included:

- Theory is referenced appropriately
- The author is not making unsubstantiated claims; ensure sources are used and cited (i.e. demonstrating ideas/evidence are taken from the literature, not just the author's opinion)

Structure & Style

Marks will be awarded for a well-structured essay. The essay should flow well with a clear introduction (including essay plan), middle and end.

Make use of summaries to help the reader through your arguments. Think about what point you are making and why, make your point and, where available, support it with evidence, and then reflect and summarise the point.

Be mindful of your use of language, both the use of colloquialisms and jargon. Where appropriate, you may use diagrams, tables and bullet points. These should be used to aid clarity.

If used, subheadings should relate to subsequent material presented and help to structure your essay. If used, appendices and footnotes should be used appropriately and not to help with word count. Key information needs to be in the main body of the text. Appendices should be clearly referred to and labelled and come after the reference section.

References
References should conform to APA (7th Edition) both in text and at the end of your essay (see University guidance). Please check references in terms of accuracy and consistency and ensure that all citations in the text are referred to in the reference section. Minor errors with referencing will not impact on the overall mark. However, disregard for APA referencing, or severe departures from APA, may impact the overall mark.
Spelling, Grammar, Typographical Errors and Presentation
All written assessments should be word-processed using double-line spacing, font size of 11pt or 12pt and in a font that is easy to read, e.g. Arial, Verdana, Tahoma. All pages should be numbered. To assist with "blind marking" please do not put your name anywhere in your submission. Work should be comprehensible, so please check for typographical, grammatical and spelling errors. Where possible, ask someone else to proofread your essay before submitting. If you need support in this area, please use the study skills department.
Word Count
Written work must stay within the specified word count and there will not be an upper percentage margin. Word count excludes: essay title, tables, figures, headings for tables/figures, the reference list, and appendices. All other words are counted. **Markers will stop marking at the point where the limit has been reached.**

*** Indicates a key area; failure on more than one of these areas is likely to result in an overall fail.**

Case Presentations

Case Presentation and Case Report Marking Criteria

Please also refer to University guidelines on written material.

Range	Assessment and Formulation Case Presentation	Anxiety and Depression Case Reports	Extended Case Report
Distinction 70-100%	Work of exceptional standard reflecting outstanding	As in Assessment and Formulation	As in previous Case Reports.

	competence/knowledge of material and critical ability above and beyond those required for a pass mark.	Case Presentation.	
Merit 60-69%	Work with a well-defined focus, reflecting a good working competence/knowledge of material and a good level of competence in its critical assessments and beyond those required for a pass mark.	As in Assessment and Formulation Case Presentation.	As in previous Case Reports.
Pass 50-59%	Work demonstrating adequate competence/working knowledge of material and evidence of some analysis. Work adheres to the relevant NICE guideline. A piece of work in this category should include the following (unless a clear rationale for exceptions is given): Reason for selecting this case, the presenting problems should be clearly identified and described with goals for therapy included. Where available, an appropriate model should be used. The assessment should include factors relevant to the development and maintenance of the difficulties. Where appropriate, the relevant disorder specific assessment and outcome tools should be used, as well as NHS Talking Therapies required measures. A formulation should be present in written narrative form, as well as a diagram (if possible). This formulation should flow logically from assessment and include precipitating and maintaining factors and, where appropriate, predisposing/developmental factors.	As in Assessment and Formulation Case Presentation and additionally: The interventions should be clearly described, have clear rationale and flow logically from formulation and goals. Outcome of the intervention should be described and evaluated. Adheres to word count.	As in previous Case Reports and additionally: You will need to clearly identify and reflect on one or two key themes or issues that were apparent or relevant to this case and discuss these with reference to relevant research/literature. It should demonstrate clear understanding of evidence base practice and provide a critical discussion of the research evidence base in relation to both the work carried out and the specific theme(s) chosen for the reflective analysis. The intervention work must be completed.

	The intervention plan should be clearly described and flow logically from formulation. There should be some critical analysis and reflection on the work and the therapeutic alliance. Throughout the presentation, a professional and ethical stance should be demonstrated. References and awareness of relevant literature generally accurate but limited. Adheres to time limit.		
Condonable Fail 40-49%	Limited competence/knowledge of core material and limited critical ability. Poorly written and presented/structured piece of work. Rationale and arguments are absent or problematic. Inappropriate application of theory to practice. Severe departures from APA referencing.	As in Assessment and Formulation Case Presentation.	As in previous Case Reports.
Fail 0-39%	Lacking in basic competence/knowledge of core material and absence or major flaws in critical analysis. Unethical practice, breaches in confidentiality**	As in Assessment and Formulation Case Presentation.	As in previous Case Reports.

Assessment and Formulation Case Presentation

Trainees give one summative case presentation. This will be presented live to a marker and a group of other trainees, so that markers have the opportunity to ask questions. Slides/resources must be submitted by the deadline, along with the client consent form. The case presentation can be of a client with either anxiety or depression and should be one of the five non-closely supervised clients (so will need to have a minimum of 5 sessions and 5

hours of supervision). The presentation needs to be of the same client being used for the formative competencies assessment (CTS-R) submission at the end of term 1.

Please note trainees should not use this case presentation client for any other formative or summative assignment. This means that this client cannot be used for any of the summative case reports.

Trainees also have the opportunity to practice giving a case presentation prior to this, by giving a formative group presentation on the assessment, formulation and intervention plan of a specific client one of the group members is working with. The cases used for the formative and summative case presentations need to be different. Markers will give formative feedback on these presentations to the wider group, to help trainees prepare for the summative case presentations in term 2.

It is recommended that trainees familiarise themselves with the case presentation guidance in the handbook and follow a similar structure to that which will be used for the summative case presentations.

The purpose of the case presentation is to demonstrate trainees' grasp of the application of cognitive theory to clinical practice and to demonstrate their skills in assessment and formulation.

Trainees need to use anonymised biographical data throughout the presentation - no identifiable information should be presented on the client or the service, i.e. change any names and identifying information**

NB *in all case reports/case presentations material presented must reflect accurately the assessment and interventions carried out with the relevant client. If misrepresentations come to light the case report will automatically fail. When submitting/delivering a case presentation trainees will be confirming that the work took place as described and that if information is falsified this may lead to a Fitness to Practice investigation.*

Trainees are marked on the content of their case presentation rather than on their presentation skills.

Case Presentation Guidelines

Trainees will be assessed on the following dimensions:

***Assessment**

Should include:

- Reason for referral and for seeking treatment at this point
- Presenting problem(s), diagnosis and co-morbidity, including presentation of DSM criteria
- Full consideration of differential diagnosis (all possible diagnoses which were considered/ruled out for this client based on their symptoms, experiences and measures) and any co-morbidity
- Relevant background/personal information, including development of the problem, predisposing, precipitating, perpetuating, protective factors and current social circumstances
- Risk assessment
- Identified treatment goals for therapy (focus on SMART goals)
- Issues relating to engagement and the therapeutic alliance
- Issues of diversity and difference (or similarity) between client and therapist and its impact on the therapeutic relationship
- Use of the relevant model to guide assessment, formulation and intervention (if it is not used, reasons for this should be given)
- A cognitive behavioural assessment of the presenting problem(s), including a description of identified situations/triggers, cognitions, emotions, physical symptoms and behaviours
- Socialisation to the model and suitability for CBT
- Scores on NHS Talking Therapies service outcome and assessment measures
- Relevant disorder specific assessment questionnaires (if not, a reason should be given)

***Conceptualization/Formulation**

- Where a particular model has been used to guide formulation, this should be accurately described including an accurate description of the theory underpinning the model
- There should also be a description of the case conceptualisation, clarified by a diagrammatic representation of the conceptualisation. The diagrammatic representation can be provided on a separate handout or included in the slides
- Ensure that the arrows on any diagrammatic formulations make sense, flow accurately and reflect both the theory and actual experience of the client
- The formulation should link and explain the presence of maintenance factors of the presenting problem(s) and, where relevant, the development of the problem
- The formulation should relate to the client's goals and flow from the assessment
- Ensure a focus on collaboration with explicit client contribution

***Intervention Plan**

The intervention plan should:

- Relate to the client's identified goals

- Directly relate to and flow from the case conceptualization
- Include reference to relevant NICE guideline(s)
- Identify anticipated difficulties, guided by the assessment and formulation process

***Link of Theory to Practice**

This is covered to some extent in previous areas.

Within the presentation, you will need to evidence a satisfactory understanding of the relevant cognitive-behavioural theory and disorder specific model. This should be described in sufficient detail prior to presenting the idiosyncratic formulation and planned intervention.

Throughout the presentation, you need to:

- Relate the clinical work carried out to relevant cognitive-behavioural theory and relevant models
- Use theory to guide your assessment, formulation and intervention plan and guide your thinking about this case
- Refer to and make use of the relevant literature pertaining to this case

***Diversity and Inclusion**

Within the assessment, conceptualisation/formulation, intervention plan and reflections you should consider diversity and inclusion in terms of the protected characteristics, areas of difference or similarity between client and therapist, the impact on the therapeutic relationship, power dynamics and any adaptations to therapy. Relevant literature related to protected characteristics and diversity should be included.

***Awareness of Professional Issues (Including Confidentiality)**

Your work should demonstrate good professional awareness, including evidence of:

- A comprehensive and personalised risk assessment, risk formulation and risk management plan that considers the client's needs, risks and contexts
- Adherence to codes of professional conduct, performance and ethics
- Client confidentiality - anonymised biographical data must be used throughout the presentation, i.e. you need to change any names and identifying information and make it clear that this has been done**

Self-Reflectivity

Throughout the presentation, you should demonstrate a reflective approach to the work you carried out and the use of methods/tools to aid this process. For example, we would expect you to provide a rationale for the work carried out that draws on your ability to reflect on theory/therapeutic alliance/socio/political/organisational/professional and ethical factors.

Reflection may involve demonstrating an awareness of the way that your own assumptions/beliefs might impact on the process and outcome of therapy, with due consideration of how this may shape and develop your practice in the future.

You may find it helpful to provide an outline of any tools or mechanisms that you used in order to aid this process (e.g. supervision discussion, protected preparation time for therapy & supervision sessions, a reflective model, thought records, listening to session recordings etc.).

Structure and Style of Presentation

Marks will be awarded for a well-structured and well-presented case presentation. Use of PowerPoint is encouraged. The case presentation should flow in a logical manner and any slides/hand-outs provided should be relevant and aid the marker. Be mindful of your use of language, both regarding the use of colloquialisms and jargon. Where appropriate, you may make use of diagrams, tables and bullet points in the presentation to clarify information. Diagrams of the case conceptualisation can be provided on a separate handout or included in the slides.

A possible structure could be based on the marking criteria e.g.: Introduction to the presentation, reason for referral, presenting problem(s), assessment, formulation, and intervention plan. Diversity/inclusion, theory to practice links, self-reflectivity and professional issues could be covered throughout the presentation. An introduction should be included, clearly outlining the structure of the case presentation and material to be covered.

Your case presentation should be clearly presented and you may wish to consider practising your presentation beforehand where possible.

References

References should be given throughout the presentation slides and provided in a reference section at the end. References should conform to APA (7th Edition) - see University guidance.

Please check references in terms of accuracy and consistency and ensure that all citations in the slides are referred to in the reference section. Minor errors with referencing will not impact on the overall mark, however disregard for APA referencing, or severe departures from APA, may impact the overall mark.

Spelling, Grammar and Typographical Errors

The information in your slides should be comprehensible, so please check for typographical, grammatical and spelling errors. Where possible, ask someone else to proofread your slides before submitting. If you need support in this area, please use the study skills department.

Length of Presentation
The case presentation should be a maximum of 25 minutes' duration. There will be up to a further five minutes for markers' questions on the presentation. **Marking will stop at 30 minutes and information not presented will not receive credit.**

*** Indicates a key area; insufficient information in any of these areas or failure on more than one of these areas is likely to result in an overall fail.**

**** Confidentiality breaches in case presentations:**

1. With Case Presentations, no identifiable information should be presented on the client or the service.
2. A minor breach in Case Presentations, where confidentiality/anonymization has occurred and been acknowledged by the author, but then a minor mistake(s) gets picked up will be returned to the author for correction. The trainee will have 48 hours (excluding weekends) to reply and correct the errors in the presentation handouts, otherwise it will be marked as a fail. The trainee will be notified via their University email account by the programme administrator. If the breach occurs during a vacation period, then they will also receive an alert to their work and personal email addresses (where these have been provided) asking them to urgently check their University accounts.
3. When major breaches are present or anonymization has not occurred and/or been made explicit, this will be an automatic fail and the trainee would need to resubmit a second submission correcting the error (and making any other changes if there are any other resubmission criteria).

Case Reports

Case Presentation and Case Report Marking Criteria

Please also refer to University guidelines on written material.

Range	Assessment and Formulation Case Presentation	Anxiety and Depression Case Reports	Extended Case Report
Distinction 70-100%	Work of exceptional standard reflecting outstanding competence/knowledge of material and critical ability above and beyond those required for a pass mark.	As in Assessment and Formulation Case Presentation.	As in previous Case Reports.
Merit 60-69%	Work with a well-defined focus, reflecting a good working	As in Assessment and Formulation	As in previous Case Reports.

	competence/knowledge of material and a good level of competence in its critical assessments and beyond those required for a pass mark.	Case Presentation.	
Pass 50-59%	Work demonstrating adequate competence/working knowledge of material and evidence of some analysis. Work adheres to the relevant NICE guideline. A piece of work in this category should include the following (unless a clear rationale for exceptions is given): Reason for selecting this case, the presenting problems should be clearly identified and described with goals for therapy included. Where available, an appropriate model should be used. The assessment should include factors relevant to the development and maintenance of the difficulties. Where appropriate, the relevant disorder specific assessment and outcome tools should be used, as well as NHS Talking Therapies required measures. A formulation should be present in written narrative form, as well as a diagram (if possible). This formulation should flow logically from assessment and include precipitating and maintaining factors and, where appropriate, predisposing/developmental factors. The intervention plan should be clearly described and flow logically from formulation. There should be some critical analysis and reflection on the	As in Assessment and Formulation Case Presentation and additionally: The interventions should be clearly described, have clear rationale and flow logically from formulation and goals. Outcome of the intervention should be described and evaluated. Adheres to word count.	As in previous Case Reports and additionally: You will need to clearly identify and reflect on one or two key themes or issues that were apparent or relevant to this case and discuss these with reference to relevant research/literature. It should demonstrate clear understanding of evidence base practice and provide a critical discussion of the research evidence base in relation to both the work carried out and the specific theme(s) chosen for the reflective analysis. The intervention work must be completed.

	work and the therapeutic alliance. Throughout the presentation, a professional and ethical stance should be demonstrated. References and awareness of relevant literature generally accurate but limited. Adheres to time limit.		
Condonable Fail 40-49%	Limited competence/knowledge of core material and limited critical ability. Poorly written and presented/structured piece of work. Rationale and arguments are absent or problematic. Inappropriate application of theory to practice. Severe departures from APA referencing.	As in Assessment and Formulation Case Presentation.	As in previous Case Reports.
Fail 0-39%	Lacking in basic competence/knowledge of core material and absence or major flaws in critical analysis. Unethical practice, breaches in confidentiality**	As in Assessment and Formulation Case Presentation.	As in previous Case Reports.

Case Reports

Trainees submit three written case reports over the course on three different clinical cases. Trainees also present a different clinical case as a case presentation.

Depression and Anxiety Case Reports (4,000 Words)

The purpose of these case reports is to demonstrate your grasp of the application of cognitive theory to clinical practice.

NB *A good case does not necessarily mean one with a good outcome*

We require you to demonstrate not just your application of CBT theory to clinical practice but also your reflections and learning related to this piece of clinical work and your understanding of evidence-base practice.

NB *in all case reports material presented must reflect accurately the assessment and interventions carried out with the relevant client. If misrepresentations come to light the case report will automatically fail. When submitting case reports trainees will be confirming that the work took place as described and that if information is falsified this may lead to a Fitness to Practice investigation.*

Depression and Anxiety (4,000 Words) Case Report Guidelines

Trainees will be assessed on the following dimensions:

***Assessment**

Should include:

- Reason for referral and for seeking treatment at this point
- Description of the presenting problem(s)/symptoms, diagnosis and co-morbidity including use of DSM 5 criteria and full consideration of differential diagnosis (all possible diagnoses which were considered/ruled out for this client based on their symptoms, experiences and measures)
- Relevant background/personal information, including development of the problem, predisposing, precipitating, perpetuating, protective factors and current social circumstances
- Risk assessment
- Identified treatment goals for therapy (focus on SMART goals)
- Issues relating to engagement and the therapeutic alliance
- Issues of diversity and difference (or similarity) between client and therapist and the impact on the therapeutic relationship
- Use of the relevant model to guide assessment, formulation and intervention (if it is not used reasons for this should be given). For depression cases, the Beck model should be used
- A cognitive behavioural assessment of the presenting problem(s), including a description of identified situations/triggers, cognitions, emotions, physical symptoms and behaviours
- Socialisation to the model and suitability for CBT
- Scores on NHS Talking Therapies service outcome and assessment measures
- Relevant disorder specific assessment questionnaires (if not a reason should be given)

***Conceptualisation/Formulation**

- Where a particular model has been used to guide formulation, this should be referenced and accurately described, including an accurate description of the theory underpinning the model

- There should be a narrative description of the case conceptualisation within the text, and clarified, where possible, by a diagrammatic representation of the conceptualisation
- The formulation should link and fully explain the maintenance factors of the client's presenting problem(s) and, where relevant, the development of the problem
- Ensure that the arrows on any diagrammatic formulations make sense, flow accurately and reflect both the theory and actual experience of the client
- The formulation should relate to the client's goals and flow from the assessment
- Ensure a focus on collaboration with explicit client contribution

***Intervention**

- Interventions (carried out or planned) should directly relate to and flow from the client's identified goals and the case conceptualisation, to demonstrate how treatment was idiosyncratic
- A minimum of 5 sessions should have been completed, including treatment/interventions
- Clear rationales for the interventions carried out should be given based on the theory, goals and case conceptualisation
- Enough detail should be given in the text so that it is clear what was done, but a blow-by-blow account of each session is not required
- The relapse prevention plan should be included
- Include reference to relevant NICE guideline(s)
- Identify any difficulties experienced and relate back to the case conceptualisation where possible

***Critical Evaluation/Outcome**

- You need to evaluate the interventions as applied and the outcome of the case
- You need to demonstrate evaluation over the course of therapy (not just at the end) so that you can demonstrate that you are on track with the intervention
- Present NHS Talking Therapies service outcomes for the client (ideally also through depiction of a graph) and critically discuss scores, considering fluctuations in scores and why these may have occurred
- You should re-administer and report on all measures that were used at assessment (if not, a reason should be given)
- Outcomes should be clearly related back to the identified goals of therapy
- You should critically evaluate the work and outcome to date; e.g. why you think the changes have occurred? Or if no changes have occurred, why this may be? Where possible, relate this back to the case conceptualisation and/or the theory/model
- Where an intervention has not been completed, you need to present the current outcome in relation to the identified goals
- Refer back to relevant NICE guideline(s), where possible

***Link of Theory to Practice**

This is covered to some extend in previous areas. Throughout the report, you need to:

- Relate the clinical work carried out to relevant cognitive-behavioural theory and relevant models throughout
- Use theory/research/literature to guide your assessment, formulation, intervention plan and critical evaluation
- Refer to, and make use of, the relevant literature to show how this was guiding your thinking about this case

***Diversity and Inclusion**

Within the assessment, conceptualisation/formulation, intervention, critical evaluation/outcome and reflections you should consider diversity and inclusion in terms of the protected characteristics, areas of difference or similarity between client and therapist, the impact on the therapeutic relationship, power dynamics and any adaptations to therapy. Relevant literature related to protected characteristics and diversity should be included.

***Awareness of Professional Issues (Including Confidentiality)**

Your work should demonstrate good professional awareness, including evidence of:

- A comprehensive and personalised risk assessment, risk formulation and risk management plan that considers the client's needs, risks and contexts
- Adherence to codes of professional conduct, performance and ethics
- Client confidentiality - anonymised biographical data must be used throughout the presentation, i.e. you need to change any names and identifying information and make it clear that this has been done**

Self-Reflectivity

Throughout the case report, you should demonstrate a reflective approach to the work you carried out and the use of methods/tools to aid this process. For example, we would expect you to provide a rationale for the work carried out that draws on your ability to reflect on theory/therapeutic alliance/socio/political/organisational/professional and ethical factors.

Reflection may involve demonstrating an awareness of the way that your own assumptions/beliefs might impact on the process and outcome of therapy with due consideration of how this may shape and develop your practice in the future.

You may find it helpful to provide an outline of any tools or mechanisms that you used in order to aid this process (e.g. supervision discussion, protected preparation time for therapy & supervision sessions, a reflective model, thought records, listening to session recordings, SP/SR etc.).

Structure and Style

Marks will be awarded for a well-structured case report. The case report should read well and flow in a logical manner. Be mindful of your use of language, both the use of colloquialisms and jargon. Trainees should refer to themselves as 'the author' rather than 'I' within academic writing.

Where appropriate, you may use diagrams, tables and bullet points. These should be used to aid clarity of information in the main text. Key information needs to be in the main body of the text and any information in tables/diagrams needs to be at least summarised within the main text. Key information such as each of the '5 Ps', risk, differential diagnosis, narrative description of the formulation, interventions, critical evaluation, diversity/inclusion and the theory underpinning the work all needs to be described within the text.

If used, subheadings should relate to subsequent material presented and help to structure your case report. If used, appendices and footnotes should be used appropriately and not to help with word count. Appendices should be clearly referred to, labelled and follow the reference section. A possible structure could be based on the marking criteria e.g.: Outline/introduction to the client and the case report, reason for referral, presenting problem(s), assessment, formulation, intervention plan and critical evaluation. Theory to practice links, self-reflectivity and professional issues could be covered throughout in the previous sections or as separate sections.

References

References should conform to APA (7th Edition) both in text and at the end of your case report (see University guidance). Please check references in terms of accuracy and consistency and ensure that all citations in the text are referred to in the reference section. Minor errors with referencing will not impact on the overall mark. However, disregard for APA referencing, or severe departures from APA, may impact the overall mark.

Spelling, Grammar, Typographical Errors and Presentation

All written assessments should be word-processed using double-line spacing, font size of 11pt or 12pt and in a font that is easy to read, e.g. Arial, Verdana, Tahoma. All pages should be numbered.

To assist with “blind marking” please do not put your name anywhere in your submission.

Work should be comprehensible, so please check for typographical, grammatical and spelling errors. Where possible, ask someone else to proofread your essay before submitting. If you need support in this area, please use the study skills department.

Word Count

Written work must stay within the specified word count and there will not be an upper percentage margin.

Word count excludes: case report title, tables, figures, headings for tables/figures, the reference list,and appendices.

Markers will stop marking at the point where the limit has been reached.

*** Indicates a key area; insufficient information in any of these areas or failure on more than one of these areas is likely to result in an overall fail.**

**Confidentiality Breaches in Case Reports:

1. In Case Reports there should be no identifiable information in relation to the client or service.
2. A minor breach in Case Reports, where confidentiality/anonymization has occurred and been acknowledged by the author, but then a minor mistake(s) gets picked up will be returned to the author for correction. The trainee will have 48 hours (excluding weekends) to reply and correct the errors, otherwise it will be marked as a fail. The trainee will be notified via their University email account by the programme administrator. If the breach occurs during a vacation period, then they will also receive an alert to their work and personal email addresses (where these have been provided) asking them to urgently check their University accounts.
3. When major breaches are present or anonymization has not occurred and/or been made explicit, this will be an automatic fail and the trainee would need to resubmit a second submission correcting the error (and making any other changes if there are any other resubmission criteria).

Extended Case Report (7,000 Words)

This must be of a client with an anxiety disorder or PTSD - a different disorder to the client in the Anxiety Case Report. The client used for the Extended Case Report can be any of the 8 closely- or non-closely supervised cases (a client with an anxiety disorder or PTSD) which have not been used for any other case report or the summative case presentation previously. For the Extended Case Report, the intervention work must be complete.

Aims

The overall aims of the Extended Case Report are for you to demonstrate your grasp of the application of cognitive theory to clinical practice by demonstrating an understanding of evidence-based practice and providing a critical discussion of the relevant research/literature evidence to this case.

You will be required to reflect on one or two key themes or issues that were apparent or relevant to this case and discuss these with reference to relevant research/literature. You may wish to include transcript of sessions with this client to illustrate your points and provide material for reflection. The area chosen may relate to any area of CBT and clinical work. Examples might include cultural or diversity issues, different cognitive-behavioural models, process issues, issues relating to the therapeutic alliance, contextual or systemic factors, or co-morbidity.

***NB** A good case does not necessarily mean one with a good outcome*

We require you to demonstrate not just your application of CBT theory to clinical practice, but also your reflections and learning related to this piece of clinical work and your understanding of evidence-base practice.

NB *In all case reports material presented must accurately reflect the assessment and interventions carried out with the relevant client. If misrepresentations come to light, the case report will automatically fail. When submitting case reports trainees will be confirming that the work took place as described and that if information is falsified this may lead to a Fitness to Practice investigation.*

Extended Case (7,000 Words) Report Guidelines

Trainees will be assessed on the following dimensions:

***Assessment**

Should include:

- Reason for referral and for seeking treatment at this point
- Description of the presenting problem(s)/symptoms, diagnosis and co-morbidity including use of DSM 5 criteria and full consideration of differential diagnosis (all possible diagnoses which were considered/ruled out for this client based on their symptoms, experiences and measures)
- Relevant background/personal information, including development of the problem, predisposing, precipitating, perpetuating, protective factors and current social circumstances
- Risk assessment
- Identified treatment goals for therapy (focus on SMART goals)
- Issues relating to engagement and the therapeutic alliance
- Issues of diversity and difference (or similarity) between client and therapist and the impact on the therapeutic relationship
- Use of the relevant model to guide assessment, formulation and intervention (if it is not used reasons for this should be given).
- A cognitive behavioural assessment of the presenting problem(s), including a description of identified situations/triggers, cognitions, emotions, physical symptoms and behaviours
- Socialisation to the model and suitability for CBT
- Scores on NHS Talking Therapies service outcome and assessment measures
- Relevant disorder specific assessment questionnaires (if not a reason should be given)

***Conceptualisation/Formulation**

- Where a particular model has been used to guide formulation, this should be referenced and accurately described, including an accurate description of the theory underpinning the model

- There should be a narrative description of the case conceptualisation within the text, and clarified, where possible, by a diagrammatic representation of the conceptualisation
- The formulation should link and fully explain the maintenance factors of the client's presenting problem(s) and, where relevant, the development of the problem
- Ensure that the arrows on any diagrammatic formulations make sense, flow accurately and reflect both the theory and actual experience of the client
- The formulation should relate to the client's goals and flow from the assessment
- Ensure a focus on collaboration with explicit client contribution

***Intervention**

- Interventions carried out should directly relate to and flow from the client's identified goals and the case conceptualisation to demonstrate how treatment was idiosyncratic
- The main body of the intervention must be completed (the client may still be seen for follow-up or relapse prevention). The relapse prevention plan should be included
- Clear rationales for the interventions carried out should be given based on the theory, goals and case conceptualisation
- Enough detail should be given in the text so that it is clear what was done, but a blow-by-blow account of each session is not required
- Include reference to relevant NICE guideline(s)
- Identify any difficulties experienced and relate back to the case conceptualisation where possible

***Critical Evaluation/Outcome**

- You need to evaluate the interventions as applied and the outcome of the case
- You need to demonstrate evaluation over the course of therapy (not just at the end), so that you can demonstrate that you were on track with the intervention
- Present NHS Talking Therapies service outcomes for the client (ideally also through depiction of a graph) and critically discuss scores, considering also fluctuations in scores and why these may have occurred
- You should re-administer and report on all measures that were used at assessment (if not, a reason should be given)
- Outcomes should be clearly related back to the identified goals of therapy
- You should critically evaluate the outcome; e.g. why you think the changes have occurred? Or if no changes have occurred, why this may be? Where possible, relate this back to the case conceptualisation and/or the theory/model
- Refer back to relevant NICE guideline(s), where possible

***Link of Theory to Practice**

This is covered to some extent in previous areas. Throughout the report, you need to:

- Relate the clinical work carried out to relevant cognitive-behavioural theory and relevant models throughout

- Use theory/research/literature to guide your assessment, formulation, intervention plan and critical evaluation
- Refer to, and make use of, the relevant literature to show how this was guiding your thinking about this case

***Critical Appraisal of Themes**

You need to clearly identify one or two key themes or issues that were relevant to this case (see suggestions above).

You should critically appraise:

- The literature around these themes
- The work/intervention with reference to this literature

You should take an objective and critical stance to the work carried out.

***Diversity and Inclusion**

Within the assessment, conceptualisation/formulation, intervention, critical evaluation/outcome and reflections you should consider diversity and inclusion in terms of the protected characteristics, areas of difference or similarity between client and therapist, the impact on the therapeutic relationship, power dynamics and any adaptations to therapy. Relevant literature related to protected characteristics and diversity should be included.

***Awareness of Professional Issues (Including Confidentiality)**

Your work should demonstrate good professional awareness, including evidence of:

- A comprehensive and personalised risk assessment, risk formulation and risk management plan that considers the client's needs, risks and contexts
- Adherence to codes of professional conduct, performance and ethics
- Client confidentiality - anonymised biographical data must be used throughout the presentation, i.e. you need to change any names and identifying information and make it clear that this has been done**

Self-Reflectivity

Throughout the case report, you should demonstrate a reflective approach to the work you carried out and the use of methods/tools to aid this process (e.g. the use of supervision), **specifically in relation to your chosen theme(s).** For example, we would expect you to provide a rationale for the work carried out that draws on your ability to reflect on theory/therapeutic alliance/socio/political/organisational/professional and ethical factors.

Reflection may involve demonstrating an awareness of the way that your own assumptions/beliefs might impact on the process and outcome of therapy with due consideration of how this may shape and develop your practice in the future.

You may find it helpful to provide an outline of any tools or mechanisms that you used in order to aid this process (e.g. supervision discussion, protected preparation time for therapy & supervision sessions, reflective models, thought records, listening to session recordings, SP/SR etc.).

You may wish to include a transcript of sessions with this client to illustrate your points and provide material for reflection.

Structure & Style

Marks will be awarded for a well-structured case report. The case report should read well and flow in a logical manner. Be mindful of your use of language both the use of colloquialisms and jargon. Trainees should refer to themselves as 'the author' rather than 'I' within academic writing.

Where appropriate, you may use diagrams, tables and bullet points. These should be used to aid clarity of information in the main text. Key information needs to be in the main body of the text and any information in tables/diagrams needs to be at least summarised within the main text. Key information such as each of the '5 Ps', risk, differential diagnosis, narrative description of the formulation, interventions, critical evaluation, diversity/inclusion, the theory underpinning the work and critical appraisal of theme/s all needs to be described within the text.

If used, subheadings should relate to subsequent material presented and help to structure your case report. If used, appendices and footnotes should be used appropriately and not to help with word count. Appendices should be clearly referred to and labelled and come after references.

A possible structure could be based on the marking criteria e.g.: Outline/introduction to the client, the case report and key themes that will be discussed; reason for referral; presenting problem(s); assessment; formulation; intervention plan; and critical evaluation and reflective analysis. Theory to practice links, critical appraisal of theme/s, self-reflectivity and professional issues could be covered throughout in the previous sections or as separate sections.

References

References should conform to APA (7th Edition) both in text and at the end of your case report (see University guidance). Please check references in terms of accuracy and consistency and ensure that all citations in the text are referred to in the reference section. Minor errors with referencing will not impact on the overall mark. However, disregard for APA referencing, or severe departures from APA, may impact the overall mark.

Spelling, Grammar, Typographical Errors and Presentation

All written assessments should be word-processed using double-line spacing, font size of 11pt or 12pt and in a font that is easy to read, e.g. Arial, Verdana, Tahoma. All pages should be numbered.

To assist with “blind marking” please do not put your name anywhere in your submission.

Work should be comprehensible, so please check for typographical, grammatical and spelling errors. Where possible, ask someone else to proofread your essay before submitting. If you need support in this area, please use the study skills department.

Word Count

Written work must stay within the specified word count and there will not be an upper percentage margin.

Word count excludes: case report title, tables, figures, headings for tables/figures, the reference list, and appendices. All other words are counted. **Work exceeding this limit will not be marked and will not receive credit.**

*** Indicates a key area; insufficient information in any of these areas or failure on more than one of these areas is likely to result in an overall fail.**

**Confidentiality Breaches in Case Reports:

1. In Case Reports there should be no identifiable information in relation to the client or service.
2. A minor breach in Case Reports, where confidentiality/anonymization has occurred and been acknowledged by the author, but then a minor mistake(s) gets picked up will be returned to the author for correction. The trainee will have 48 hours (excluding weekends) to reply and correct the errors, otherwise it will be marked as a fail. The trainee will be notified via their University email account by the programme administrator. If the breach occurs during a vacation period, then they will also receive an alert to their work and personal email addresses (where these have been provided) asking them to urgently check their University accounts.
3. When major breaches are present or anonymization has not occurred and/or been made explicit, this will be an automatic fail and the trainee would need to resubmit a second submission correcting the error (and making any other changes if there are any other resubmission criteria).

CTS-R Recording, Cover Sheets and Consent Forms

Assessment of Clinical Skills/CBT Competencies via Formative and Summative Assessments Using the CTS-R for Recordings of Clinical Sessions Submitted Via Secure Data Transfer

You will formally submit four therapy video recordings over the course. The first will be formative and the other three will be summative.

For full-time trainees, these are to be submitted at the end of terms 1 and 2, around mid-term 3 and at the end of term 3.

For part-time trainees, these are to be submitted at the end of term 1, early in term 3, by Easter of year 2, and towards the end of year 2.

In addition, three formative assessments of therapy sessions will be completed within university group supervision. For full-time trainees this will be in terms 1, 2 and 3. For part-time trainees this will be once every two terms during the two years. All these video recordings should be of those clients you use as your closely supervised clients and some link to the other course assessments (case reports). The formative recording submitted at the end of term 1 should be an assessment/formulation session and this links to the summative case presentation; this client should be one of the five non-closely supervised cases.

Two additional “live competency assessments” (or LCAs), using actors, will be assessed by course supervisors at the beginning and end of the course. These are formative assessments and are intended to assess your training needs, inform supervision and provide formative feedback for ongoing clinical skills development at the end of the taught course. The outcomes are also used to assess the contribution of the training course to CBT skills development.

All competency assessments during the training course are assessed using the CTS-R (Cognitive Therapy Scale Revised). The Manual of the Revised Cognitive Therapy Scale is available on ELE and trainees must familiarise themselves with this document.

To aid understanding of the CTS-R, there will be opportunities to view previous trainees' clinical sessions and feedback as part of the teaching programme, where consent has been given for this purpose.

Guidance on Recording Sessions

In CBT, it is standard practice to record therapy sessions which can be given to the client to listen to between sessions and used for supervision and reflective practice. For the purpose of assessment and supervision, with client consent, video recordings will be used to assess your clinical skills.

You will be expected to submit recordings via secure data transfer as part of the clinical assessment and bring recordings to supervision.

It is essential that you obtain the consent of your client for the recording to be used for supervision and/or assessment and submit the consent form in the appropriate place. The client consent form also asks whether your client will be willing for the recording to be used in

future training, which is optional. **Please note that there is one consent form for trainees and supervisors to use for making recordings of supervision and one consent form for clients to complete regarding use of their details in supervision and for assessments**, so do ensure you are sending the correct one to your client.

If clients have typed their signature or are unable to sign the consent form and tick the relevant boxes, they should email yourself or your service to say they have read the attached consent form and which elements they consent to. For assessments, you'll be required to submit a screenshot of this email with any of the client's contact details redacted/concealed.

You should consult your workplace supervisor and manager about your Workplace policies on making, transporting, storing and disposing of the recordings in line with Information Governance policies and procedures. All services have been consulted on the University's process for submitting and storing recordings, and these comply with NHS information governance guidelines. If there is any confusion regarding this in your service, please do refer them to **HI-CBT@exeter.ac.uk**.

You will formally submit four video recordings via secure data transfer for assessment of clinical sessions (one formative, three summative) over the course.

Recording Equipment

All employers should provide trainees with video recording equipment. Please ensure that the recordings are saved in a file format playable on Windows media player or VLC media player when submitting recordings. **If any issues are unresolved, please get in contact with the programme team immediately.**

Reflective Summaries and Self-Ratings

Each of the formative and summative assessments of CBT competences via CTS-R submitted/viewed need to be accompanied by a written reflective summary on 1 or 2 themes/issues relevant to the session and a self-rating using the CTS-R. Please see the 'reflective practice' section of the handbook for further guidance. You can find all the forms on your ELE page. If you have any issues finding these, please contact **HI-CBT@exeter.ac.uk**.

Guidance on Formative CBT Competencies Assessments via CTS-R

Within university group supervision – formative assessment of CBT competencies.

Term 1 - the focus of training will be working with depression. Therefore, it is anticipated that you will bring a client with a presenting problem of depression as your closely supervised

client throughout term 1 supervision (and also throughout term 2 for part-time trainees). You will bring a video recording of a full therapy treatment/intervention session to be observed within group supervision for formative assessment using the CTS-R and also present your CTS-R self-rating and Reflection for formative feedback. It is anticipated that you will obtain a minimum overall mark of 30% for this work.

Term 2 – the focus of training will be working with anxiety disorders including PTSD. Therefore, it is anticipated that you will bring a client with a presenting problem of one of the anxiety disorders as your closely supervised client throughout term 2 supervision (this will be in term 3 and the start of year 2 for part-time trainees). You will bring a video recording of a full therapy treatment/intervention session to be observed within group supervision for formative assessment using the CTS-R and also present your CTS-R self-rating and Reflection for formative feedback. It is anticipated that you will obtain a minimum overall mark of 40% for this work.

Term 3 - the focus of training will be working with complexity/co-morbidity across anxiety and depression. This does not mean that the client brought for close supervision at the university needs to be presenting with complexity/comorbidity. In term 3, full-time trainees will bring a client, presenting with a different anxiety disorder than you worked with in term 2 as your closely supervised case throughout term 3 supervision - this should be a client with PTSD if you have not already brought a client with this presentation in term 2. For part-time trainees the third closely-supervised case will be brought to university supervision for the final 2 terms of year 2. You will bring a video recording of a section of a therapy treatment/intervention session (10 – 20 mins in length), highlighting an area for development in line with a specific CBT competency/CTS-R item (that will be linked to your supervision goals), to be observed within group supervision for formative assessment using the CTS-R. You will also present your full CTS-R self- rating and Reflection for formative feedback. It is anticipated that you will obtain a minimum overall mark of 40% for this work.

End of Term 1 Formative Assessment of CBT Competency in Assessment and Formulation Skills Using the CTS-R.

All trainees must submit a video recording by the deadline at the end of term 1. The recording must be clearly audible and be of a complete session. Both therapist and client must be front facing and clearly visible. This session should demonstrate your assessment & formulation skills (e.g. either session 1, 2 or 3). You will also need to self-rate your CBT competencies using the CTS-R.

You must submit your recording along with a completed front cover sheet which includes your own ratings and a CTS-R Reflection of the recording presented. You should also include a copy of the formulation and submit the client consent to record form. The recording should be of work carried out with the client you intend to present for your Summative Assessment and Formulation Case Presentation, and so should be a non-closely supervised case (who has

been taken to workplace supervision during term 1 and that you will have at least 5 sessions with and accrue at least 5 hours of supervision with). They should not be the client you are bringing to university supervision in term 1 as the university supervised client will be used for the summative CBT competencies assessment.

We expect trainees to obtain a minimum CTS-R mark of 40% on the submitted formative CBT competencies assessment at the end of term 1.

Guidance on SUMMATIVE CBT Competencies Assessments via CTS-R

The Summative CBT Competencies Assessments (CTS-R & Reflection) must be submitted by the deadlines. The video recording must be clearly audible and be of a complete (unedited) therapy treatment/intervention session (50 – 60mins, unless extended time agreed and in accordance with relevant NICE Guidance, e.g. PTSD and Social Anxiety Disorder).

Both therapist and client must be front facing and clearly visible. If there is a chance of any client details showing on the recording (e.g. their full name if you are using Teams), you must make the client aware of this and gain their verbal consent at the start of the session.

Your recording must be submitted along with a completed front cover sheet which includes your own self-ratings of CBT competencies and a CTS-R Reflection of the recording presented. You should also include the formulation and submit the completed client consent to record form. Please ensure to submit a screenshot of the client confirming their signature via email if their signature was typed on the form. Any client contact details in the screenshot must be hidden/concealed.

You MUST achieve a minimum CTS-R mark of 50% which corresponds to a raw score of 36 and above. However, you MUST also achieve a rating of at least 2 on EVERY item in order to pass. Your CTS-R Reflection must also be passed as satisfactory.

Depression Module (PYCM038) – you will submit a video recording demonstrating CBT competencies for depression at the end of term 2 for full-time trainees, or early in term 3 for part-time trainees. This submission should be of a session from the treatment phase (session 3- 4 onwards) of your work with the same client that you have written up for your Depression Case Report and be the same client you have brought to University supervision during term 1 as your closely supervised client (during terms 1 & 2 for part-time trainees).

Anxiety Module (PYCM039) - you will submit a video recording demonstrating CBT competencies for anxiety at mid-term 3 for full-time trainees, or by Easter of year 2 for part-time trainees. This submission should be of a session from the treatment phase (session 3- 4 onwards) of your work with the same client that you have written up for your Anxiety Case Report and be the same client you have brought to University supervision during term 2 as your closely supervised client (during term 3 and term 1 of year 2 for part-time trainees).

Clinical Practice Module (PYCM040) - The final submission of a session video recording demonstrating CBT competencies should be of the client you have brought to University supervision during term 3 as your closely supervised client with a different anxiety disorder presentation than the term 2 assessment (either term 2 or term 3 client must be a client with PTSD). For part-time trainees this is the client brought to university supervision for the final two terms of year 2. This submission should be of a session from the treatment phase (session 3- 4 onwards) of your clinical practice. This is submitted at the end of term 3 for full-time trainees or towards the end of year 2 for part-time trainees.

Reflective Practice

Reflective practice has long been recognised as a key component in skills development in professional training. Trainees will complete and submit a number of assessed pieces of reflective writing based on the application of CBT techniques to both clients in the workplace and to their own lives.

CTS-R Reflection

You will be required to submit a brief reflection with your competency assessments. This should be between 200 - 500 words.

You should choose to reflect on one or two themes that were of relevance to the session. We would expect you to identify the area that you are going to reflect on and then provide a reflective analysis of this area followed by a plan. Your analysis should demonstrate your ability to reflect on your practice and in particular in relation to the formulation of this client's presentation. The analysis should provide a critical evaluation of the therapy skills that you demonstrate within the recording, drawing on relevant CBT theory, research and literature and identify areas for improvement. The following model may be help with this.

The four stage experiential learning model (Kolb 1984 and Lewin 1946) in Bennett-Levy et al. (2004 p. 19) is the most widely used model in adult education (see fig. 1)

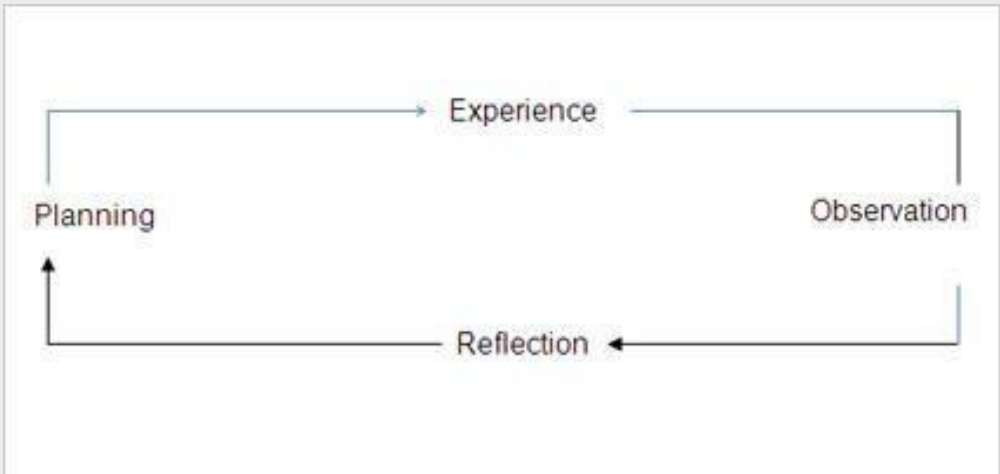


Figure 1. Experiential learning cycle (Bennett-Levy et al., 2004)

Different terms have been used by different authors to reflect the same four stages. Plan, Experience, Observe, and Reflect.

Effective learning is said to proceed through a series of these cycles.
Experience: The experience
Observe: What happened
Reflect: Making sense of what happened by

- Relating it to previous experience and knowledge
- Searching for understanding
- Generalising, abstracting principles
- Fit with the formulation

Plan: With the new understanding, how can I take this forward?

CTS-R Reflection Guidelines

The purpose of the reflections is to demonstrate your ability to:

- Reflect on your experience of CBT practice
- Critically analyse and make sense of that experience (informed by CBT theory and literature where appropriate)
- Extract useful learning and plan for change

You will be assessed on the following dimensions:

Introduction of Topic of Reflection

- Clear identification of one or two issues relevant to the session
- Description of reflective process (e.g. may have involved the use of a model such as Kolb's learning cycle, discussion with supervisor, use of thought records etc.)

Experience and Observation

- Description of the relevant concrete experience within the session, e.g. client and therapist behaviour, verbal communications and events
- Observations of therapist automatic thoughts, emotions and impulses

Critical Analysis

- Description of the relevant concrete experience within the session e.g. client and therapist behaviour, verbal communications and events
- Observations of therapist automatic thoughts, emotions and impulses

Understanding and Use of Theory

- Integration of critical analysis with existing knowledge of CBT
- Integration of critical analysis with relevant CBT literature and research where appropriate

Summary and Implications for Future Practice

- Summary of learning
- Description of concrete and specific plans for active experimentation, further learning and clinical practice (including awareness of own assumptions etc.)

Structure and Style

- Clear structure with a logical flow
- May use existing models of reflection such as Kolb's learning cycle to structure

Spelling and Grammar

Work should be double spaced and page-numbered. Work should be comprehensible and so please check for typographical, grammatical and spelling errors. Where possible ask someone else to proof read your reflection before submitting. If you need support in this area please use the study skills department.

References

References should conform to APA (7th Edition) both in text and at the end of your reflection (see University guidance). Please check references in terms of accuracy and consistency and ensure that all citations in the text are referred to in the reference section. Minor errors with referencing will not impact on the overall mark, however

disregard for APA referencing, or severe departures from APA, may impact the overall mark.

Word Count: 200 – 500 words

Self-Practice/Self-Reflection Tasks, Blogs and Reflective Summary

Trainees will have the opportunity to engage weekly, or fortnightly, throughout the course in pre-set self-practice CBT tasks designed to prepare for or deepen learning in the concurrent taught components of the course. Trainees will be required to complete a minimum **of 10 self-practice/self-reflection tasks** and write about their experience on an electronic blog on ELE. This will be open to view for the current cohort and core course staff. These blogs may follow a similar format (and conform to the same 200-500 word count) to the CTS-R reflections, but it is expected that the learning community will develop its own style.

The purpose of the blog is to encourage a community of learning in which reflective practice may be developed through the observation of and interaction with the work of others and formative feedback from experienced clinicians. Trainees will NOT be asked to post personal information on the blog but rather to reflect on the experience and insights gained that are applicable to their future CBT practice with clients. Copies of a minimum of 10 self-practice/self-reflection (SP/SR) blogs will be submitted with a reflective summary of learning for summative assessment (see guidelines and criteria for SP/SR summary below).

The summative self-practice/self-reflection reflective summary of learning (500 words) may follow a similar format as the individual blogs and the CTS-R reflections but may cover a number of themes that have emerged from the overall experience of engaging in the self-practice/self-reflection tasks and blogs.

Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., & Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy, 29, 203-220.*

Self-Practice/Self-Reflection Reflective Summary Guidelines

The purpose of the summative SP/SR reflective summary is to demonstrate your ability to:

- Reflect on your experience of CBT SP/SR
- Critically analyse and make sense of that experience (informed by CBT theory and literature where appropriate)
- Extract useful learning and plan for change

A minimum of 10 SP/SR blogs MUST be included as appendices to the reflective summary (the blogs are not marked but need to be included).

You will be assessed on the following dimensions:

Introduction of Topic of Reflection
• Clear identification of themes/issues relevant to SP/SR tasks • Description of reflective process used (e.g. may have involved the use of a model such as Kolb's learning cycle, discussion with supervisor or peers, use of blog, use of own thought records, conceptualisations etc.)
Experience and Observation
Description of the relevant concrete experience within SP/SR, e.g. observations of therapist's automatic thoughts, emotions and behaviours in relation to process (rather than content) of self-practice.
Critical Analysis
• Analysis of experience and observations of completing the SP/SR tasks and beyond, taking an objective and critical stance and presentation of alternative interpretations in order to help make sense of experiences • Analysis would usefully be informed by therapist formulation
Understanding and Use of Theory
• Use of existing knowledge of CBT and/or relevant CBT literature/research to help understand and critically analyse experiences of SP/SR • Demonstration of understanding of theory and integration of theory to practice
Summary and Implications for Future Practice
• Summary of learning extracted from SP/SR • Description of concrete and specific plans for active experimentation, further learning and clinical practice (including awareness of own assumptions etc.)
Structure and Style
• Clear structure with a logical flow • May use existing models of reflection such as Kolb's learning cycle to structure • A minimum of 10 SP/SR blogs MUST be included as appendices to the reflective summary
Spelling and Grammar
Work should be double spaced and page-numbered. Work should be comprehensible and so please check for typographical, grammatical and spelling errors. Where possible, ask

someone else to proofread your reflective summary before submitting. If you need support in this area, please use the study skills department.

References

References should conform to APA (7th Edition) both in text and at the end of your reflective summary (see University guidance). Please check references in terms of accuracy and consistency and ensure that all citations in the text are referred to in the reference section. Minor errors with referencing will not impact on the overall mark, however disregard for APA referencing, or severe departures from APA, may impact the overall mark.

Word count: 500 words

Clinical Portfolio

Overview of Assessment of Clinical Practice

At the end of the course, each programme member is required to submit a clinical portfolio which will include:

1. **Front sheet**
2. **Overall Summary** of supervision hours, supervised practice and 8 completed cases (a minimum of 3 different presenting problems, of which one of the closely-supervised should be depression and one of the closely-supervised should be PTSD. One of the non-closely supervised cases must also be depression, and one of the 8 cases must be social anxiety disorder).
3. **Supervision contracts** from each term (each two term period for part-time trainees)
4. Evidence of your **BABCP membership**
5. Formative supervisors' reports (Workplace & University)
6. **Summative supervisors' reports** (Workplace & University)
7. **BABCP supervision logs** (Workplace & University) evidencing a minimum of 70 hours of supervision (see calculation below)*
8. **Clinical log** of at least 200 hours supervised CBT practice
9. **Client summary sheets** for all 8 supervised clients (3 x closely supervised and 5 x non-closely supervised) which will include **all Summative assessment feedback** (case presentation and case reports), including CBT competency assessment (CTS-R & Reflection) marks for the supervised cases, **a written or diagrammatic formulation**, a **sample of supervision preparation forms**, a **patient evaluation questionnaire** and **copies of letters/reports** relating to the 8 cases.

10. Evidence of **co-therapy** via the 'co-therapy reflection form' (one form per co-therapy client)
11. **CTS-R Self-Rating and Reflection for 6 sessions** (include these with the client summary sheets along with the letters/reports/PEQ and supervision preparation forms) along with the markers' feedback on the 6 CTS-Rs and reflections (these should all have reached a pass/satisfactory mark)
12. **Teaching hours** log (plus 200-500 word reflections on learning points for each taught session missed)
13. For trainees taking the KSA route, please submit a copy of your **KSA assessment feedback.**

In the clinical portfolio, the trainee and the service can be identified but no identifiable information on clients should be included. Please ensure that all identifiable information has been concealed and the document has been saved as a PDF.

This clinical portfolio forms one of the required assessments for module PYCM040. It also meets the NHS Talking Therapies curriculum and BABCP requirements for a level 2 accredited course and will be marked as Pass/Fail.

At the end of terms one and two (end of terms two and by Easter of year 2 for part-time trainees) you will need to submit a portfolio progress review form, to evidence that you are on track with meeting portfolio requirements.

Confidentiality Breaches in Clinical Portfolios:

1. The trainee and the service can be identified, but no identifiable information on Clients should be included
2. If confidentiality breaches occur in relation to clients, this will be marked as an automatic fail and the trainee will be asked to address the area of concern (and any other changes) for resubmission

Supervision

As part of the programme, you will receive two hours of university-based group supervision a week (fortnightly for part-time trainees). Timings are adjusted if there are more or fewer than 3 trainees in a supervision group. This will amount to approx. 35 hours using the group formula below. You will also receive regular supervision from your workplace supervisor over the year (or over two years for part-time trainees). Combined, this will provide you with a variety of group and individual supervision, totalling a minimum of 70 hours of supervision. Over the course of the training, you need to have received a minimum of 70 hours of supervision and 200 hours of supervised CBT practice.

You need to have seen at least 8 completed cases (seen for an absolute minimum of 5 sessions but usually more, from start to completion/termination) and have received 5 hours minimum of supervision, from a supervisor who is a BABCP accredited therapist, on each of these 8 cases. The University will provide the supervision for up to 3 of these cases.

You need to have worked with a minimum of 3 different problem presentations: 1 of these must be post-traumatic stress disorder (PTSD), 1 must be depression and 1 must be an anxiety disorder. Another of the 8 cases should also be depression and one of the 8 cases should be social anxiety disorder.

Please note that when calculating your supervision hours for the 8 cases, it is recognised that time spent in group supervision offers greater value than simply calculating the time spent on an individual's case, and dividing the overall time spent in the group by the number of participants.

The BABCP recommends using the following two calculations:

1. Time spent discussing a particular case in group supervision is multiplied by two.
For example, if there are three participants in a two-hour group, 30 minutes might be spent discussing each case.
30 minutes x 2 = 60 minutes' equivalent case supervision time.
This calculation should be used for the 'Client Summary Sheet' when working out supervision hours per client.

2. Overall group clinical supervision equivalent time is calculated in the following way: The time spent in the group is divided by the number of participants in the group, and this time is then doubled.
For example, if there are 3 participants in the group, and the group meets for two hours; the formula would be:
2 hours ÷ 3 people = 40 minutes x 2 = 1 hour 20mins equivalent group supervision time.
This calculation should be used for the 'BABCP Supervision Logbook' and contributes towards the 70 supervision hours that are required.

3 of your 8 cases will need to be brought to University supervision and must be closely supervised. This means they will also have to be formally assessed using video or live practice and assessed to meet a reasonable standard as judged by the CTS-R. The summative recordings you submit will meet the 'closely supervised' requirement.

Supervision Reports

At the end of terms 1 and 2, both university and workplace supervisors will complete formative supervisor's reports. You will need to submit these at the end of terms 1 and 2 and

keep a copy for your records. For part-time trainees these formative reports will be completed and submitted at the end of term 2 and by Easter of year 2. You must submit your supervisor reports via the ELE submission portal and keep a copy for your Clinical Portfolio.

At the end of term 3, both university and workplace supervisors will complete summative supervisor's reports. For part-time trainees, the summative supervisor reports will be completed and submitted towards the end of year 2. You will need to submit your summative supervisor reports via ELE's submission portal and keep a copy for your records. You must also submit your summative supervisor reports in your Clinical Portfolio.

Please note that all supervisor's reports must be hand-signed/electronically signed and you should keep the original copies of your reports. If a signature is typed, your supervisor will need to email a copy of your report to **HI-CBT@exeter.ac.uk**, CC you in and confirm their signature.

Co-Therapy

Trainees need to complete several courses of therapy as a co-therapist with an experienced therapist/supervisor in their service leading. 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 three sessions that are close together.

There should be a minimum of:

- **Three co-therapy clients** throughout the course of the training programme
- **A minimum of three jointly delivered sessions per client** during the training, with at least one of these taking place early in Term One.
- Each session should be followed by a **reflective discussion** with the experienced therapist.

Trainees will need to include a reflective account of their learning from the co-therapy experience in the clinical portfolio, using the 'Co-Therapy Reflection Form' (one form per course of co-therapy).

To meet the co-therapy requirement, trainees should be sitting in on live sessions rather than watching a recording.

Trainees cannot include these co-therapy hours towards the required 200 clinical practice hours, as they are not leading the sessions or working independently.

The lead therapist and trainee can agree between them how co-therapy will work. For example it may be in session one the trainee just observes, in session two the trainee contributes, and in session three the trainee takes a more active role (such as assisting with change methods, providing some chunking summaries, helping with adherence to the agenda – these are just suggestions). It may be possible for the trainee to help the lead

therapist in preparing for the sessions and/or in writing up the session notes. Patient consent will be needed for a trainee to join the session and services are encouraged to set up co-therapy opportunities in advance of the training starting, so that trainees can start one of these in the early weeks of the course.

It is hoped that these co-therapy experiences will help trainees' confidence and competence by being able to observe CBT in practice. It may also be very helpful for the lead therapist to have someone to assist with sessions/admin and an opportunity for the lead therapist to reflect on therapy progress with the client.

Clinical Hours

In order to achieve at least 200 hours of supervised CBT practice by the end of the course, it is recommended that full-time trainees aim to have completed 40 clinical hours by the end of term 1 and 90 clinical hours by the end of term 2. For part-time trainees, clinical hours can be accrued over the two years. Clinical hours will be discussed as part of 1:1 tutorials each term.

1:1 Tutorials

Each term, you will have a 1:1 tutorial. You can request additional meetings with your personal tutor if needed. In this tutorial you can discuss any queries you may have and any support you may need for your learning and wellbeing. Your tutor can also review your progress with your clinical portfolio and you will submit a portfolio progress review form at the end of terms one and two (or end of term two and by Easter of year 2 for part-time trainees).

Please give yourself time to prepare for your tutorial including any questions/issues you may have in advance of your meeting.

KSA Trainees

For those trainees who do not have a BABCP-recognised core profession, they will need to include their assessment feedback from their completed KSA portfolio in the clinical portfolio. You will have submitted your completed KSA portfolio at the beginning of term 1 and, prior to this, will have received feedback on this along with a KSA tutorial with the KSA tutor to assist you in completing your KSA portfolio.

Successful completion of the course contributes to the following KSA criteria:

3. Psychopathology/diagnostic skills - teaching
4. Models of therapy - behaviour therapy and cognitive therapy

5. **Competency in key relationship skills** - assessed by supervisors' reports and successful completion of CTS-R
8. **Awareness of risk** - taught lectures and assessed within marking criteria of case reports
9. **Comprehension of research** - assessed by successful completion of the academic essay and extended case report
10. **Commitment to ethical practice** - lecture and assessed by successful completion of case reports
14. **Receptive to scientist practitioner approach** -assessed by successful completion of case reports where trainees are required to *"relate the clinical work carried out to relevant cognitive theory and relevant models. You should use theory to guide your assessment, formulation and intervention plan and guide your thinking about this case. You should refer to and make use of the relevant literature pertaining to this case"*

You can find the forms needed for your clinical portfolio on your ELE page. If you have issues locating these, please contact **HI-CBT@exeter.ac.uk**.

Mitigations

Mitigation requests for assessments should be made prior to the assessment deadline in question. Students are responsible for making applications for mitigation.

Mitigations for Formative Submissions

If you are requesting a mitigation for a formative submission, please contact **HI-CBT@exeter.ac.uk** and the Programme Lead with a brief reason for mitigating, as well as the date you would like to request. The programme team will then process the request.

Mitigations for Summative Submissions

For summative submissions, there are two main types of mitigation: self-certifications and mitigation requests that are formally made and sent to the Cedar Mitigations team.

Self-Certifications
Using the **self-certification option**, you can request 72-hour evidence-free extensions via the ELE submission portal. You can request a self-certification up to 4 times in a 12 month period. Students with an independent learning plan (ILP) that specifically supports the possible need for extensions will have no limit to these extensions in a 12 month period.

Please note that not all submissions are eligible for this extension. Typically, these are available for academic written submissions, but not CTS-R/clinical submissions. Please

contact **HI-CBT@exeter.ac.uk** if you're unsure whether your submission is eligible for a self-certification.

Evidence-Based Mitigations
When self-certification isn't an option, you can apply for **an evidence-based mitigation** by completing part 1 of the mitigation request form and emailing it to **CEDAR-Mitigations@exeter.ac.uk**. You can request a 1 or 2 week extension (up to 3 weeks in exceptional circumstances).

If you're unable to meet a 2 week extension (e.g. a client has dropped out), you can request a deferred deadline. These dates are determined by the programme team. Please contact your personal tutor if you are wanting to request to submit on a deferral date.

If you're unsure as to what evidence you need to include in your request, the most important thing is submitting your mitigation request in the first instance. Once you've done this, both the programme team and Cedar Mitigations team can advise on next steps.

The Cedar Mitigations team receive a high volume of queries, so the clearer your request is, the quicker they will be able to process it. For more information on this, please refer to the Cedar PGT Handbook: **https://ele.exeter.ac.uk/course/view.php?id=8259&section=1**

No one is allowed to make a mitigation request on your behalf. Should you be unable to make a mitigation request before the deadline (e.g. due to an emergency), you can make a retrospective mitigation. Please contact **HI-CBT@exeter.ac.uk** for more information on this.

The mitigation request form and supplementing evidence form can be found on your ELE page. Please contact **HI-CBT@exeter.ac.uk** if you have any issues finding these.

Course Assessment Flowchart

A course assessment flowchart will be available on ELE in term 1. This will provide a clear timeline of the activities involved with each submission, and which clients are linked to which submissions.

Confidentiality Breaches

Case Reports:

1. In Case Reports there should be no identifiable information in relation to the Client or Service.

2. A minor breach in Case Reports, where confidentiality/anonymization has occurred and been acknowledged by the author, but then a minor mistake(s) gets picked up will be returned to the author for correction. The Trainee will have 48 hours (excluding weekends) to reply and correct the errors, otherwise it will be marked as a fail. The Trainee will be notified via their University email account by the Programme Administrator. If the breach occurs during a vacation period, then they will also receive an alert to their work and personal email addresses (where these have been provided) asking them to urgently check their University accounts.
3. When major breaches are present or anonymization has not occurred and/or been made explicit, this will be an automatic fail and the Trainee would need to resubmit a second submission correcting the error (and making any other changes if there are any other resubmission criteria).

Clinical Portfolios:

1. In the Clinical Portfolio, the Trainee and the Service can be identified but no identifiable information on Clients should be included.
2. In Clinical Portfolios, if confidentiality breaches occur in relations to Clients, this will be marked as an automatic fail and the Trainee will be asked to address the area of concern (and any other changes) for resubmission.

Case Presentations:

1. With Case Presentations, no identifiable information should be presented on the client or the service.
2. A minor breach in Case Presentations, where confidentiality/anonymization has occurred and been acknowledged by the author, but then a minor mistake(s) gets picked up will be returned to the author for correction. The trainee will have 48 hours (excluding weekends) to reply and correct the errors in the presentation handouts, otherwise it will be marked as a fail. The trainee will be notified via their University email account by the programme administrator. If the breach occurs during a vacation period, then they will also receive an alert to their work and personal email addresses (where these have been provided) asking them to urgently check their University accounts.
3. When major breaches are present or anonymization has not occurred and/or been made explicit, this will be an automatic fail and the trainee would need to resubmit a second submission correcting the error (and making any other changes if there are any other resubmission criteria).

Tutorials

Academic Tutorials:

Tuesdays 09.30-12.30 / 13.30-16.30

These are an opportunity to:

- Reflect on any homework set
- Review literature
- Ask questions, give and receive feedback
- Address any queries around assessments

Skills-Based Tutorials:

Tuesdays 09.30-12.30 / 13.30-16.30

These are an opportunity to:

- Facilitate the development of clinical skills and enable the trainee to acquire the clinical competencies required to become an effective CBT therapist
- Consolidate learning from workshops and enable the trainee to practice the key clinical competencies relating to a wide variety of relevant theoretical models that have been explored in workshops
- Provide a regular chance for further skills practice, with a primary focus on experiential exercises, problem based learning and case based discussion
- Provide the chance to use self-reflection, self-practise and enquiry to enhance clinical skills

Individual Tutorials:

1 x half hour tutorial per term (additional meetings with your tutor can be arranged upon request)

These are an opportunity to:

- Review and reflect on your development and the course
- Address personal development (including your wellbeing and any learning needs) in a safe environment
- Give and receive feedback on assessed work

- Give and receive feedback on the course
- Review your clinical portfolio progress

NB: *If trainees have any concerns or issues that may be impacting on their ability to participate fully in the training or causing them any distress or concern, trainees are strongly encouraged to notify either their tutor or any member of the course team as soon as possible, rather than wait for their 1:1 tutorial. Additional tutor meetings can be arranged between you and your tutor, should this be needed.*

Attendance

We expect your attendance to be 100% because absences can affect the quality of the learning experiences of the course. As such we do not expect you to take holidays when teaching has been scheduled. Should exceptional circumstances for leave arise, then any requests for absence must be made in writing to the programme lead and agreed prior to leave being taken.

For HI CBT training less than 100% attendance can result in failure to meet BABCP requirements for individual accreditation.

If a programme member is ill for a prolonged period of time or other unforeseen circumstances intervene to prevent attendance then the staff team will attempt to negotiate an alternative package of teaching attendance so that the programme member can still meet the requirements. Each programme member is required to keep a log of their attendance at teaching sessions, follow the catch-up procedure for any missed teaching and provide feedback on teaching sessions. Attendance and engagement will be reviewed by their individual tutor.

A register to record the attendance of each programme member will be taken at the beginning of each teaching session which will reviewed by the programme lead. This register can be located at the reception area of the Washington Singer building or the room the teaching is taking place, or will be recorded online when sessions are delivered remotely.

If you miss any of the teaching days **it is your responsibility to inform both your employer and the relevant university staff members.** If you are off work on sickness absence please let your 1:1 tutor or the programme lead know this. You should NOT attend university sessions if you are off work on sickness absence unless you, your service and the university all agree this is appropriate and there is a clear rationale for this. If any of our sessions conflict with your religious events, please let us know so that we can make arrangements for you.

Missed Sessions

If trainees miss any teaching sessions (including Clinical Skills Tutorials) or more than an hour of a teaching session they should take the following actions:

- Inform the programme lead (Karen Tate) and programme administrator as well as your employer
- Read the teaching materials on ELE for the missed session(s)
- Speak to peers about any practical/experiential exercises and ideally complete these in own time
- Evidence that you have taken all necessary steps using the 'HI Missed University Sessions Catch-Up Form' which is available on ELE
- This includes a 200-500 word reflection on learning points for each missed session, which will need to be included in the clinical portfolio in the 'Teaching Log' section
- Please also send the reflection/s to your 1:1 Tutor within 4 weeks of the missed teaching, for them to sign off. This will be reviewed and discussed in your next 1:1 tutorial

Timekeeping

We expect your timekeeping on the programme to be rigorous. Timekeeping will be monitored and your employer will be informed of any recurrent lapses, either at the start or end of the day or returning from breaks. We maintain vigilance around this aspect out of consideration for the member of staff delivering the teaching session and for fellow programme members.

Workplace Buddy System: Who Are They and What Do They Do?

Your buddy is a previous trainee (so someone who has been through their HI CBT training at the University of Exeter and might know something about what you are experiencing at what stages of the training); they will be familiar with the various aspects of the trainee role and be familiar with the roles of the workplace and university staff. They are a point of contact and may be able to offer some guidance/advice or signpost you to the appropriate person who might help you. They are someone who can comprehend the high and low points of being a trainee. A buddy may be someone who you contact once or twice a term, or not at all. They are not a substitute or alternative to support arrangements that are in place, but can be a good sounding board. The university 1:1 tutor is the main point of contact for difficulties with training and tutors are there to help and support, please do not hesitate to contact your tutor where this would be helpful.

Programme Member Support Systems

We recognise that the training course is likely to be stressful at specific points in the programme, due to course deadlines and/or personal circumstances. University attendance, clinical practice and independent study may at times be difficult to balance, and students may also have personal life events which may at times impact on stress levels and the ability to balance the demands of the course with other areas of their lives.

Within the training programme we hope to promote a mutually supportive atmosphere in which students feel able to share concerns and issues with one another, with the programme team and with their clinical supervisors. However, we recognise that the programme team and supervisors cannot necessarily provide all the support that may be required, and other sources of support may at times need to be accessed.

Students are encouraged to make use of the following support whilst on the course:

- **1:1 Tutor:** You can talk with your 1:1 tutor, either at your 1:1 tutorial or at any other time, if you begin to experience difficulties. In the event of significant difficulties that may impede your ability to study, your tutor may need to discuss this with the Programme Lead and with your workplace manager/clinical supervisor to discuss a supportive way forward.
- **Programme Lead (Karen Tate):** You are welcome to talk to the Programme Lead in the case of any difficulties you may experience, in relation to the course and/or any personal circumstances for which you will need support and which may impact on your ability to study. They will have 'office hours' available for such discussions. At times it may be useful for them to liaise with your workplace manager or clinical supervisor/s to discuss a supportive way forward.
- **Wellbeing Services:** All students can access support through the University Wellbeing Services. More information can be found on the University wellbeing services web pages.
- **Reed Mews Wellbeing Centre:** There is also a University Wellbeing Centre that is free and confidential and available to all students. Appointments are available during term time by emailing wellbeing@exeter.ac.uk and a reduced service is offered during the vacation (tel 01392 264381).
- **Email Counselling:** A professional online counselling is available to all students during term time. Students can get in touch by following this link: e-counselling@exeter.ac.uk. More details on how the service works are then forwarded to anyone expressing an interest. This facility can be particularly helpful for students who can't easily attend sessions in person or don't want face-to-face counselling.

Programme Module Descriptors

The HI CBT Programme Descriptor can be found here:
https://www.exeter.ac.uk/study/postgraduate/courses/psychology/pgdipptpr_hicbt/

Module descriptors for the programme can be located on the following pages:

PYCM037:
https://www.exeter.ac.uk/study/studyinformation/modules/info/?moduleCode=PYCM037&ay=2023/4&sys=0
PYCM038:
https://www.exeter.ac.uk/study/studyinformation/modules/info/?moduleCode=PYCM038&ay=2023/4&sys=0
PYCM039:
https://www.exeter.ac.uk/study/studyinformation/modules/info/?moduleCode=PYCM039&ay=2023/4&sys=0
PYCM040:
https://www.exeter.ac.uk/study/studyinformation/modules/info/?moduleCode=PYCM040&ay=2023/4&sys=0

Reading list for all HI modules

The reading lists can found on your course ELE page, including electronic reading lists with links to electronic books and journals via the University library.

Useful websites and links

- Competencies: **https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/competence-frameworks-0**
- NHS Talking Therapies: **https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/**
- Referencing: **https://owl.purdue.edu/**
- BABCP – **https://www.babcp.com/Default.aspx**

Supervision Guide

Throughout the course, trainees receive supervision from supervisors within the university and from their workplace-based supervisors. Please see the Supervision Guide below for details of supervision and a link to Using Supervision Competences. Should there be any difficulties that arise within your supervisory relationship, in the first instance please try to work with your supervisor to address these. If difficulties continue, please discuss this with your 1:1 tutor, a Clinical Lead or the Programme Lead.

https://cedar.exeter.ac.uk/media/universityofexeter/schoolofpsychology/cedar/documents/hiiapt/COMPETENCES_ability_to_make_use_of_supervision.pdf

Overview of Supervision and Assessment of Clinical Practice

As part of the programme, you will receive two hours of university-based group supervision a week, which will be held either at 10.30am - 12.30pm on Tuesday mornings or at 2.30pm – 4.30pm on Tuesday afternoons. University supervision will be fortnightly over 2 years for part-time trainees. You will also receive weekly individual supervision from your workplace supervisor. Over the course, you need to have received a minimum of 70 hours of supervision and 200 hours of supervised CBT practice.

Please note that when calculating your supervision hours for your Clinical Portfolio, it is recognised that time spent in group supervision offers greater value than simply calculating the time spent on an individual's case, and dividing the overall time spent in the group by the number of participants.

The BABCP recommends using the following two calculations:

1: Time spent discussing a particular case in group supervision is multiplied by two.
For example, if there are three participants in a two-hour group, 30 minutes might be spent discussing each case.

30 minutes x 2 = 60 minutes' equivalent case supervision time.

This calculation should be used for the 'Client Summary Sheet'.

2: Overall group clinical supervision equivalent time is calculated in the following way: The time spent in the group is divided by the number of participants in the group, and this time is then doubled.

For example, if there are 3 participants in the group, and the group meets for two hours; the formula would be 2 hours divided by 3 people = 40 minutes x 2 = 1 hour 20mins equivalent group supervision time.

This calculation should be used for the 'BABCP Supervision Log'.

By the end of the course, you need to have seen at least 8 completed cases (seen for 5 sessions or more from start to completion/termination of treatment) and have received 5 hours minimum of supervision, **from a supervisor who is a BABCP accredited therapist**, on each of these cases. The University will provide the supervision for up to 3 of these cases and there should be a focus on one client per term (one client every two terms for part-time trainees).

3 of these 8 cases must be closely supervised. This means they will need to have been formally assessed using video or live practice observation of your clinical sessions and assessed by the university to be to a reasonable standard of CBT competency in accordance with the Cognitive Therapy Scale – Revised (CTS-R). There will be a formative CTS-R assessment of your CBT competencies in assessment & formulation skills at the end of term 1. There will 3 summative CTS-R assessment of a full therapy session demonstrating CBT competencies submitted during the course. 1 of the 3 closely supervised **cases must be a client with PTSD and 1 must be a client with depression.**

Your Supervisors

University - there will be a rotation of University Supervisors so that you will have one supervisor for Term 1 and another Supervisor for the duration of Terms 2 & 3 (for part-time trainees supervisors may change for year 2). Your University Supervisor will provide you with intensive skills-based supervision, helping to develop your CBT competencies. They will supervise up to 3 clients during the training.

Workplace - your workplace based supervision will involve skills-based and caseload supervision. The workplace supervisor will hold an overview of all your clinical cases. They will also support you in applying CBT theory to your cases and will be able to support you in working in your clinical setting and dealing with clinical issues such as risk.

Both University and Workplace supervisors will be providing a dual function in their role as supervisor. They will facilitate your development as Cognitive Behavioural Therapists through skills-based supervision. They will also assess your competency as a CBT therapist via CTS-R assessment and provide Supervisor Reports at the end of each term (see Supervisor Report for details of competencies being assessed). They will be offered training in the requirements of supervision and the clinical assessment associated with the programme and will also be offered ongoing continued professional development (CPD) in CBT supervision.

Both your Workplace and University based clinical supervisors will liaise about your progress at least once per term (once every two terms for part-time trainees). They are requested to attend the Leads and Supervisors Meeting held at the university each term and may liaise again around the time of preparing your Supervisor Reports.

We have provided a supervision contract for you and both your supervisors to work through during your initial meetings to help you discuss and agree the nature and content of your supervision (Supervision Contract is available on ELE). This will form the Supervision Contract between yourself, University Supervisor and Workplace Supervisor. You are responsible for ensuring the contract is completed, signed and presented in your clinical portfolio.

Supervision Feedback

We have provided the Helpful Aspects of Supervision Questionnaire (HASQ, Milne 2008) supervisee feedback form on supervision which can be a useful tool to help you review supervision with your supervisor. During each term we ask you to provide feedback to your supervisor by using the Supervisory Relationship Questionnaire (SRQ, Palomo et al., 2010). At the end of each term, we ask you to provide feedback on your experience of University supervision for that term on Accelerate. If you have any concerns about your cases or with supervision please do raise these with your supervisors in the first instance, or then with a Clinical or Programme Lead if necessary.

Your Role as Supervisee

In addition to filling in the clinical and supervision logs and reports, you will also need to think about your role as a supervisee. This will include coming prepared for your supervision (using the Supervision preparation form and Supervision template); preparing a Supervision Question; reviewing recordings of sessions in advance and locating the section of the recording that relates to the Supervision Question, supervision goal/CBT skill you are wanting to develop; keeping notes on discussions in supervision and carrying through jointly agreed action points. In addition to preparation time during the week, you will have 1 hour dedicated to supervision preparation prior to your university supervision session each week, from either 9.30 - 10.30am for morning supervision groups and 1.30 – 2.30pm for afternoon supervision groups. Consent to record forms for clinical and supervision sessions are available on ELE.

In order to develop a reflective approach to the work you carry out and link theory, practice and supervision, a Reflective Practice log can be used to aid you in this process. Additionally, this may help you when writing your Case Reports and CTS-R Reflections as you will have

ongoing records of learning experiences from teaching, SP/SR blogs, your clinical work and your discussions/experience in supervision.

Assessment of Clinical Practice

Supervision Reports

At the end of terms 1 and 2, both university and workplace supervisors will complete formative supervisor's reports. You will need to submit these at the end of terms 1 and 2. For part-time trainees these reports will be completed and submitted at the end of term 2 and by Easter of year 2. You must submit your supervisor reports via PDF document. Please note that all supervisors reports must be hand-signed. Digital signatures are also accepted. If a signature cannot be provided or is typed, the supervisor must email the report to the programme Administrator as confirmation of their signature, and copy you in so that you can provide evidence of this in your clinical portfolio.
You should keep the original copies of your reports.

Clinical Portfolio

At the end of the course each programme member is required to submit a clinical portfolio which will include: your supervision contracts, Summative University and Workplace Supervisors' Reports and Supervision Logs.

Guidance on the Use of Supervision

In order to ensure that you make the most effective use of supervision we suggest you read this guide and the criteria included within the supervisors' reports. In addition we have included below some suggested content of supervision and supervision methods and topics. Please also see the suggested plan for supervision sessions over the course above.

Content of supervision

- Content of supervision will focus on acquisition of knowledge, conceptualisation and clinical skills within a cognitive behavioural model(s).
- Associated issues will also be discussed when it is relevant to do so e.g. medication, hospitalisation, case management.
- Identification (and collaborative change of these if appropriate) of supervisee thoughts, attitudes, beliefs and values and the impact of these on therapeutic and professional behaviour.
- Discussion and working through relationship and process aspects of supervision.

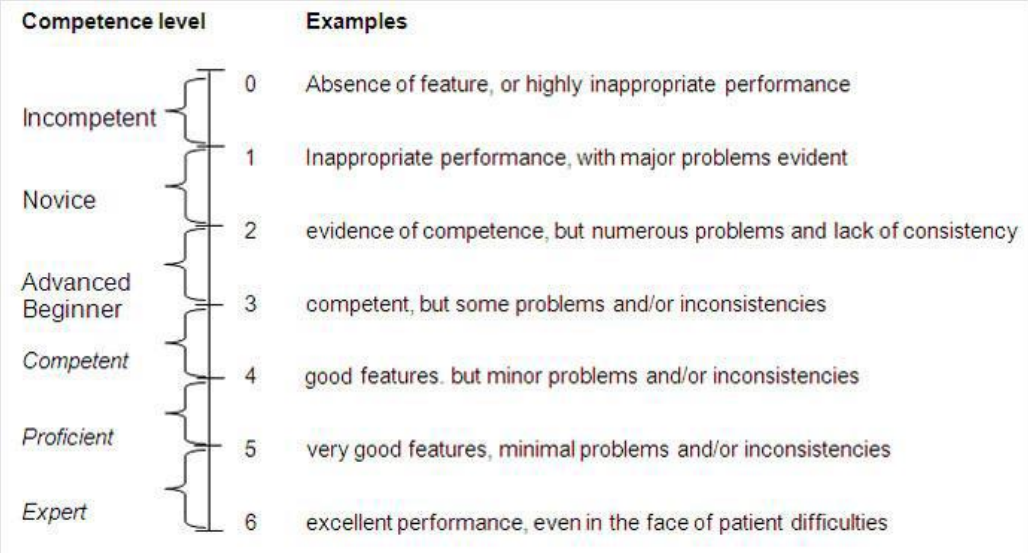
Supervision Methods and Topics

- Discussion of therapeutic relationship and engagement issues.
- Case conceptualisation/formulation.
- Rehearsal of therapeutic techniques e.g. simulation, role-play.
- Discussion about therapeutic strategies.
- Case Presentations.
- Homework.
- Review of video recordings
- Direct observation of practice
- Identification of supervisee thoughts, attitudes, beliefs with exploration of the impact of these on therapeutic and professional behaviour.
- Review of risk and therapist/service user safety.
- Review of clinical guidelines/manuals/protocols.
- Review of psychoeducational material.
- Experiential exercises.
- Reflective practice
- Other strategies as agreed.

Formative Supervisor Reports

To assist with assessment of your ability to use supervision and your competence, strengths and areas for improvement, the adapted Dreyfus scale (1989), as used with the CTS-R (2001), will be used as a guide to facilitate feedback on competency.

Incompetent: The therapist commits errors and displays poor and unacceptable behaviour, leading to negative therapeutic consequences.
Novice: At this level the therapist displays a rigid adherence to taught rules and is unable to take account of situational factors. He/she is not yet showing any discretionary judgement.
Advanced Beginner: The therapist treats all aspects of the task separately and gives equal importance to them. There is evidence of situational perspective and discretionary judgement. **Competent:** The therapist is able to see the tasks linked within a conceptual framework. He/she makes plans within this framework and uses standardised and routinized procedures.
Proficient: The therapist sees the patient's problems holistically, prioritises tasks and is able to make quick decisions. The therapist is clearly skilled and able.
Expert: The therapist no longer uses rules, guidelines or maxims. He/she has deep tacit understanding of the issues and is able to use novel problem solving techniques. The skills are demonstrated even in the face of difficulties (e.g. excessive avoidance).



Scoring system example

Summative Supervisor Report

CBT Supervision indicators to help the supervisor reflect and comment on each aspect of supervision before marking each section on the report as 'Satisfactory' or 'Unsatisfactory'.

Ability to use supervision

Please comment on the trainee's ability to use supervision and the supervisory relationship Please consider the following in relation to the trainee's skills & attitudes in relation to supervision:

- Attendance – regular/punctual?
- Completed supervision contract?
- Able to present material in an accessible way – to the supervisor & other supervisees
- To give a clear presentation of the client, to enable the group to gain a clear understanding of the clients presenting difficulties
- Demonstrate preparation for supervision: selected section of a recording/supervision question that relates to this
- Appropriate supervision question – reflecting relevant clinical issues & relevant to trainees learning
- Openness to feedback from the group
- Demonstrate ability to reflect on & learn from action points
- Ability to implement action points into clinical work & demonstrate this in the following supervision
- Ability to participate fully in the group supervision process and demonstrate professional practice within this setting – including: listening skills, respect of others in the group, showing empathy to others in the group & providing constructive criticism

- To demonstrate self-awareness: ability to recognise own thoughts, feelings, assumptions, beliefs and potential impact on the therapeutic an supervisory relationship
- Use of relevant paperwork prior to & during supervision
- Able to follow up on any homework tasks set from supervision e.g. reading up on a specific model
- Learning in supervision reflect trainees goals in their supervision contract

Areas of competency/strengths

Please comment on the following areas:

Assessment and Formulation

Please comment on the trainee's ability to:

- Identify key areas for assessment in a cognitive behavioural context
- Organise assessment detail according to diagnostic criteria
- Demonstrate an understanding of the relationship between assessment & formulation
- Ability to complete 'hot cross bun'/maintenance formulation
- Ability to complete a developmental/longitudinal formulation & access the relevant information from the client
- Conduct a thorough risk assessment – with appropriate follow up
- Demonstrate use of generic and problem-specific clinical measures
- Able to collaboratively agree SMART goals – reflected in the formulation
- Consider engagement issues and therapeutic alliance
- Awareness of any potential difficulties that may arise, e.g. literacy, communication difficulties
- Have an understanding of the clients suitability for CBT, within the service that they are able to offer

Use of Theory

In order to help supervisors assess the ability of the trainee to appropriately apply theory to practice, whilst also appropriately deviating from protocol when necessary, it is suggested that the following questions could help structure the assessment of this:

- Which model have you used/is informing your practice?
- What is the rationale for your choice of model?
- How do your interventions relate to this model and your client's goals for treatment?
- What is your rationale for the interventions?

It needs to be clear that trainees are applying their learning from the course direct into their clinical work and not 'relying on', or 'resorting to' using existing skills, or skills from another form of intervention.

Also, as appropriate, asking trainees to do HW on the theory that they are using with their clients and bringing this to supervision to discuss in relation to their client and to share with peers.

Techniques and Skills

Please comment on the following:

- The trainee's ability to select appropriate intervention, relevant to the model and stage of therapy
- The trainee's ability to be flexible in the use of a range of both cognitive & behavioural techniques used/observed, e.g. DTR's, BE's, ERP, Positive data log, etc.
- Demonstrate a creativity with the use of techniques
- Implementation of techniques appropriate to the clients goals for therapy
- The trainee's ability to demonstrate a range of skills used/observed in the process of therapy, e.g. agenda setting, negotiating homework