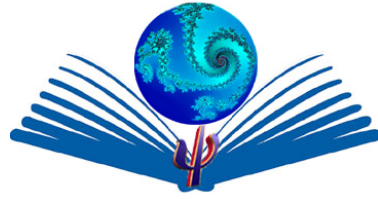


International Institute for Cognitive Therapy



STUDENT HANDOUT

**DIPLOMA IN COGNITIVE
BEHAVIOURAL THERAPY**

Belfast

Northern Ireland

www.learncognitivetherapy.com

September 2010

STUDENT HANDOUT

DIPLOMA IN COGNITIVE BEHAVIOURAL THERAPY

INTERNATIONAL INSTITUTE FOR COGNITIVE THERAPY

Belfast, Northern Ireland

1. Overview and Goals of the Diploma in CBT

To teach students to achieve the level of knowledge and clinical skills required to operate effectively as psychological therapists, using evidence based Cognitive Behaviour Therapy methods routinely in their work.

The Goals of the training programme are as follows:

1.1 Attain the level of theoretical knowledge required to practise as a cognitive therapist

- Acquire a solid understanding of the theoretical basis of cognitive therapy. This includes the generic cognitive model of emotional disorder and models specific to common mental health issues (anxiety, depression, anger, guilt, jealousy)
- Appreciate how theory, research and clinical practise further the development of cognitive therapy by disbursing new information
- Employ established models and treatment protocols; deduce from research and clinical literature the appropriately altered models and treatment protocols to meet the needs of each individual patient
- Review the empirical basis of cognitive therapy for different psychological disorders

1.2. Develop formulation and therapy skills:

- Evaluate, formulate and treat a minimum of 8 patients/clients with cognitive behavioural therapy for the duration of the course. Clinical cases will be selected according to recommendations provided from the course Director and taking into account the appropriate level of complexity to meet individual learning requirements
- Establish a sufficient number of cognitive behavioural skills and apply them in clinical practise
- Cultivate an ability to apply these skills when working with patient/client groups and to difficult interpersonal relationships in their own workplace
- Inculcate and maintain warm, respectful, collaborative relationships with patients/clients, and develop the ability to comprehend and ameliorate difficulties in the therapeutic process (conflict, both patient and therapist issues) within the cognitive behavioural framework.
- Identify and resolve difficulties in practice, whether arising from theoretical, practical, interpersonal, personal or ethical problems (to be done under supervision)

2. Admission Requirements

Candidates will be expected to comply with the following entry criteria:

2.1. ESSENTIAL ENTRY CRITERION

The applicant must have studied the Certificate in CBT run by the International Institute for Cognitive Therapy prior to applying for the Diploma in CBT. Students accepted in the Diploma will have a minimum of 50 hours of specialist CBT training at Certificate level or higher taught by a recognised CBT trainer. Any previous CBT training not delivered by a BABCP accredited CBT therapist/trainer will not count towards accreditation within BABCP for the requirement of “minimum amount of 200 hours of CBT training” as the trainer is not recognised by the BABCP.

Those who have studied the Certificate in CBT within the International Institute for Cognitive Therapy will have accumulated from 50-70 hours of face-to-face CBT training from which 35 hours are theory and 35 hours practice. Study time to complete the Certificate in CBT was around 56 hours. No examinations were required to obtain this qualification, although this will change for 2010.

If you received your CBT training elsewhere than at the IICT, you are required to attach the handbook of your training with your application form (tutor led hours, syllabus, objectives, course contents ...). In order to be eligible to study the Diploma in CBT, your previous training should be equivalent to the level obtained by the Certificate in CBT organised by the IICT, in contents, depth, and amount of hours. If you were accepted in this training programme is because the Director of the Institute deemed that your qualifications, experience, and personal abilities met the minimum entry requirements for you to apply for the programme.

2.2. AND ONE of the following:

A) Typical health, social care or other relevant professional qualification with any of the following core professions: Psychology (Clinical psychology, Counselling psychology, Educational psychology, Forensic psychology, Health psychology, Occupational Psychology Sport & Exercise Psychology), Nursing (Mental Health Nursing, Learning Disability Nursing, General Nursing), Medicine (Psychiatric Medicine, General Practice), Others (Occupational Therapy, Counselling [e.g. BACP, COSCA], Social Work, Probation Service, Teaching, Clergy).

B) Applications from those who do not hold an Honours degree in a relevant subject as above will be considered e.g. Psychology (without specialisation) , if they have experience working in mental health or social care services and have studied a minimum of a Diploma in Counselling.

Students who successfully complete the course are awarded a Diploma in Cognitive Behavioural Therapy by the International Institute for Cognitive Therapy. The Diploma is designed to contribute substantially towards professional accreditation of eligibility to practise cognitive therapy.

3. Content of the course

The Diploma in CBT is mainly concerned with common mental disorders in adulthood, particularly anxiety and mood disorders. However, additional topics such as anger, guilt, jealousy, health anxiety, and personality disorders will be addressed as part of the course.

The Diploma in Cognitive Behavioural Therapy consists of 18 days of training (126 hours). There are 10 modules in the course. Each module is comprised of 14 hours over a 2 day period with the exception of the module about personality disorders and health anxiety. These modules will be limited to 1 day (7 hours each). The Diploma in Cognitive Behavioural Therapy does not have a research component.

Participants in this programme can expect to augment their current CBT knowledge by increasing their competency in the following areas:

- Module 1: CBT for OCD
- Module 2: CBT for Depression
- Module 3: CBT for anger, jealousy and guilt
- Module 4: CBT for social anxiety
- Module 5: CBT for Panic disorder and agoraphobia
- Module 6: CBT for Personality disorders
- Module 7: CBT for Health anxiety
- Module 8: CBT for Post-traumatic disorder
- Module 9: CBT for Generalised Anxiety disorder
- Module 10: Advanced CBT skills – Practical weekend

Students are asked to give written feedback on each teaching session, each monthly supervision and on the course as a whole. The course Director will analyse the questionnaires and take action where appropriate.

This course is taught on one weekend per month (Saturday and Sunday, from 10 am to 6 pm. Group supervision takes place from 5 pm to 6 pm, on each Saturday and Sunday during the last hour of class. The course will commence in September 2010 and will end in May 2011.

Each candidate will have a minimum of 50 hours of CBT instruction taught by a recognised CBT trainer who studied at the IICT or elsewhere. Therefore, on completion of this Diploma, students will have a minimum 200 hours of face-to-face CBT training (between the Certificate in CBT and Diploma in CBT from IICT) required by the BABCP for accreditation taught by recognised BABCP CBT therapist/trainer. Each module has been designed to offer students 50% of theory with the remaining 50% of the module dedicated to practising and improving CBT skills.

Diploma students will have to read scientific journals that are provided for each training module. Students will also be required to complete exercises for each topic in order to develop their CBT skills and self-reflective practice. All exercises to be completed will be found on the handout of the module.

Estimated amount of study time required to cover one module is around 25 hours. Therefore, a minimum of 225 hours of study time and time spent on exercises will be required in order to be properly prepared to pass the final examination and write the 2 case studies at the end of the course.

4. Programme timetable at a glance

MODULE	DATE
Module 1: CBT for Obsessive Compulsive Disorder	11/12 September 2010
Module 2: CBT for Depression	9/10 October 2010
Module 3: CBT for Panic disorder and agoraphobia	6/7 November 2010
Module 4: CBT for anger, jealousy and guilt	4/5 December 2010
Module 5: CBT for social anxiety	15/16 January 2011
Module 6: CBT for Personality disorders	12 February 2011
Module 7: CBT for Health anxiety	13 February 2011
Module 8: CBT for Post-traumatic disorder	5/6 March 2011
Module 9: CBT for Generalised Anxiety disorder	2/3 April 2011
Module 10: Advanced CBT skills – Practical weekend	7/8 May 2011

5. Structure of the course

Each class is structured in a way that lectures and practical exercises are interwoven. Participants will practise their new skills through experiential learning and clinical case presentations. There will also be seminars, where trainees role-play designated therapeutic encounters to develop core practise skills and awareness of associated theory. Participants will be able to watch and listen to many videos and audio recordings of real clients. Students will be directed to read current literature and to access relevant learning resources.

One hour of group supervision will be provided at the end of each class (from 5 pm to 6 pm).

6. Training Venue

Belfast International Youth Hostel
22-32 Donegall Road, Belfast, BT12 5JN
Tel. +44 (0) 2890315435, Email: info@hini.org.uk
<http://www.hini.org.uk/hostels/belfast.cfm>

7. Physical Resources at the Institute for Cognitive Therapy

The training room can comfortably hold 40 people. Only 25 students are accepted in the Diploma each year. The room is adequately ventilated and lit. Appropriate heating is available during the cold season. The room is not accessible to the general public circulating around the venue. The location is extremely quiet with no internal or external noise, not even traffic.

There is a parking lot nearby. Disabled people will have easy access to the building.

Presenters use the latest technology in their classes. Powerpoint Presentations are displayed with a projector; audio recordings of clients are digitalised and shown to the class with subtitles to enable students to easily follow the conversation. Video recordings are in digital format, with subtitles and displayed through the projector. A clear sound system with external speakers is provided for each class. The volume is sufficient for the size of the room

8. Coursework and Examinations

8.1. Components to be assessed

1. **Theoretical Knowledge through Examination:** Students will have to pass a True/False exam with 450 items at a passing grade (65%). Items about basic Cognitive behavioural principles covered during the Certificate in CBT will also be included in the exam. Exam will contain questions from the reading materials recommended even if they haven't been covered in class.

Examination will take place on 7th May 2011 and it will take 3 hours.

2. **Evidence based Practice through Clinical Case Reports:** Students enrolled in the Diploma are required to write TWO clinical reports describing clinical cases they have treated during the course. The cases should be presented in the context of reference to the relevant theory and research. In addition, they should be referenced in comparison to assigned clinical literature whether or not the topic was discussed in class.

The first clinical report should be submitted on 5th March 2011 and the other on 8th May 2011. Case reports are between 3,000 and 4,000 words at a passing grade (60%). Case reports include: references to relevant literature, a description of the patient, a cognitive-behavioural formulation of the case in a graphical manner, a treatment plan demonstrating knowledge of appropriate cognitive therapy interventions, an evaluation of outcome, roadblocks encountered, supervision provided for that case, and a concluding discussion. Both clinical cases should show an advanced understanding of evidence-based practice in relation to the patient's problem.

Students are required to write the reports without grammar or spelling mistakes. Students whose first language is not English should place special attention to this requirement. Grades will depend on the written papers being properly expressed.

3. **Clinical Practice through Supervisor's Report:** A crucial assessment objective of the Diploma in CBT is to be able to achieve satisfactory ratings of clinical competency. This is assessed by your clinical supervisor.

Clinical Supervisors will assess each student's clinical competency based on the Cognitive Therapy Scale. This scale is a recognised professional measure of cognitive therapy performance. The evaluation uses a 15 to 20 minute audiotape or videotape of the client/ patient interaction in each supervised session. Where audio/ video recordings cannot be used [e.g. therapist only works with foreign clients], demonstrations of role-play will have to be carried out during each supervised session for those 8 clients who require close supervision for the previously stated reasons.

A student will not be able to obtain the qualification unless the supervisor's report indicates that the trainee has progressed satisfactorily (an average of 3.5 from the CTS-R) taking into account the last three supervised sessions).

Trainees will fail the entire course if the supervisor's report is not satisfactory even if the two case reports and exam have been passed. If a student fails this part, he/ she is eligible to obtain the Diploma after one year providing the next supervisor's report shows the necessary improvement at the required level (3.5 in the CTS-R averaged for the last 12 months). Your Student Handbook Pack contains a copy of the **Cognitive Therapy Scale-Revised** and a template of the **Supervisor's Report** that your individual supervisor will use to assess your clinical work and that should be completed by **8 May 2011**.

The student is further advised that she/ he will fail the Diploma if she/ he misses more than 20% of group or individual supervision for the duration of the course i.e. More than 4 hours of group supervision or more than 4 individual supervision sessions for the duration of the course.

In order to assess the student's clinical competence, the Director of the Institute will inspect the supervision logs provided by the individual supervisor in addition to consideration of the final supervisor report.

8.2. Marking Scheme

All written assignments are marked "blind". Marks are assigned as "Fail" (less than 60%) or "Pass". A "Fail" is awarded when a trainee fails to achieve these criteria.

To ensure that marking is blind, only the Student Representative of the course will have access to reference number and name corresponding to each student.

8.3. Marking Criteria of the clinical case reports

- Demonstrate proficient knowledge and understanding of cognitive therapy's theoretical base
- Discuss relevant literature professionally
- Demonstrate critical judgement and independent thought
- Demonstrate a thorough understanding of the clinical implications of theory and research

- Student has integrated theoretical and clinical learning
- Expresses ideas in a clear, concise way
- Complies with the specified task as assigned
- Required presentation of clinical report observes academic conventions to include adequate editing, proofing, grammar, punctuation, spelling; appropriate use of footnotes, references and bibliography; deliver the case on the due date; deliver it in the required length
- Demonstrate proficiency in devising, , effectuating and evaluating focused, coherent cognitive therapy treatment programmes incorporating a range of cognitive-behavioural methods
- Appraise the competence in reflecting and learning from practical experience

You can read more about what BABCP requires from Case Studies (**Appendix 1**). You can also see a sample of a case study submitted for accreditation written by John Dunlop (BABCP Accredited CBT therapist) (**Appendix 2**)

8.4. To earn the Diploma in Cognitive Therapy, students are also required to complete:

- Weekly therapy sessions with a minimum of two cognitive therapy patients/clients
- 25 hours of private study for each module selected (225 total hours for all modules of the Diploma)
- Attend 80% or more of scheduled teaching and supervision sessions. Meeting this requirement enables the student to attain the qualification (minimum of 1 hour of individual supervision per month) and attend the 2-hour monthly group supervision)

8.5. Presenting the Case Reports after the due date or failure to complete the Examination/ monthly supervision (group or individual)

A student unable to submit all required work on the specified dates is required to report that fact to the Director of the International Institute for Cognitive Therapy. In exceptional situations only, the Director may see fit to allow a postponement for a student [this is only in cases of severe illness or similar level of emergency]

9. Attendance

Students are required to attend a minimum of 80% of scheduled teaching and supervision sessions to receive the qualification. An attendance register is kept to assure that this mandatory attendance is met. A maximum of 4 classes may be missed (4 of the 18 total number). Missing more than 4 classes in total will disqualify the student from qualification.

In the case of a missed session, the student must follow the missing class online. The Director of the Institute will provide the student with a personal username and password

to access this training platform. Exercises and tests must be completed and submitted to John Dunlop (one of the tutors of the Institute) for the module student was unable to attend. This is compulsory to qualify for the Diploma.

10. Clinical Supervision

10.1. Individual Clinical Supervision

10.1. 1. Clinical Supervision Criterion by the BABCP

The British Association for Behavioural and Cognitive Psychotherapies (BABCP) recommends that ***“The supervision of the clinical practice should be carried out by individuals who are accredited as individual CBT practitioners by BABCP. Although the amount of supervision received can vary, only trainees who have received at least five hours supervision on at least eight cases (covering three problem types) would be likely to meet Minimum Training Standards for supervision of cases. In addition, three of these 8 clients should be considered to be ‘closely supervised’ (see below for more details of these criteria)”***.

BABCP defines “Close supervision” as follows:

- a. That the case work has been formally assessed using audio, video or live practice and assessed to a reasonable standard as judged by a recognised CBT assessment scale or other form of assessment of quality. The Institute requires that individual supervision is assessed by the Cognitive Therapy Scale- Revised (2001)
- b. That the work has been supervised by a BABCP accredited individual therapist. The Institute recommends that only accredited BABCP CBT therapists supervise your clinical work to avoid future problems if trainee wants to become accredited by BABCP.
- c. Where group supervision takes place, hours in group supervision is not considered to be equivalent in hours spent to that carried out in individual supervision (although its importance is acknowledged). Time spent in group supervision has to be calculated by the time spent discussing the client in question during supervision and multiplying this by 2. For example, if there are 4 participants in a group supervision session each discussing 1 case, 15 minutes might be spent discussing each case. This should be multiplied by 2 making 30 minutes of supervision on this case (this attempts to take into account the importance of group discussion when this may not be directly about the case in question). Where supervision is delivered in a group format only, access to individual must be provided by the course. You are likely to be in a group with 6 other students, therefore each 1-hour group supervision would be equivalent to 20 minutes counting towards your individual supervision.
- d. That the work is assessed by written case work and/or mandatory log book, which is then formally assessed by the course Director. You can print the mandatory supervision log book from file called **“Logbook for Supervision”** included in your Student Handout Pack (**Appendix 3**)

Cases defined as non-closely supervised should meet all of the criteria except for Criterion a.

10.1.2. Guidelines for Individual Supervisors

The International Institute for Cognitive Therapy recommends to students that the following requirements be met to ensure compliance with BABCP criteria for close supervision for the duration of the course:

- 1- Supervisor to be a BABCP CBT therapist
- 2- A minimum of 8 hours supervision for the duration of the Diploma in CBT (the course will provide the equivalent to individual 40 minutes per month from group supervision (6 participants per group X 1 hour = 10 min per participant X 2 = 20 min X 2 session of 1 hour = 40 min). At the end of the course participants will have around 6 hours from group supervision).
- 3- It is compulsory to receive personal supervision for at least 1 hour per month for the duration of the course (9 hours). The total amount of supervision hours (group and individual) will be around 15 hours for the entire duration of the course.
- 4- Students should be able to work with 8 clients with at least three different problem types. These eight cases will be closely supervised. A minimum of 5 sessions with each client/patient is required (less than 5 hours of sessions for one client- will not be considered towards the 8 minimum amount of clients that BABCP recommends)
- 5- A mandatory log book for supervision is provided with this Student handout for the student and clinical supervisor to record amount of supervision per month. This log will be submitted three times a year (November, February and May) by the student.
- 6- Supervisors are required to submit a report about the progression of the student in clinical practice based on the CTS-R completed after each supervision session. Such report should be sent to the Director of the Institute at the end of the course in June 2010. A template of the Report can be found in the Student Handout Pack (**Appendix 4**). The supervisor will also have to average the scores of the 12 items of the last three CTS-R and write about the result in the final report. A minimum of 3.5 should be averaged in order to pass the Diploma in CBT. An example of a Supervisor report is included in this pack (**Appendix 5**).
- 7- Students are encouraged to have at least 200 hours of clinical practice for the whole duration of the course (September to June]. However, working with 3 clients a week X 30 weeks, students will have a minimum of 90 hours of clinical practice. You may need more time to complete the 200 hours required by BABCP for accreditation purposes; you can plan how many sessions you can realistically work until you meet this requirement.
- 8- Students are required to write a case report (3000-4000) words about two out of the minimum 8 cases "**Closely supervised**" that they should have treated during the duration of the course. Criteria to assess these cases are against the recommendations established by the BABCP.
- 9- Supervisors need to become familiar with the use of the Cognitive Therapy Scale Revised (**Appendix 6**). Your supervisor must read the Manual of how to use the scale. Such manual can be found in your Student Handout Pack (**Appendix 7**) as well as two examples: One from the trainee (**Appendix 8**) and the other from the supervisor (**Appendix 9**)

10.1.3. Role of the CBT Clinical Supervisor established by the International Institute for Cognitive Therapy

The Clinical supervisor is expected to:

- Comply with the BABCP Clinical Supervision protocol
- Administer a minimum of one hour of clinical supervision/support per month (ideally 1.5 hours a month or more)
- Help you select four clients suitable for your necessary skill development (You can find the suitability criteria from document called “Letter from Employer” that you will find in your Student Handbook Pack)
- Read the course handbook , including the guidance for supervisors (section 10.1.2)
- Liaise regularly (once a month minimal) with the course leader to address student progress through each step of the course. Act on individual student needs
- Evaluate your practise formatively by using the Cognitive Therapy Scale- Revised (2001), and cumulatively during the clinical practice assessment
- Provide support and guidance to students when needed
- **FOLLOW ALL INSTRUCTIONS PROVIDED WITHIN THE SUPERVISION PACK (STUDENTS SHOULD READ DOCUMENT TO KNOW MORE ABOUT THE SPECIFIC ROLE OF SUPERVISOR)**

10.2. Group Supervision

John Dunlop, Sylvia Buet, and Paul Quinn will be offering group supervision to students once a month for two hours (from 5 pm to 6 pm each Saturday and Sunday after class). A total of 18 hours of group supervision was included in the fee of the Diploma in CBT. Individual supervision is not included in the fee.

11. What else will I have to do to obtain accreditation within the BABCP after I complete this Diploma in CBT?

The Diploma will provide a significant component of the current requirements for accreditation as a CB Therapist by the British Association of Cognitive and Behavioural Psychotherapies (BABCP) – but those applicants who may eventually wish to take this path should note that:

- 1- **CLINICAL PRACTICE:** A substantial amount of additional supervised clinical CBT experience in particular will be required to fulfil BABCP accreditation criteria e.g. if you only conducted 90 hours of clinical sessions for the duration of the course, you still need to accumulate another 110 hours after finishing the Diploma before you can apply for accreditation within the BABCP.
- 2- **CLINICAL CASE REPORTS:** Complete two more clinical case reports at the same academic level as you completed during the Diploma, which should have achieved a minimum mark of 60% for a passing grade.

- 3- **QUALIFICATIONS:** You will need to provide photocopies of all your qualifications, including the Certificate in CBT (or equivalent study) and Diploma in CBT that you have completed at the IICT.
- 4- **MINIMUM TRAINING BY A RECOGNISED TRAINER:** BABCP requires you to have 200 hours of CBT training by a recognised trainer and another 250 hours of CBT training through self-study, attending workshops, conferences, etc. Therefore, you should be able to meet the requirement of the BABCP for minimum training received in CBT (200 hours) by a recognised trainer and the remaining hours of CBT training as well by studying both Certificate and Diploma in CBT at the IICT.

All members of staff working at the Institute have a minimum of a BABCP accreditation as CBT therapist. The Director of the Institute and main lecturer is also a BABCP accredited CBT trainer.

If you completed the Certificate in CBT at the Institute, your face-to-face CBT training is 56 hours for those who completed this programme in 2007 and 70 hours for the year 2008. This Diploma gives you 126 hours of CBT training. Trainees will have a minimum of 200 hours of CBT training at the end of the course combining the hours studied between the Certificate (or equivalent qualification) and the Diploma in CBT.

- 5- **OTHER CBT TRAINING:** BABCP also requires 250 hours of CBT training apart from the minimum 200 by a recognised CBT trainer. The Certificate and Diploma levels should meet this criterion as the commitment to study and practice skills outside class has been taken into account and between the Certificate and the Diploma self-study and CBT practice/self-reflective skills should not be less than 280 hours.
- 6- **TIME SPENT ON SKILLS DEVELOPMENT/THEORY:** The courses (both Certificate and Diploma) have been designed to provide both knowledge and skills with a ratio of 1:1. Study time and practical tasks should have had a similar ratio.

The exercises to complete at home should take a similar amount of time as reading the theoretical materials.

- 7- **SUPERVISION:** Your individual supervision should continue and include a minimum of 1 hour of supervision a month (using audio/video tapes/ role plays) in EACH supervision session in order to be considered “close supervision”. Your supervisor should also use a competency scale such as the “Cognitive Therapy Scale-Revised” and record each supervision session in a log book.
- 8- **CPD:** Ongoing Continuous professional development (CPD). A minimum of 30 hours a year should be spent on developing the knowledge and CBT skills e.g. by attending conferences, workshops, reading, watching CBT recordings, etc.
- 9- **CORE PROFESSION:** If you don't have a core profession as stated in point 2.2. of this Handout you be required to request BABCP accreditation through the KSA path. It is strongly advised that all prospective students look over the BABCP website (www.babcp.com) PRIOR to sending in an application. This is to ensure that they have a clear understanding of what the Minimum Training Standards for the Practice of CBT consist of. [NB: this advice applies to all potential applicants whether or not she/he intends to continue on to apply for BABCP accreditation. This information on the BABCP Training Standards is relevant to all students as it

is an overview of all CBT related skills and competence at all levels of achievement. This will provide the applicant with an excellent overview covering skills and competence essentially and allow he/she to gauge their qualifications for acceptance into the program.

- 10- To learn more about the two paths for accreditation go to <http://www.babcp.com/silo/files/provisional-accreditation-guidelines-feb09-rev.pdf> if you have a core profession as stated in point 2.2. Or visit this link if you need to obtain your BABCP accreditation through the KSA route <http://www.babcp.com/silo/files/ksa-criteria-and-guidelines-june-2006.pdf>

12. How students gain Clinical Practice

Students will be required to work with at least 2-3 clients (ideally 4-6) on a weekly basis from assessment to completion or termination of therapy over the duration of the programme. Students have the responsibility to seek suitable placement by themselves. It is assumed that applicants are qualified and experienced clinicians with their clinical work taking place at their normal place of employment with the acknowledgement and support of their line managers.

The Institute supplies a letter for applicants to share and discuss with their employer for the purpose of he/she providing us with recommendations as to the types of clients the potential student should or should not treat. The **letter for your employer (Appendix 10)** is included in your Student Handbook Pack. It is mandatory that this letter be presented to the person referring your clinical cases for the purpose of the Institute ascertaining that the Director's recommendations are followed.

Trainees should also hold a professional indemnity insurance before the course starts if insurance is not covering their clinical placement e.g. Howden Professionals (www.howdenpro.co.uk). You need to provide a photocopy of this insurance to your employer if you are not covered in your placement.

Course staff is available to support learning and to help students to cope with the considerable psychological and practical demands of the course.

13. Student Representation

Student Representation creates a structure to ensure that students' views are heard. The International Institute for Cognitive Therapy is committed to receiving and responding to student feedback in order to bring about improvement in the quality of the student experience and development of learning and teaching within the institution.

An important role of the Student Representative is to make sure that marking is blind by keeping the names and the reference of each student from the examiner. A student will be elected to this position on the first day of the course.

14. Course Fees and Cancellation Policy

£3995 is the total cost of the Diploma in Cognitive Behavioural Therapy. Coffee breaks, handouts, support materials and group supervision are all included in the fee. Lunches and accommodations are not.

Handout materials for each module are sent by email a few days before each class. It is the responsibility of the student to print the appropriate handouts.

The maximum amount of students will be 25.

If you wish to withdraw from the course, the following refund policy will be applied:

- * On or before 1 August 2010: 80% refund.
- * Between 2 August 2010 and 15 August 2009: 70%
- * Between 16 August and 30 August 2010: 50%
- * 31 August 2010 or later: No refund

If you wish to withdraw from the course you should notify the International Institute for Cognitive Therapy in writing.

The Institute is unable to refund all or part of the tuition fee in case of withdrawal due to illness of the student during the course. Students are advised to take out appropriate insurance to cover this eventuality. Insurance is also required to cover flights or/and accommodations if lecturer is absent due to illness. In this case the class would be postponed until further notice.

Long term absence of the lecturer (more than 1 month) will result in a replacement presenter who will teach for the remainder of the course. In the case of this development no refunds will be issued.

15. Cancellation of a Weekend Training

Sometimes, it is unavoidable to cancel training events due to weather conditions or illness of the presenter. In those eventualities, that training will be rescheduled or taught in its entirety online with more video demonstrations to watch than the usual amount we could cover in class, some exercises to be completed and corrected by the tutor and a self- If you get sick with flu, it is recommended that you stay home from work or class and limit contact with others to keep from infecting them.

16. Teaching, Group Supervision and Support Members of Staff

The Diploma in Cognitive Behavioural Therapy will be presented by **Sylvia Buet**, the founder and Director of the International Institute for Cognitive Therapy, **Paul Quinn**, **Marla Stromberg**, and **John Dunlop**. **All presenters at IICT are BABCP accredited Cognitive Behavioural Psychotherapists. Sylvia Buet is also a BABCP accredited Trainer in CBT.**

SYLVIA BUET

Sylvia is a registered Psychologist, accredited by the British Association for Behavioural and Cognitive Psychotherapies (BABCP) as a Cognitive Behavioural Psychotherapist. She

has gained accreditation within the BABCP as a Trainer in CBT. Sylvia founded the International Institute for Cognitive Therapy in the UK. She has successfully provided CBT training in a wide range of topics related to Cognitive Behavioural Therapy (CBT) for the past three years. Sylvia spent several years as a popular CBT lecturer at University of Ulster in UK.

Sylvia trained at University of Valencia (Spain) earning her BSc. Hons. Degree in Psychology in 1991. She holds a Masters degree in Counselling & Guidance and a Post-Graduate Diploma in Human Resource Management. Both were earned at University of Ulster (UK). Additionally, Sylvia is a Level II EMDR practitioner since 2003.

Sylvia was the former founder of the International Trauma Institute. She and Dr. Mervin R. Smucker, provided training to mental health professionals in PTSD and related conditions on a global basis, training in PTSD and related conditions to mental health professionals from around the world.

Among other accomplishments, Sylvia is a regular presenter at International Conferences. Her main interests are Post-traumatic Stress Disorder, Obsessive Compulsive, Panic disorder and relationship dissolution. She is the main presenter of the International Institute for Cognitive Therapy for the Certificate and Diploma in CBT training programmes. Examine her CV at your leisure. You will find it included in your Student Handbook Pack (**Appendix 11**)

PAUL QUINN

Paul trained at undergraduate level at the University Of Ulster Jordanstown obtaining a BSc (Hons.) in 1995. He then travelled to the University Of Dundee Scotland in 1996 obtaining a postgraduate Diploma with Distinction in Cognitive Behavioural Psychotherapy.

In 1997 he also trained as an EMDR therapist obtaining certificates at level I and level II. In 2000 he returned to Scotland and completed his Masters MSc. in Cognitive Psychotherapy at the University of Dundee. In addition he has also undertaken specialist training in DSM IV (1994) guide to diagnosis.

Since 1999 he has been involved in the teaching, training, and supervision of various mental health professionals at The Queens University Belfast, University of Ulster Jordanstown and Magee campuses.

He is an accredited BABCP Psychotherapist and specialises in the treatment of Depression, anxiety disorders and PTSD.

Paul will be presenting two topics for the Diploma in CBT: A two-day training workshop on depression and another two days on Social Anxiety. He will also be in charge of group supervision. You can read his CV as it is included in your Student Handbook Pack (**Appendix 12**)

MARLA STROMBERG

Marla Stromberg is a BABCP accredited Cognitive Behavioural Psychotherapist and is registered with the UKCP.

She currently runs a private practice in London, providing individual CBT as well as supervision to therapists in training and to recently qualified therapists.

Before going into full-time private practice, Marla held a post in the NHS in London (2006-2007). She worked on the Newham Demonstration Site of the IAPT (Improved Access to Psychological Therapies). The Improving Access to Psychological Therapies (IAPT) programme is aimed at supporting Primary Care Trusts in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders.

Marla was one of seven therapists employed to work on the pilot project, providing CBT assessments and treatment to a population who would normally have difficulty accessing mental health services.

Prior to this post, Marla worked in the private sector, running CBT groups for Anger Management, Panic Disorder, Body Dysmorphic Disorder and Depression. She also provided individual therapy.

Marla obtained her CBT qualification from the Middlesex Hospital, London in 1994. She attended University College London's Academic Department of Psychiatry. The UCL course was the first CBT course to be set up in the UK. It ran from 1970-2002. She trained under the well-known behaviour therapist and psychologist Vic Meyer.

She obtained her MSc in Experimental Methods in Psychology from UCL (University College London, 1992).

Marla's main interests are anger management, panic disorder, relationship problems and social phobia.

For the Diploma in CBT, Marla will be teaching a one-day workshop on Personality Disorders. She will supervise a group the weekend she is training and she is available as a supervisor if any trainee is interested in personal supervision with her in London or elsewhere.

JOHN DUNLOP

John Dunlop is a BABCP Accredited Cognitive Behavioural Psychotherapist who has in excess of seven years experience treating a wide spectrum of emotional and psychological problems.

John specialises in mood and anxiety disorders of a complex and usually comorbid nature. His expertise encompasses depression, panic attacks, GAD (generalised anxiety disorder), social anxiety, low self-esteem, PTSD, sexual problems, jealousy and anger issues. John holds the Diploma in Therapeutic Counselling and obtained his BABCP accreditation through the KSA route. In addition, he trained as an EMDR therapist in 2005, obtaining both level I, II, and level III certificates.

John is currently working towards BABCP accreditation as a CBT supervisor. He will be assisting the Director of the Institute and Paul Quinn in monitoring the progress of students performing exercises and role-play in class. John will intervene with appropriate feedback to ameliorate difficulties as they arise.

John will be presenting specialist topics within the Diploma in CBT, particularly about GAD. His main involvement will be to provide students with group and individual supervision for the duration of the course. He is also in charge of correcting written exercises and quizzes from students, either face-to-face or online. Peruse his CV at your leisure as it is included in your Student Handbook Pack (**Appendix 13**)

17. BABCP Guidelines for Good Practice of Behavioural and Cognitive Psychotherapy

Trainees should ensure that they adhere to the BABCP Guidelines for Good Practice of Behavioural and Cognitive Psychotherapy during training. A copy of these guidelines can be found in your Student Handout Pack (**Appendix 14**)

18. Validation from University

The Diploma in CBT is not accredited by any University. However, the programmes run by the International Institute for Cognitive Therapy have been mentioned in the “Mapping of Psychological Therapies: Overview of courses available in Northern Ireland and the border region of the Republic” (2008). This report was issued by the NICCT on behalf of the Department of Health, Social Services & Public Safety (DHSSPS).

The intended purpose of the mapping is to locate and report on the range of psychological therapies available to the public in Northern Ireland. The Diploma in Cognitive Behavioural Therapy has the distinction of being one of the only four CBT training programmes in the region that offers CBT training with similar equivalence to a Post-Graduate Diploma programme.

Some private programmes have the same prestige as some Universities offering advanced training in Cognitive Behavioural Therapy leading to accreditation within the British Association for Behavioural and Cognitive Psychotherapies (BABC). The International Institute for Cognitive Therapy offers quality training facilitating participants to become accredited Cognitive Behavioural Therapists. The IICT programmes meets several criteria established by BABCP for accreditation.

Academic Programme

19.1. COGNITIVE BEHAVIOURAL THERAPY FOR OCD

Presented by Sylvia Buet, MSc

BABCP Accredited Cognitive Behavioural Psychotherapist and Trainer in CBT

This workshop will provide clinicians with the advanced therapeutic techniques to effectively make an accurate diagnosis, conceptualise and treat obsessive compulsive disorder using cognitive behavioural therapy. Particular focus will be placed on how clinicians can improve well-established exposure-based treatments which have been unsuccessful for certain types of OCD.

The course provides an overview of the nature of obsessive compulsive disorder, its clinical features, and how empirically-based interventions are applied in practise. Participants will also have the opportunity to learn about recent theoretical advances in

the treatment of OCD to enable them to deal with more complex cases such as those with pure obsessions or mental rituals.

LEARNING OBJECTIVES

At the end of the workshop participants will learn how to:

- 1- Diagnose obsessive compulsive disorder
- 2- Make a differential diagnosis
- 3- Develop Case formulations for OCD
- 4- Engage and motivate clients to stay and engage in therapy
- 5- Manage comorbid disorders commonly associated with OCD
- 6- Use various psychometric tools for OCD
- 7- Correctly apply Exposure and Response Prevention for the different types of OCD
- 8- Devise effective behavioural experiments in combination with other CBT interventions
- 9- Develop advanced therapeutic skills to deal with pure obsessions
- 10-Apply different arguments to cognitive restructuring faulty appraisals for sexual and aggressive obsessions
- 11-How to deal with mental rituals and develop creative interventions to address them.
- 12-Overcome roadblocks in using CBT treatments e.g. using exposure, when clients reach a plateau, when other comorbid disorders may interfere with the treatment of OCD, etc.

19.2. COGNITIVE BEHAVIOURAL THERAPY FOR DEPRESSION

Presented by Paul Quinn

BABCP Accredited Cognitive Behavioural Psychotherapist

Since the early 1960's and early 70's most Psychological interventions focussed primarily on behavioural-based treatments for anxiety disorders. Somehow depression was not thought the appropriate target for such interventions as it was deemed a more biological state and thus less responsive to psychological treatment. The development of Psychotropic drugs had appeared to confirm this theory.

However two authors Beck and Ellis released significant papers to begin challenging this theory. Beck 1963, 1964 (Archives of general Psychiatry) proposed new cognitive theories and therapy for depression. Again, in 1979 a publication by Beck et al (1979), Titled coping with depression proved ground breaking in providing a protocol for treating depression using a psychological model. Since this time numerous outcome trials (RCTs) have proven its clinical effectiveness in the treatment of mild, moderate and even severe episodes of depression.

With Depression affecting somewhere between 5-10% of the population with lifetime prevalence reported at some 25% with women twice as likely to experience it than men psychological therapies are proving an effective measure in managing this condition.

This highly evidenced based and practical workshop will cover a range of CBT assessments and interventions for depression with active participation throughout.

LEARNING OBJECTIVES

This two-day workshop will cover:

- 1) Introduction to DSM- IV-TR (1994) criteria for depression including identifying mild, moderate and severe depression. We will examine Safran and Segals' (1990) suitability criteria for treatment as well as comorbidity, prevalence, risk factors and associated emotions to depression such as guilt anger and shame.
- 2) A detailed overview of Beck's (1967, 1976) cognitive model for the theory and treatment of depression will be illustrated.
- 3) Assessment including risk assessment will be demonstrated with routine Psychometrics to further aid our assessment.
- 4) A detailed case formulation of how to conceptualise a presentation of a major depressive disorder will follow including the consideration of roadblocks to effective treatment.
- 5) Current protocols for treatment using Beckian therapy will be considered alongside references made to other clinicians such as Padesky's (1995) and Leahy's (2000) treatment plans and interventions for depression. This will include how to do activity scheduling, tracking of negative automatic thoughts, setting up behavioural experiments and challenging core beliefs.
- 6) Relapse preventions and Blueprints for recovery schedules will be considered including behavioural activation models.
- 7) Current research including NICE guidelines for depression will be critically appraised.

19.3. COGNITIVE BEHAVIOURAL THERAPY FOR GUILT, ANGER AND JEALOUSY

1 day – SOCRATIC QUESTIONING FOR GUILT PROBLEMS

1 day – SOCRATIC QUESTIONING FOR JEALOUSY AND ANGER

Presented by Sylvia Buet

BABCP Accredited Cognitive Behavioural Psychotherapist and Trainer in CBT

This workshop will help participants to enhance their CBT skills to deal with guilt, anger and jealousy more effectively. These emotions are commonly associated with an array of psychiatric disorders. The main focus of this workshop is to present innovative ideas and arguments about how to use cognitive restructuring to challenge underlying beliefs leading to guilt, anger and jealousy.

Guilt problems will be addressed during the first day of training from a purely cognitive perspective. Excess of responsibility is a feature leading to guilt present in disorders such as generalised anxiety disorder, obsessive compulsive disorder and depression, among others. More than 40 compelling arguments and cognitive interventions will be proposed. Participants will be able to easily derive questions from those arguments to modify clients' dysfunctional underlying beliefs that make them experience guilt.

The second day of the training will cover anger and jealousy combining both cognitive and behavioural interventions. A new integrative cognitive behavioural model of jealousy (Leahy, 2008) will be presented and practised. Leahy conceptualises jealousy as a form of agitated worry. Participants will be able to design CBT intervention plans derived from formulations to address jealousy following guidelines provided.

The emphasis of the second day of training will be placed on providing participants with enhanced skills to use Socratic questioning more effectively with these emotions. Many innovative arguments for challenging underlying beliefs leading to anger and jealousy will be explained and practised.

LEARNING OBJECTIVES

At the end of the workshop, participants will learn how to:

1. Make an assessment of anger, jealousy and guilt and define when these emotions are symptoms of psychiatric disorders
2. Identify themes and cognitive distortions associated to anger, guilt and jealousy
3. Develop case formulations for guilt, anger and jealousy problems
4. Become more creative in developing questions to challenge underlying assumptions and beliefs with the aid of more than 40 arguments and cognitive interventions
5. Become familiar with Leahy's model of Jealousy

19.4. CONTEMPORARY COGNITIVE BEHAVIOURAL APPROACHES TO TREATING SOCIAL ANXIETY

Presented by Paul Quinn

BABCP Accredited Cognitive Behavioural Psychotherapist

Social anxiety sometimes referred to as social anxiety is classified as the third most common Psychiatric disorder with only major depression and alcoholism having a higher lifetime prevalence. Clinically significant social anxiety prevalence rates are reported globally between 7-13%.

Social anxiety most commonly develops in early childhood and adolescence (Schneider et al 1992) and if left untreated follows a chronic and unremitting course. Comorbidity with other mental health disorders, particularly depression, is often reported with many misdiagnosed at first point of contact with mental health services.

Recent psychological models have proved effective in the treatment of this common problem with early models by Hartman (1983, 1986) providing the platform for Wells and Clark (1995) more advanced cognitive model.

This workshop will be highly practical and evidence based providing participants with a wide range of CBT interventions for the assessment and treatment of Social anxiety.

LEARNING OBJECTIVES

This 2-day workshop will cover:

- 1) Introduction to DSM-IV-TR (1994) criteria for social anxiety differentiating between the generalised and specific types. In addition, the DSM-IV-TR (1994) diagnostic criteria of avoidant personality will be considered.

- 2) Assessing for clinically significant social anxiety using Psychometric tools such as the Social phobia inventory (SPIN) (Connor et al., 2000) and the Fear of Negative Evaluation (FNE) (Leary, 1983) scales.
- 3) A detailed cognitive behavioural assessment will be demonstrated to include the development of Social anxiety, genetic traits, family environment and life experiences.
- 4) A detailed examination of Wells and Clarks (1995) model for social anxiety will be considered asserting that an individual's appraisals, attentional strategies and safety behaviours serve to maintain the condition. Furthermore, an individual case conceptualisation will be derived from a case study using the above model.
- 5) Treatment plans and interventions using Wells and Clarks (1995) model will be applied as well as references to other specialist authors Hope et al (2006) treatment for managing social anxiety.
- 6) We will consider current thinking in the field and examine individual versus Group treatment and how video feedback is an integral component of treatment.
- 7) A blueprint for recovery will be developed to consider longer-term relapse prevention strategies.

19.6. COGNITIVE BEHAVIOURAL THERAPY FOR PANIC DISORDER AND AGORAPHOBIA

Presented by Sylvia Buet

BABCP Accredited Cognitive Behavioural Psychotherapist and Trainer in CBT

Community surveys indicate about 7–28% of the normal population will experience an occasional unexpected panic attack (Brown and Cash, 1990; Wilson et al., 1991). However, not every person experiencing panic attacks develops panic disorder. The UK prevalence is only around 2%. According to Clark's model, the main reason why the rate is lower than the number of people who experience panic attacks is because there is a relatively enduring tendency in those suffering from the disorder to misinterpret bodily sensations perceiving an imminent danger with catastrophic consequences at psychological, social, or physical levels.

Cognitive behavioural interventions have received the most empirical support for the treatment of PDA. However, clinicians still continue to struggle to deal with this type of disorder. Clinicians need to be adequately trained to become more skillful in applying more contemporary Cognitive models for the treatment of panic disorder and agoraphobia.

This workshop will provide a comprehensive overview of the assessment, conceptualisation and treatment of panic disorder and agoraphobia. Different theoretical models of panic will be presented and contrasted, and their application to the assessment and treatment of panic considered. Particular attention will be paid to the design and implementation of behavioural experiments in the treatment of panic, which will include guidelines for effective symptom-induction techniques. Core elements of PD and

agoraphobia, as catastrophic misinterpretation of bodily symptoms, safety behaviours and actual avoidance will be appropriately dealt with.

Participants will have the opportunity to watch videos or listen to audio recordings of real clients addressing different CBT interventions to deal with common panic sensations such as palpitations, dizziness and fear of fainting, lightheadedness, breathlessness, fear of choking, derealisation and depersonalisation, fear of losing control of bladder or bowels, etc.

LEARNING OBJECTIVES

At the end of the 2-day workshop participants will learn:

- 1- To provide participants with the theoretical foundation to diagnose, conceptualise and treat PD/A including: Diagnosis of Panic disorder with/without Agoraphobia, psychometric tools and structured interviews to assess PD, maintaining factors, effectiveness of CBT for PD and agoraphobia, medication and CBT, nocturnal panic attacks, how to deal with comorbidity, how to minimise dropouts ...
- 2- Learn about the two main CBT models of Panic Disorder (Oxford protocol vs. Albany protocol), similarities and differences.
- 3- Be able to draw different cognitive behavioural case formulations of panic and agoraphobia depending based on case studies provided.
- 4- Correctly apply CBT interventions covered during the course for the treatment of Panic Disorder and Agoraphobia (discussion techniques, cognitive restructuring, and behavioural experiments).

19.5. COGNITIVE BEHAVIOURAL THERAPY FOR PERSONALITY DISORDERS

Presented by Marla Stromberg

BABCP Accredited Cognitive Behavioural Psychotherapist

Patients with personality disorders (PD) are amongst the most challenging to treat. Moreover, in out-patient settings they can constitute up to 50% of a clinician's caseload. Although cognitive-behavioural therapy (CBT) has been shown to be effective in treating a wide range of psychological problems (depression, anxiety) there is limited outcome research into the effectiveness of CBT for personality disorders. Many of the studies are uncontrolled (no comparison group) whilst only a small number are controlled. The existing results are mixed with some studies suggesting that patients with a diagnosis of one or more PD's do improve with CBT based interventions (Felske et al, 1996; Marchand et al, 1998; Mavissakalian & Hamman, 1987) and other studies suggesting that the presence of a personality disorder results in little or no improvement (Turkat & Maisto, 1985). It is important to bear in mind that these findings are based on standard cognitive therapy techniques and not therapeutic techniques tailored to the specific needs of personality disordered patients. Beck et al (2004) suggest that we may see more positive responses to treatment if we modify our treatments to address the specific challenges presented to us by our patients with PD's.

In order to maximise treatment effectiveness, standard cognitive therapy techniques need to be modified in order to best help these individuals with long-standing personality problems. In this workshop, participants will be taught how to adapt standard cognitive behavioural techniques to their work with personality disordered individuals.

LEARNING OBJECTIVES

This one-day workshop will cover:

- 1) An introduction to the diagnostic criteria for Personality Disorders (ICD-10 and DSM-IV); describe the general characteristics of the three personality disorder clusters; an understanding of the complexities of the diagnostic issues surrounding PD's: (stability versus instability); an overview of the more common assessment instruments-are they adequate/reliable/valid; describe the key clinical features of all ten DSM-IV TR personality disorders.
- 2) How to make clinical decisions like "prioritising" when depression and anxiety are present- what to do when co-morbid problems present themselves; developing cognitive conceptualisations of personality disorders
- 3) An overview of the main cognitive, behavioural and experiential techniques used in treating individuals with PD's; an understanding of the dysfunctional assumptions these patients live their lives by; understanding which core beliefs/schemas tend to be associated with which personality disorder; an emphasis on schema work (in contrast to work on automatic negative thoughts).
- 4) Understanding the importance of the therapeutic relationship in working with PD patients; the challenges that come with working with PD patients.
- 5) What modifications to "standard cognitive therapy" need to be made when working with these patients; specifically, the modifications required for specific personality styles.

19.6. COGNITIVE BEHAVIOURAL THERAPY FOR HEALTH ANXIETY

Presented by Sylvia Buet

BABCP Accredited Cognitive Behavioural Psychotherapist and Trainer in CBT

Many people are unduly worried about their health. Health anxiety is a broad term which refers to difficulties ranging from milder worries about somatic symptoms to full-blown hypochondriasis, which involves the fear of having a serious medical disease or the belief that one has such an illness which persists despite medical reassurance. Excessive health anxiety can be complex and difficult to treat. However, Cognitive Behavioural Therapy has now been shown to be an effective treatment for hypochondriasis in several randomised controlled trials.

The purpose of this workshop is to review the current state of knowledge about the aetiology, assessment, case formulation, and treatment of hypochondriasis. Many roadblocks and difficulties will be highlighted and discussed during the course of this training. Particular emphasis will be placed on showing participants how they can adapt common cognitive restructuring methods to this type of problem. It is a challenge to use CBT interventions with patients suffering from persistent health anxiety because

retribution techniques have the potential to provide reassurance to them and perpetuate their disorder. Four treatment components will be covered during the training: cognitive modification strategies, response prevention, exposure to feared health problems, and exposure to themes related to death.

LEARNING OBJECTIVES

At the end of the 1-day workshop, participants will learn how to:

- 1) Describe the important clinical features of excessive health anxiety, with an emphasis on hypochondriasis and its differential diagnoses
- 2) To complete an initial assessment
- 3) Develop a cognitive-behavioural case formulation and treatment plan for selected cases
- 4) Identify external stimuli and maintaining factors, including catastrophic bodily interpretations
- 5) Use psychometric tools to assess health anxiety and death fears
- 6) Identify and modify maladaptive health-related beliefs
- 7) Design behavioural experiments
- 8) Help the patient discontinue reassurance and safety-seeking behaviours including attending unnecessary medical investigations or avoidance of anxiety-provoking stimuli
- 9) Design an effective relapse prevention programme

19.7. COGNITIVE BEHAVIOURAL THERAPY FOR PTSD: A HEURISTIC PTSD ASSESSMENT MODEL TO MAXIMISE TREATMENT EFFECTIVENESS

Presented by Sylvia Buet

BABCP Accredited Cognitive Behavioural Psychotherapist and Trainer in CBT

Trauma outcome studies have consistently found that the most effective treatments for Post-traumatic Stress Disorder are Cognitive Behavioural Therapies focusing on emotional processing of traumatic material. However, these empirically-supported treatments still fail for a high percentage of individuals. Recent estimates indicate that up to 58% of trauma patients who complete CBT are still diagnosed with PTSD at post-treatment (Resick, 2002; Tarrier, 1999), and that only 28% of patients in "real world" CBT clinical practises are successful completers of exposure therapy (Zayfert et. al., 2005).

In this workshop, participants will be offered a new heuristic model that aids the decision making process of clinicians when they need to match the best possible CBT intervention for the specific trauma characteristics of their patient. Buet's (2007) heuristic model is an expansion of Smucker et al's algorithmic model where a decision chart has been developed to help clinicians reduce failures in treatment. This new assessment heuristic model provides a guideline to match the specific trauma characteristics of the client with the best available CBT interventions.

A range of CBT approaches are extensively covered in this training program, in theory and practice, including Exposure Therapy and a new Cognitive Therapy model for PTSD (Ehlers' and Clark's, 2000).

LEARNING OBJECTIVES

This 2-day workshop will cover:

- 1) Introduction to trauma and PTSD: Diagnostic criteria for PTSD, limitations with the current definition of trauma, comorbidity, prevalence, types of trauma, PTSD risk factors, PTSD predominant emotions, current status of research on PTSD and effectiveness of CBT treatments.
- 2) Symptom management and stabilisation techniques when trauma processing work is not recommended.
- 3) An innovative heuristic PTSD assessment model to help clinicians in their decision making process about what interventions to use, for whom, when and in what order e.g. when to focus on stabilisation vs. trauma processing, assessment of predominant emotions, how to adapt CBT interventions depending on comorbidity.
- 4) How to maximise the effectiveness of Prolonged Exposure and how to overcome possible roadblocks in its application e.g. when client is dissociated
- 5) Ehlers and Clarks' Cognitive model for PTSD (2000) – How to use reliving to uncover and reappraise trauma meanings.

19.8. COGNITIVE BEHAVIOURAL THERAPY FOR GENERALISED ANXIETY DISORDER

Presented by Sylvia Buet and John Dunlop
BABCP Accredited Cognitive Behavioural Psychotherapists

CBT is now considered the only consistent and empirically supported form of psychotherapy for Generalised Anxiety Disorder (GAD). It has demonstrated the greatest overall improvement across studies, especially at 1-year follow up. However, failure rates can be as high as 60%. There are many difficulties that clinicians need to overcome to be able to help clients with this problem: One of them is the high rate of comorbid disorders associated with GAD. Studies of clinical samples have found that over 75% of patients with a current principle diagnosis of GAD have other co-occurring anxiety or mood disorders (Brawman-Mintzer et al., 1993; Brown & Barlow, 1992; Massion et al., 1993).

The emphasis of this workshop will be placed on identifying and preventing possible roadblocks which may hinder progress in therapy when dealing with this type of population.

LEARNING OBJECTIVES

At the end of this 2-day workshop, participants will have learned how to:

- 1) Describe the important clinical features of Generalised Anxiety Disorder and their differential diagnosis
- 2) Differentiate between normal and pathological worry

- 3) Different CBT approaches to treating GAD e.g. Metacognitive therapy vs. Standard Cognitive therapy
- 4) Complete an initial assessment
- 5) Develop a cognitive-behavioural case formulation and treatment plan for selected cases.
- 6) Use psychometric tools to assess Generalised Anxiety Disorder
- 7) Help patients discontinue the use of reassurance and safety-seeking behaviours and other maintaining factors
- 8) Apply cognitive therapy methods specifically for GAD and worry
- 9) How to make CBT treatments more effective and overcome possible roadblocks
- 10) Design an effective Relapse prevention programme

This course uses a range of effective teaching methods with a mixture of formal presentations, video demonstrations, case presentations, role-play and group discussions. This training program is eminently practical in facilitating development of the necessary therapeutic skills although all exercises will be carried out in a safe, non-threatening classroom environment.

19.9. ADVANCED CBT SKILLS

Taught by Sylvia Buet and John Dunlop

Practical weekend to practise advanced CBT skills covered within the Diploma in CBT.