



**Trinity College Dublin**

Coláiste na Tríonóide, Baile Átha Cliath

The University of Dublin

## **Foundation Course in Cognitive Behavioural Psychotherapy**

**Course Handbook for Students  
2019-2020**

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## Welcome to the Foundation course

We would like to welcome you to the Trinity College Dublin (TCD) Foundation Course in Cognitive Behavioural Psychotherapy (CBT). We accept that CBT principles are widely available, and each student will have had a different level of exposure to these principles. We therefore hope that you will find the course sufficiently stimulating, challenging and interesting. There may be as many reasons for taking up the course as there are students. We hope that you will come out of the course with a sense that you have learnt enough to use in your everyday work and to allow you to make an informed decision about the role you would like CBT to play in your private and professional life.

We recognise the difficulties involved in completing any course whilst working full or part-time. There is a lot of information to take on board in this course and it can be an emotional and frustrating experience. The self-practice and self-reflection components for example, will be new to a lot of trainees and can raise a lot of emotions and awareness of uncomfortable feelings. Though we can assure you that you will not be alone in having these feelings, do not hesitate to approach us should this become difficult to manage. Collaboration is one part of the core principles of CBT, so experience this by participating in as much of the lectures, reflection and self-practice as possible and we aim to play our part by guiding you through it. Do not hesitate to give us feedback so that we can continue to develop the course and teaching methods.

## Aims of the Foundation Course

The trainee completing the foundation course will be able to use CBT models and theory to inform their current practice without becoming a qualified cognitive therapist. The trainee will therefore develop a good understanding of CBT principles and their application but without the rigours of clinical assessment. Clinicians such as medical doctors, psychiatrists, psychologists, mental health nurses, social workers, social care workers, occupational therapists, physiotherapists and counsellors/psychotherapists from other modalities may find this course helpful as a way of using the principles to inform their current practice without becoming cognitive behavioural psychotherapists.

The foundation year will aim to provide a platform from which trainees can make decisions about how to use CBT and how far they want to take CBT training. The aims are therefore to:

- develop confidence in using principles of CBT in current practice
- improve the dissemination of CBT theory
- start to practice low-intensity delivery of the cognitive behavioural models (CBM)
- prepare trainees for the clinical Post-Graduate Diploma year (if eligible)

### Note:

- ***Trainees cannot call themselves cognitive behavioural therapists after this course and cannot practice as cognitive behavioural therapists in Ireland.***

## Attendance Requirements

Students are expected to attend at least 70% of all teaching days. This means a full day, from 9.30am to 4.30pm. Naturally you will gain more from the course if you exceed the minimum, and again the expectation is that you will attend every week. Students are welcome to attend and complete all 4 modules but must complete assessments for at least 3 of the modules to be awarded the Certificate of Completion of the Course.

## Course Structure

The course will be over an academic year. It will comprise attendance at and completion of assessments for 3 of the 4 modules available. This will translate to 15 days of tutor led study days which run from 9.30am – 4.30pm. To facilitate time off work due to trainees being in full-time employment, the structure will include a 3-day block at the start of each module and 2 further days roughly 3 – 4 weeks later. The workshops are facilitated where possible in the Medical Teaching Centre at St Patrick's University Hospital. See timetable for details. The course is run as an extramural course within the Discipline of Psychiatry, Trinity College Dublin in collaboration with St Patrick's University Hospital. The certificates of completion will be awarded by St Patrick's University Hospital and Trinity College Dublin. These certificates of completion are generally posted to students in August.

## Course Objectives

Learning objectives for the course are that the trainees will have:

- a sound grounding in cognitive behavioural principles
- confidence in using the CBT Model in client focused clinical decision making
- The following modules will be taught:

### **Module 1: Introduction to CBT Theory, Psycho-education & The Collaborative Therapeutic Relationship**

After completing this module, students should be able to:

1. understand the literature informing CBT
2. appreciate the use of collaborative therapeutic alliance in CBT
3. understand and be able to utilise Socratic dialogue in clinical practice
4. understand the accepted CBT session structure
5. understand basic principles of focusing a session by setting and following a clear concise and realistic agenda
6. understand the appropriate use of psychoeducational material
7. be able to socialise the patient to the CBT model

## **Module 2: Behavioural Tasks, Goal Setting, and Homework**

After completing this module, students should be able to:

1. understand how to incorporate appropriate psycho-educational material into therapy
2. understand a range of cognitive and behavioural strategies including behavioural activation and activity scheduling, Identify and prioritise clear and appropriate therapy goals
3. negotiate homework with clients, explain the underlying rationale and anticipate potential obstacles to completion

## **Module 3: CBT Case Conceptualisation & Cognitive Behavioural Change Methods**

After completing this module, students should be able to:

1. understand theory underpinning case conceptualisation in CBT
2. know longitudinal conceptualisation of how their problems developed
3. understand theoretical models of change
4. understand how to plan for behavioural and cognitive change
5. understand how to identify NATs and the use of thought records
6. challenge unhelpful thinking patterns, assessing evidence, responsibility pies, continuum / perspective of others and looking at common cognitive errors and devising simple behavioural experiments

## **Module 4: CBT informed practice for Psychosis**

After completing this module, students should be able to:

1. understand theory underpinning the use of CBT in psychosis
2. understand and manage the challenges of therapeutic engagement in psychosis
3. understand how to use normalisation and the stress-vulnerability model with individuals with psychosis
4. understand how to assess and conceptualise what maintains and triggers psychotic experiences for each individual
5. understand how individuals might better cope with experiences such as hallucinations, delusions, and negative symptoms
6. understand challenges in the treatment of psychosis including cognitive impairment, and risks of aggression and suicide.

### **Course outline**

The first module will focus on basic *CBT theories*. This will include learning theories and models behind the behavioural and cognitive interventions. By the end of the module the trainee should have an idea of basic CBT assessment including the use of scales/psychoeducational material and how we use CBT Theory to help build effective Therapeutic relationships.

The second module will start to consider *treatment planning* in relation to anxiety and depression. The focus will be on the *disorder specificity* of the CBT model. The idea of this module is that the student will start to think about applying some of the theory from Module 1 to anxiety and depression-based disorders that may be encountered in clinical practice. At the end of this term the student should start to understand and accurately assess some *Axis 1* disorders and to formulate a treatment plan. We will start to consider some interventions for working with these disorders. Alongside applying the CBT model to patients, students are introduced to the concepts of self-practice of the CBT model and the role of reflective practice for health professionals.

The third module will focus mainly on basic *models of change* in CBT. The trainee will start to develop an understanding of basic CBT interventions, why and how they work. Practice in the application of such interventions in the classroom will be through role-play and self-practice. As you develop some of these CBT “micro-skills” we anticipate that you will be able to use and practice these in your own work context and become competent in sensitively intergrating them into your clinical practice.

The fourth module will focus on developing CBT informed skills for working with individuals with Psychosis. Students will develop an understanding of the engagement process and the role of normalisation and the the stress vulnerability model. Students will be encouraged to use the CBT model to conceptualise what can trigger and maintain psychotic experiences and what strategies might help individuals to cope better with distressing experiences.

## Teaching methods

The teaching is intended to be interactive. There are three modules, each focusing on developing your knowledge of CBT and preparing you for applying that knowledge clinically. There are several components to this. Workshop facilitators are encouraged to use role-play, video and audio to model the principles.

1. Foundation Course-specific didactic lectures
2. Interactive teaching with discussions and video/audio examples
3. Group work and practice of applying CBT in simulated clinical situations
4. Self-practice – where you apply CBT principles to yourself
5. Reflection – where self-practice and lectures are reflected upon using a) group discussions and b) reflective diaries

## Assessments

End of Module 1 (Essay)

End of Module 2 (Reflective essay)

End of Module 3 (OSCE)

End of Module 4 (Case Conceptualisation)

1. **ESSAY** Trainees will submit an essay on theoretical aspect of CBT –max word count 1500 words (course contribution 35%)
2. **REFLECTIVE ESSAY:** Trainees will participate in SP/SR as a way of practicing interventions. They will write a reflective essay upon completion of the 2<sup>nd</sup> module (course contribution 35%).
3. **OBJECTIVE STRUCTURED CLINICAL EXAMINATION (OSCE):**  
End of module exam (course contribution 30%)
4. **CASE CONCEPTUALISATION:** Trainees will submit a CBT Case Concetualisation of an individual with psychosis – max word count 1500 words (course contribution 30%)

Overall pass required on each assessment is 50%. If a student completes all 4 modules the end of year mark will be made up of their highest 3 module scores.

## Late submission penalties for Essay, Reflective Essay and Case Conceptualisation

Initial 10% + 5% weekly thereafter, automatically failed if >4 weeks late. If the student fails, this assignment they be asked to resubmit within 5 weeks and all resubmitted pass scores are 50%.

## **OSCE failures**

If a student fails the OSCE or are absent for it, they will be asked to repeat it at the next available opportunity which will most likely be in the following academic year.

## **What is an OSCE?**

This is a type of examination designed to test clinical skill performance and competence in skills such as communication, collaboration and level of therapist knowledge of specific principles. It is aimed at assessing competence in clinical skill not theoretical knowledge.

## **How does it work?**

It will involve a circuit of 5 short (10 minute) stations. At each station, each candidate will be examined on a 1:1 basis by an impartial examiner. They will be expected to role-play a clinical situation with one actor per station. Each station will present the trainee with a standardized clinical situation. All trainees will be expected to complete all the stations on the circuit. It is recommended that students bring in paper/clipboard and pens to facilitate the collaborative completion of each OSCE. It is also permitted for students to bring in notes or some basic CBT information if they think it will help with the tasks set.

## **How is it assessed?**

Assessment is done using a standardized marking sheet with a detailed marking scheme. This will have a set of competencies that trainees will be expected to demonstrate. A mark will be allocated for each of the competences within each station on a 0 (area of real weakness) – 6 (area of strength). See appendix 1 for the marking sheet.

## **Competencies to be rated**

The 5 OSCE stations will test several competencies, including the following:

- Agenda setting
- Explaining the CBT model
- Goal setting
- Homework setting
- Developing a CBT Maintenance Cycle

## **Practice for the OSCES**

Regular teaching slots throughout the timetable will be used for the purpose of developing skills for the final OSCE exam.

## Reflective Log and Essay

A reflective essay is submitted after completion of module 2 and accounts for 35% of each student assessment. A hard copy of the assignment should be submitted to the course administrator by hand or left at the main reception of the hospital clearly marked for their attention. Electronic copies of this assignment will not be accepted. Students are advised to record SP/SR tutorial attendance, themes, homework tasks in the Self Focussed Practice Log. It would also be helpful to keep a reflective diary throughout the year to assist them with the end of year reflective essay. There will be a separate SP/SR Workbook provided at the beginning of Module 2 which should be brought to all SP/SR tutorials.

This Reflective Essay looks for students to reflect and write about their personal experiences throughout the course. It aims to assess your overall level of engagement with, and knowledge of reflection. There is some evidence that reflection has personal and professional impacts. There are now theories that attempt to explain its processes, along with specific models (e.g. Bennett-Levy's 2006 declarative procedural-reflective model). Reflection may have a moderating function through a bridging effect on self-practice, self-awareness and clinical theory and practice.

You may therefore wish to demonstrate how you have reflected, discuss the experience and its impact on you. Though this is a personal reflective piece, it is also an academic assignment. For this reason, you are expected to demonstrate and critically analyse your understanding and application of reflective theory, how reflection may/may not have helped to bridge your personal experience, the experience of the self-practice and CBT practice.

Reflection related learning has been associated with development of the 'self-as-learner' or the concept of a learning identity (Kolb and Kolb, 2009). As such, reflection has various impacts. Ultimately, through SP/SR one may develop a reflexive style of learning so that one develops a 'learner self'. This concept of 'self as learner' has been identified by many theorists (e.g. Kolb and Kolb, 2009) and encompasses the notion of a learning identity. Chaddock, Thwaites, Bennett-Levy and Freeston (2014) highlight the presence and importance of this concept of the "learner self" in SP/SR. Kolb and Kolb (2009) offer a clear explanation the concept of a learning identity, which links to reflective practice in stating that:

"People with a learning identity see themselves as learners, seek and engage life experiences with a learning attitude and believe in their ability to learn. Having a learning identity is not an either-or proposition. A learning identity develops over time from tentatively adopting a learning stance toward life experience, to a more confident learning orientation, to a learning self that is specific to certain contexts and ultimately to a learning self-identity that permeates deeply into all aspects of the way one lives their life."

The important point here is that one develops an identity of themselves, which has the potential for a broader impact than the learning from the specific subject of focus of the reflective practice. As such, reflective writing needs to offer evidence of how one has

reflected, what has been learnt or reinforced about the self-as-learner and as well as how this has been applied in the learner's wider life. This is in keeping with the DPR model (Bennett-Levy, 2006; Bennett-Levy, Thwaites Chaddock and Davis, 2009), which proposes that reflection is the engine of lifelong learning. For example: "Now, whenever I...I will/try to..." which shows internalisation of the reflective process.

It is therefore important that writing/essays demonstrate evidence of reflection on the different areas or features of the participant that can be impacted upon by SP/SR, which together comprise their sense of 'self-as-learner'. These features adapted from the works of Bennett-Levy and others are described below.

**Personal-self:** Bennett-Levy (2006) proposes that the personal-self develops prior to becoming a therapist. It encompasses the personal self-schema and personal developmental experiences (see Bennett-Levy, 2006 for a detailed explanation). As such the reflective essay should demonstrate evidence of reflection and learning on and about, the self. Among other evidence of learning, this may include evidence of development of self-awareness, links to developmental experiences, and evidence of any personal change due to the SP/SR. For example, "I am now more aware of/that..." "I no longer..." "I need to...", which may all be linked to specific SP/SR experiences and exercises. This can include clear and specific examples of application in own life outside of SP/SR practice.

**Therapist-self:** Once one undertakes therapy training, the new learning leads to the development of the therapist-self. This is different to the personal-self but can influence and enhance it and *vice versa* (Bennett-Levy (2006). SP/SR has been shown to impact on the therapist-self, by deepening the sense of knowing of concepts and procedures (Bennett-Levy, 2006), and potentially impacting on the therapist's use of skills. Reflective practice writing should demonstrate evidence of reflection on the impact of SP/SR on knowledge, skills and identity as a therapist. This includes knowledge of concepts and theories of therapy and the procedures, as well as factors such as empathy and other interpersonal skills. For example, "having done SP/SR, I... am now better able to...have a deeper understanding of..." All this should be linked to specific examples, such as "...when I did...I then...and realised that..."

**Knowledge of reflective processes and theories:** SP/SR is now a researched and structured approach, which is developing a strong theoretical basis, and growing evidence base (e.g. Bennett-Levy et. al. 2001). Best practices are emerging and being proposed (Thwaites et al., 2014), making it important that an SP/SR participant understands the theory basis and evidence for his/her practice. The reflective essay writing needs to offer evidence of reflection on knowledge of theories and models that inform the participant's reflective practice. Without this, the self-as-learner's continued enhancement of the personal- and therapist-self may be difficult to achieve. As such, the writing needs to show an awareness, and application of the theories and emerging best practices, as well as an awareness of the research evidence. For example, the writer may link reflection on any of the above features to specific SP/SR theories and research. They may discuss the importance of the level of engagement with SP/SR, the importance of goal setting, the need for awareness of issues of safety or the importance of reflecting with a peer and so on.

**The bridging effect:** Reflection has been hypothesised to work by bridging the participant's personal- and therapist-self learning (Bennett-Levy and Finlay-Jones, 2016). Without such a bridging effect, reflection and self-focused practice may separately impact on these various aspects of the 'self'. The reflective practice participant may run the risk of not developing in an optimal way. For example, one may develop a good sense of personal self-awareness from reflecting on the self, but not be able to link this learning to clinical practice, or *vice versa*. This makes it important to be able to demonstrate ability to integrate the personal and professional reflection. Amongst others, Smith (1985) writes of the importance of the congruence between the therapist's practice and 'who he is' as a person, in order to achieve optimal therapist functioning and reduce mechanical application of techniques. As such, the reflective writing should demonstrate evidence of reflection on the integration of personal and therapist-self as well as 'self' and patient experience. For example, writers can discuss how their personal experience led to increased understanding of the model, the patient, application of specific interventions etc. SP/SR bridged their personal experience and professional understanding and experience.

You will be rated on your assignment's level of clarity, depth of reflection, comprehension of reflective theory, specificity of personal examples and experience and the clarity of application of self-practice exercise to ideas or possibilities for future personal or professional change.

The essay needs to be informed by learning and reflections from the entire course. It should be logical and well-structured. Reference should be made to literature on reflection, and should support own learning, discoveries and discussion. The essay should be between 1,800 – 2,200 words. This will be marked by an external moderator and will not be read by the course staff. Students are advised to keep a reflective diary throughout the year to assist them with the end of year reflective essay.

The Reflective Essay Marking Scale and feedback sheet are included as an appendix.

### **Case Conceptualisation**

This assessment for Module 4 is used to demonstrate that the student can apply the theoretical model of CBT for Psychosis to an individual with whom they are working in their clinical setting. By its nature it is a written account of a clinical presentation, but it is understood that the understanding of how the conceptualisation has been developed will necessarily include some diagrammatic representation of the individual's experiences. A good conceptualisation will also include some reflection on the challenges and learning that have taken place in the process of working with the individual described. The Marking Sheet of the Case Conceptualisation is included as an appendix.

## **Facilities and Practical Points**

### **St. Patrick's University Hospital**

Students and Staff participating in the CBT course are guests of St. Patrick's University Hospital and as such it is very important that we respect the facilities that have been provided for us. In particular students must make sure they take all of their belongings and leave the room tidy at the end of teaching sessions. Failure to do so could jeopardise our access to these excellent facilities in future. Please note that students should make arrangements to keep their belongings secure as the classroom will not be locked between teaching sessions. Students can use the visitor's car park but will have to pay the relevant parking fees. Lunch is available in the St. Patrick's University Hospital Canteen at a charge.

### **Email Communication**

Students can expect to send emails to [cbtfound@tcd.ie](mailto:cbtfound@tcd.ie) to contact the course administrator and preferentially we will use email to contact you. We anticipate sending workshop materials the week following the workshop. Whilst we would endeavour to deal with issues as promptly as possible, all course staff work on a part-time basis, and this means that you must allow at least a week for queries to be dealt with. Please note that many of the workshops are given by external facilitators and their other commitments may necessitate some changes in the timetable. In the event of short notice changes to the timetable students are encouraged to communicate this change with fellow students by text or using other social media channels to ensure that the message is communicated effectively.

### **Course Feedback**

The philosophy of the course is that students are nurtured as individuals and are encouraged to achieve their full potential. The course staff are committed to excellence in teaching and to the enhancement of the learning experience of each student. We are, however, aware that at times the student experience may fall below the expected standard. In these instances, we encourage and welcome feedback from students. In the first instance minor issues might be raised informally with any member of the course staff. If this fails to remedy the situation, we would encourage you to make a formal complaint directly to the Course Director. This may either be made verbal or in writing. If the complaint is regarding the Course Director then the complaint would be best addressed to the MSc Course Coordinator, Dr Craig Chigwedere, CBT Department, Patrick's University Hospital, Dublin 8 or Professor Aiden Corvin, Head of Discipline of Psychiatry in TCD.

### **Respectful Communication**

In line with the College's Dignity and Respect Policy it is essential that students show respect in their interaction with all fellow students and staff involved with the course and those working in St Patrick's Hospital where the course is situated. Any lack of respect noted by staff or reported to course staff will be dealt with seriously in line with College Policy.

In the first instance the course director will communicate to the student (s) their responsibility to behave in a respectful manner at all times. If there are further lapses the

student will be asked to meet with the Course Director and/or Head of Department to discuss their conduct.

**Reflective Essay Marking Scale (REMS) Scoresheet**

**Student:**

**Date:**

**Marker:**

**Score:**

0=Absence of feature, or highly inappropriate reflection	4= Good reflection on the feature, but minor problems/ inconsistencies
1=Very basic and/or inappropriate reflection on the feature	5= Very good reflection on feature, minimal problems/ inconsistencies
2= Evidence of reflection on the feature, but lack of consistency	6= Excellent reflection on the feature
3= Competent, but some problems and/or inconsistencies	

Using the scale above, please score the quality of reflection within the piece of writing/essay on each of the following features:

Feature to Be Rated	Comments for the Participant		Score
	Strengths	Limitations	
<b>Personal-self:</b> <i>Does the reflective writing demonstrate evidence of learning about the self, including development of self-awareness, links to early developmental experiences, and experience of personal change due to the SP/SR practice?</i>			
<b>Therapist-self:</b> <i>Does the writing demonstrate evidence impact of SP/SR on factors such as</i>			

<p><i>knowledge of concepts and procedures, use of specific skills, empathy and other interpersonal skills?</i></p>			
<p><b>Evidence of Bridging:</b> <i>Does the writing demonstrate evidence of the integration of learning from reflection on the personal and therapist-self, as well as how SP/SR experience links to clinical and personal practice?</i></p>			
<p><b>Understanding of reflective process:</b> <i>Does the writing show awareness, understanding and application of SP/SR theories and suggested best practices, as well as how they inform the writer's own reflective practice?</i></p>			

**Overall Comments:**

Trainee \_\_\_\_\_

Marker Initials \_\_\_\_\_

### *Case Conceptualisation Feedback For Trainees*

Case Conceptualisations are marked on this scale:

<b>0</b>	<b>10</b>	<b>20</b>	<b>30</b>	<b>40</b>	<b>50</b>	<b>60</b>	<b>70</b>	<b>80</b>	<b>90</b>	<b>100</b>
<b>Fail</b>	<b>Clear Fail</b>			<b>Borderline Fail</b>	<b>Pass</b>		<b>Distinction</b>			

We recognise four classes of result:

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

We take into account:

- Ability to describe the patient's problems, conceptualise development and maintenance of difficulties/distress in cognitive behavioural terms and identify relevant goals, including appropriate use of diagrams to summarise complex patterns or information

Marks out of 40% \_\_\_\_\_

- Ability to describe a treatment programme which follows logically from the conceptualisation and is clearly cognitive-behavioural, and assesses outcomes on relevant dimensions or scales

Marks out of 20% \_\_\_\_\_

- Awareness of factors contributing to or preventing change, ability to reflect on therapeutic relationship and clinicians learning from experience of using CBT model

Marks out of 20% \_\_\_\_\_

- Ability to present and structure relevant material clearly, coherently and concisely including appropriate use of diagrams, references

Marks out of 20% \_\_\_\_\_

**OVERALL MARK** \_\_\_\_\_

**GRADE** \_\_\_\_\_

	<b>Interpersonally Effective</b> (empathy, warmth, & genuineness)	<b>Collaborative</b> (encouraging effective teamwork)	<b>Guiding</b> (helping to develop own perspective on problems/solutions)	<b>Conceptually Integrated</b>	<b>Well- paced</b>	Other comments
Scores 0	Makes patient disengage and become distrustful /hostile. <b>0</b>	Patient is actively prevented or discouraged from being collaborative. <b>0</b>	No attempt at guided discovery (e.g. hectoring or lecturing). <b>0</b>	Absence of appropriate conceptualization. <b>0</b>	Poor time management, aimless or overly rigid. <b>0</b>	
Scores 1	Difficulty showing empathy, genuineness & warmth. <b>1</b>	Therapist is too controlling, dominating or passive. <b>1</b>	Little opportunity for discovery by patient. Persuasion and debate used excessively. <b>1</b>	Lack of, or inappropriateness of conceptualization leads to neutral impact. <b>1</b>	Too slow or fast for current needs and capacity of patient. <b>1</b>	
Scores 2	At times impedes empathic understanding of patient's communication. <b>2</b>	Occasional attempt at collaboration but didactic style or passivity. <b>2</b>	Some use of questioning but unhelpful in assisting patient access to thoughts, emotions or connections between themes. <b>2</b>	Some rudimentary conceptualization arrived at but not well integrated into task. Does not lead to a clear rationale. <b>2</b>	Reasonable pacing but digressions or repetitions from therapist – inefficient, unbalance, over time. <b>2</b>	
Scores 3	Understands explicit meaning of patient's communication, trust developing, and some inconsistency. <b>3</b>	Teamwork evident but problems with collaborative set. (E.g. not enough time allowed for patient to participate actively). <b>3</b>	Some reflection evident. Primarily uses a questioning style that is following a productive line of discovery. <b>3</b>	Cognitive conceptualization partially developed with some integration and leading to coherence. <b>3</b>	Good pacing evident some of the time, but diffuse at times. Some problems evident. <b>3</b>	
Scores 4	Understands implicit & explicit meaning of patient communication. Minor problems. <b>4</b>	Effective teamwork is evident, but not consistent. Minor problems evident. <b>4</b>	Moderate degree of discovery evident. Therapist uses a questioning style with skill and leads to some synthesis. <b>4</b>	Cognitive conceptualization moderately developed and integrated. Minor problems evident. <b>4</b>	Balanced allocation of time. Minor problems evident. <b>4</b>	
Scores 5	V. good IP effectiveness. Patient confident they are understood, facilitates self-disclosure. Minimal problems. <b>5</b>	Effective Teamwork throughout, both in terms of verbal content and use of written summary. Minimal problems. <b>5</b>	Effective Reflection evident. Uses skilful questioning style leading to reflection, discovery and synthesis. Minimal problems. <b>5</b>	Cognitive conceptualization very well developed and integrated – credible understanding that is helpful for task. <b>5</b>	Good time management skills evident, running smoothly. Minimal problems <b>5</b>	
Student Score	/5	/5	/5	/5	/5	Total Score /25

Assessor Notes on OSCE: