Appendix 1: Standard Measures

Supervisor:_____Date of Rating_____
( ) Videotape ( ) Audiotape ( ) Live Observation

Directions: For each time, assess the therapist on a scale from 0 to 6, and record the rating on the line next to the item number. Descriptions are provided for even-numbered scale points. If you believe the therapist falls between two of the descriptors, select the intervening odd number (1, 3, 5). For example, if the therapist set a very good agenda but did not establish priorities, assign a rating of a 5 rather than a 4 or 6.

If the descriptions for a given item occasionally do not seem to apply to the session you are rating, feel free to disregard them and use the more general scale below:

0	1	2	3	4	5	6
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

Please do not leave any item blank. For all items, focus on the skill of the therapist, taking into account how difficult the patient seems to be.

Part I. GENERAL THERAPEUTIC SKILLS

____1. AGENDA

0 Therapist did not see agenda.

2 Therapist set agenda that was vague or incomplete.

4 Therapist worked with patient to set a mutually satisfactory agenda that included specific target problems (e.g., anxiety at work, dissatisfaction with marriage.)

6 Therapist worked with patient to set an appropriate agenda with target problems, suitable for the available time. Established priorities and then followed agenda.

____2. FEEDBACK

0 Therapist did not ask for feedback to determine patient's understanding of, or response to, the session.

2 Therapist elicited some feedback from the patient, but did not ask enough questions to be sure the patient understood the therapist's line of reasoning during the session or to ascertain whether the patient was satisfied with the session.

points at end of session.

____3. UNDERSTANDING

0 Therapist repeatedly failed to understand what the patier thus consistently missed the point. Poor empathic skills

2 Therapist was usually able to reflect or rephrase what th said, but repeatedly failed to respond to more subtle con ability to listen and empathise.

4 Therapist generally seemed to grasp the patient's "interr by both what the explicitly said and what the patient cor subtle ways. Good ability to listen and empathise.

6 Therapist seemed to understand the patient's "internal re was adept at communicating this understanding through and non-verbal responses to the patient (e.g., the tone of response conveyed a sympathetic understanding of the p Excellent listening and empathic skills.

____4. INTERPERSONAL EFFECTIVENESS

0 Therapist had poor interpersonal skills. Seemed hostile, some other way destructive to the patient.

2 Therapist did not seem destructive, but had significant ir At times, therapist appeared unnecessarily impatient, alc difficulty conveying confidence and competence.

4 Therapist displayed a satisfactory degree of warmth, cor genuineness, and professionalism. No significant interp

6 Therapist displayed optimal levels of warmth, concern, genuineness, and professionalism, appropriate for this pa session.

____5. COLLABORATION

0 Therapist did not attempt to set up a collaboration with p

possible to take an active role during the session (e.g., by offering choices) so they could function as a "team".

____6. PACING AND EFFICIENT USE OF TIME

0 Therapist made no attempt to structure therapy time. Session seemed aimless.

2 Session had some direction, but the therapist had significant problems with structuring or pacing (e.g., too little structure, inflexible about structure, too slowly paced, too rapidly paced).

4 Therapist was reasonably successful at using time efficiently. Therapist maintained appropriate control over flow of discussion and pacing.

6 Therapist used time efficiently by tactfully limiting peripheral and unproductive discussion and by pacing the session as rapidly as was appropriate for the patient.

Part II. CONCEPTUALIZATION, STRATEGY, AND TECHNIQUE

____7. GUIDED DISCOVERY

0 Therapist relied primarily on debate, persuasion, or "lecturing". Therapist seemed to be "cross-examining" patient, putting the patient on the defensive, or forcing his/her point of view on the patient.

2 Therapist relied to heavily on persuasion and debate, rather than guided discovery. However, therapist's style was supportive enough that patient did not seem to feel attacked of defensive.

4 Therapist, for the most part, helped patient see new perspectives through guided discovery (e.g., examining evidence, considering alternatives, weighing advantages and disadvantages) rather than through debate. Used questioning appropriately.

6 Therapist was especially adept at using guided discovery during the session to explore problems and help patient draw his/her own conclusions. Achieved an excellent balance between skilful questioning and other modes of intervention.

____8. FOCUSING ON KEY COGNITIONS OR BEHAVIOURS

4 Therapist focused on specific cognitions or behaviours r problem. However, therapist could have focused on mo
or behaviours that offered greater promise for progress.

6 Therapist very skillfully focused on key thoughts, assum
etc. that were most relevant to the problem area and offered
for progress.

9. STRATEGY FOR CHANGE (Note: For this item, focus on the qual strategy for change, not on how effectively the strategy was implem change actually occurred.)

0 Therapist did not select cognitive-behavioural technique

2 Therapist selected cognitive-behavioural techniques; ho overall strategy for bringing about change seemed vagu promising in helping the patient.

4 Therapist seemed to have a generally coherent strategy f reasonable promise and incorporated cognitive-behaviou

6 Therapist followed a consistent strategy for change that promising and incorporated the most appropriate cogniti techniques.

____10. APPLICATION OF COGNITIVE-BEHAVIOURAL TECHNIQUE item, focus on how skillfully the techniques were applied, not on hc were for the target problem or whether change actually occurred.)

0 Therapist did not apply any cognitive-behavioural techn

2 Therapist used cognitive-behavioural techniques, but the flaws in the way they were applied.

4 Therapist applied cognitive-behavioural techniques with

6 Therapist very skillfully and resourcefully employed co techniques.

____11. HOMEWORK

4 Therapist reviewed previous homework and assigned "standard" cognitive therapy homework generally relevant to issues dealt with in session. Homework was explained in sufficient detail.

6 Therapist reviewed previous homework and carefully assigned homework drawn from cognitive therapy for the coming week. Assignment seemed "custom tailored" to help patient incorporate new perspectives, test hypotheses, experiment with new behaviours discussed during session, etc.

For instructions on the use of the scale, see: Young J.E, & Beck, A.T. (Augu
Therapy Scale Rating Manual.

For permission to use this scale or a copy of the Rating Manual, please write

University of Pennsylvania, Centre for Psychotherapy Res
Room 754, Science Centre
3600 Market Street
Philadelphia, PA 19104-2648

Part III. ADDITIONAL CONSIDERATIONS

12. (a) Did any special problems arise during the session (e.g., non-adherence to homework, interpersonal issues between therapist and patient, hopelessness about continuing therapy, relapse?)

YES NO

____ (b) If yes:

0 Therapist could not deal adequately with special problems that arose.

2 Therapist dealt with special problems adequately, but used strategies or conceptualisations inconsistent with cognitive therapy.

4 Therapist attempted to deal with special problems using a cognitive framework and was moderately skilful in applying techniques.

6 Therapist was very skilful at handling special problems using cognitive therapy framework.

13. Were there any significant unusual factors in this session that you feel justified the therapist's departure from the standard approach measured by this scale?

YES (please explain below) NO

Part IV. OVERALL RATINGS AND COMMENTS

14. How would you rate the clinician overall in this session, as a cognitive therapist?

SECTION 4

The 40-item Learning Styles Questionnaire

This short questionnaire will help you discover your learning style preferences. We all develop learning 'habits' that make us happier to learn in some ways and less happy to learn in other, less familiar, ways. Most people are only vaguely aware of their learning preferences. This questionnaire will clarify your preferred ways of learning so that you are in a better position to select experiences that suit your style and/or to broaden your scope by strengthening under-utilised styles.

There is no time limit for the completion of this questionnaire. It will probably take you 5 to 10 minutes. The accuracy of the results depends on how honest you are. There are no right or wrong answers. If you agree more than you disagree with a statement put a tick (✓) in the box. If you disagree more than you agree with a statement put a cross (×) in the box. Be sure to mark each item with either a tick or a cross.

1	☐	I quite like taking risks.
2	☐	Before taking part in a discussion or meeting, I like to read the appropriate papers and prepare carefully.
3	☐	I like to be absolutely correct about things.
4	☐	I like practical, tried and tested techniques.
5	☐	I often do things just because I feel like it, rather than thinking about them first.
6	☐	I make decisions only after weighing up the pros and cons of different possibilities.
7	☐	I prefer to solve problems using a systematic approach that reduces guesswork and uncertainty.
8	☐	What matters most is whether something works in practice.
9	☐	I actively look for new things to do.

10 ☐ I prefer to establish the facts and think things through before reaching a conclusion.

11 ☐ I like to check things out for myself rather than take them for granted.

12 ☐ When I hear about a new idea or technique, I immediately start working out how to apply it to my situation/problems.

13 ☐ I like the challenge of trying out different ways of doing things.

14 ☐ I prefer to have as many bits of information about a subject as possible. The more I have to sift through the better.

15 ☐ I am quite keen on sticking to fixed routines, following procedures and keeping to timetables.

16 ☐ In discussions, I like to get straight to the point.

17 ☐ I prefer to jump in and do things as they come along rather than plan things out beforehand.

18 ☐ I prefer to base decisions on hard evidence and not to trust a hunch or intuition.

19 ☐ I like to fit things into some sort of pattern, framework or model.

20 ☐ I tend to judge people's ideas on their practical merits.

21 ☐ In discussions, I usually come up with lots of spontaneous ideas.

22 ☐ I prefer to look at a problem from as many different angles as I can before starting to solve it.

23 ☐ I prefer to evaluate the soundness of my ideas before sharing them.

24 ☐ In meetings and discussions, I put forward ideas that I know are down-to-earth and realistic.

25 ☐ Usually I talk more than I listen.

26 ☐ If I have to write a report or a formal letter, I prefer to have several rough drafts before settling on the final version.

27 ☐ I am rather fussy about how I do things – a bit of a perfectionist.

28 ☐ I find that I can often work out more practical ways of doing things.

29 ☐ I find rules and procedures take the fun out of things.

30 ☐ I like to consider many options before I make up my mind.

31 ☐ I believe that careful, logical thinking is the key to success.

32 ☐ I prefer ideas with an obvious relevance to my life and work.

33 ☐ I'm usually the 'life and soul' of the party.

34 ☐ I like to think through the consequences before taking action.

35 ☐ I like to understand the assumptions, principles and rationale upon which things are based.

36 ☐ In my opinion, it doesn't matter how you do something, as long as it works.

37 ☐ I enjoy the excitement of a crisis situation.

38 ☐ I usually do more listening than talking.

39 ☐ I like meetings and discussions to be structured and orderly.

40 ☐ I do whatever I need to, to get the job done.

Ф.И.О.:_____

Контактный телефон:_____

E-mail:_____

АНКЕТА ПО СТИЛЮ ОБУЧЕНИЯ

Этот короткая анкета поможет Вам определить Ваши предпочтения в стиле обучения. Все мы приобретаем «привычки» в обучении, которые радуют или расстраивают нас в зависимости от того, каким образом мы усваиваем информацию. Большинство людей имеют лишь поверхностное представление об их предпочтениях в обучении. Эта анкета поможет прояснить Ваши предпочтения с тем, чтобы Вы могли выбирать для себя наиболее предпочтительные практики для эффективного обучения.

Для заполнения анкеты Вам, возможно, потребуется 5 - 10 мин., хотя ограничения по времени нет. Точность результатов будет зависеть от того, насколько Вы были честны при заполнении. Не существует правильных или неправильных ответов. Если Вы скорее согласны, чем не согласны с утверждением, поставьте утвердительный знак (√), если же Вы скорее не согласны с утверждением, чем согласны, поставьте знак несогласия (X). Обозначьте свое согласие или несогласие с каждым из утверждений.

□ 1. Мне достаточно нравиться рисковать

□ 2. Прежде, чем принять участие в дискуссии, я предпочитаю почитать соответствующую информацию и тщательно подготовиться

□ 3. Мне нравится быть абсолютно точным

□ 4. Мне нравятся практичные, проверенные временем техники

□ 5. Я часто делаю что-то, потому что так чувствую, а не потому, что обдумываю это заранее

□ 6. Я принимаю решения только после того, как оценю все «за» и «против» различных возможностей

□ 7. Я предпочитаю решать задачи, используя систематический подход, который снижает неопределенность

□ 8. Для меня самое главное, чтобы что-то работало на практике

□ 9. Я активно ищу новые виды деятельности

□ 10. Я предпочитаю оценить факты и все обдумать перед принятием решения

□ 11. Я предпочитаю все проверять самостоятельно, а не воспринимать как само собой разумеющееся

□ 12. Когда я узнаю о какой-то новой идее или практике, я сразу стараюсь применить ее к моей ситуации

□ 13. Мне нравится принимать вызов пробовать новые вещи

□ 14. Я предпочитаю иметь как можно больше информации касательно какого-то предмета. Чем больше информации для анализа, тем лучше

- ☐ 15. Я склонен к установленным процедурам, инструкциям, расписанию.
- ☐ 16. Во время обсуждения я предпочитаю сразу переходить к сути дела
- ☐ 17. Я предпочитаю справляться с задачами по мере их поступления, а не планировать все заранее
- ☐ 18. Я предпочитаю принимать решения на основании очевидных доказательств, а не доверять интуиции
- ☐ 19. Я предпочитаю соотносить вещи с какой-либо моделью, основой или примером
- ☐ 20. Я предпочитаю оценивать людей по их практическим заслугам
- ☐ 21. Во время обсуждения я часто высказываю спонтанно возникшие идеи
- ☐ 22. Я предпочитаю оценить проблему с различных сторон прежде, чем приступить к ее решению
- ☐ 23. Я предпочитаю оценить убедительность моих идей прежде, чем высказывать их
- ☐ 24. На собраниях и во время обсуждений я предпочитаю отстаивать приземленные, реалистичные идеи
- ☐ 25. Обычно я говорю больше, чем слушаю
- ☐ 26. Если мне нужно написать отчет или официальное письмо, я предпочитаю сделать несколько черновых копий прежде, чем утвердить финальную версию
- ☐ 27. Я немного нервничаю по поводу того, как я делаю что-то: в какой-то мере, я – перфекционист
- ☐ 28. Я считаю, что часто могу находить более практичные способы решения задач
- ☐ 29. Я считаю, что правила и процедуры делают вещи менее привлекательными
- ☐ 30. Я предпочитаю рассмотреть различные варианты прежде, чем определиться
- ☐ 31. Я считаю, что тщательное, логическое обдумывание – ключ к успеху
- ☐ 32. Мне нравятся идеи с очевидной значимостью для моей жизни или работы
- ☐ 33. Я обычно «душа компании»
- ☐ 34. Я предпочитаю думать о последствиях прежде, чем предпринимать какие-либо действия
- ☐ 35. Я предпочитаю понимать предпосылки, принципы и рациональную составляющую вещей
- ☐ 36. Мне кажется, если что-то работает, то не важно, как ты это делаешь
- ☐ 37. Я наслаждаюсь ощущениями кризисной ситуации
- ☐ 38. Я обычно больше слушаю, чем говорю
- ☐ 39. Мне нравится, когда встречи и обсуждения четко структурированы
- ☐ 40. Я делаю все, что нужно, чтобы сделать работу

TRAINING ACCEPTABILITY RATING SCALE (TARS): CBT training

Name:……..

Date:…….

Instructions: Based on the training that you received, please rate your agreement with the following statements on this scale:

1 = strongly disagree
2 = moderately disagree
3 = slightly disagree
4 = slightly agree
5 = moderately agree
6 = strongly agree

The first six statements concern the appropriateness or acceptability of the workshop's content: do you think that the material was 'socially valid'?

		CIRCLE YOUR LEVEL OF AGREEMENT
1	**General acceptability:** this approach to CBT training would be appropriate for a variety of mental health service providers.	1 2 3 4 5 6
2	**Effectiveness:** the CBT training will be beneficial for mental health service providers who receive it	1 2 3 4 5 6
3	**No negative side-effects:** the CBT training will **not** result in therapy that leads to harm to clients	1 2 3 4 5 6
4	**Appropriateness:** most participants would accept that this CBT training programme provided an appropriate approach to training in cognitive behavioural therapy	1 2 3 4 5 6
5	**Consistency:** the CBT training was consistent with common sense and good practice in helping mental health service providers to provide CBT treatments	1 2 3 4 5 6
6	**Social validity:** most mental health service providers would approve of training in this therapy method (e.g. would recommend it to	1 2 3 4 5 6

The next 12 questions focus on your impressions of the teaching process and outcomes (i.e. how competently you think the training was conducted, and whether it was helpful or not).
For each question please circle the statement that best expresses your opinion.

PLEASE CIRCLE ONE ANSWER:

7 **Did the training improve your understanding of CBT treatments?**
Not at all A little Quite a lot A great deal

8 **Did the training help you to develop CBT skills?**
Not at all A little Quite a lot A great deal

9 **Has the training made you more confident as a CBT therapist?**
Not at all A little Quite a lot A great deal

10 **Do you expect to make use of what you learnt in the training in your clinical practice?**
Not at all A little Quite a lot A great deal

11 **How competent were the presenters/ supervisors?**
Not at all A little Quite a lot A great deal

12 **In an overall, general sense, how satisfied are you with the training?**
Not at all A little Quite a lot A great deal

13 **Did the training cover the topics it set out to cover?**
Not at all A little Quite a lot A great deal

14 **Did the presenters/ supervisors relate to the group effectively?**
(e.g. made you feel comfortable and understood)
Not at all A little Quite a lot A great deal

15 **Were the presenters/ supervisors motivating?** (e.g. energetic, attentive and creative)
Not at all A little Quite a lot A great deal

16 **How much were you able to implement the training in your practice?**
Not at all A little Quite a lot A great deal

17 **What was the most helpful part of the training for you personally?**

……..

……..

……..

18 **What change, if any, would you recommend?** (e.g. to the content or training methods)

……..

……..

……..

19 **Please make any other comments that you would like to offer.**

……..

……..

D. Milne
DM/KM/11th October, 2007, DCP pilot of EBS manual

(Part I from Davis, J.R, Rawana, E.P & Capponi, D.R. (1989).
Acceptability of behavioural staff management techniques.
Beh Res Treatment, 4, 23-44,
Part II from Milne & Noone 1996; CFF Project, HATQ).

ОЦЕНКА ЭФФЕКТИВНОСТИ ТРЕНИНГА (ОЭТ)

Имя:……

Дата:……...

Инструкции для заполнения: Оцените обучение когнитивно-поведенческой терапии, которое Вы получили в рамках семинара, посредством skype-общения или обоими этими способами, используя следующую шкалу:

1 = полностью не согласен / не согласна
2 = не вполне согласен / согласна
3 = скорее не согласен / не согласна
4 = скорее согласен / согласна
5 = вполне согласен / согласна
6 = полностью согласен / согласна

Утверждения 1-6 касаются применимости / полезности данного тренинга. Считаете ли Вы, что полученное обучение является социально-значимым?

		Оцените, насколько Вы согласны с нижеприведенными утверждениями					
1	**Общая применимость:** обучение когнитивно-поведенческой терапии будет интересно многим учреждениям и консультантам, предоставляющим услуги в области ментального здоровья.	1	2	3	4	5	6
2	**Эффективность:** прохождение данного обучения, вероятно, будет полезно для вышеупомянутых учреждений и консультантов.	1	2	3	4	5	6
3	**Отсутствие отрицательных побочных эффектов:** использование когнитивно-поведенческой терапии, вероятно, не причинит вред клиентам.	1	2	3	4	5	6
4	**Уместность:** большинство участников признало бы, что обучение обеспечило уместный подход к обучению когнитивно-поведенческой терапии.	1	2	3	4	5	6
5	**Последовательность:** в обучении последовательно совмещались как здравый смысл (понимание	1	2	3	4	5	6

процессов), так и практика для обеспечения лучшей помощи учреждениям в предоставлении услуг когнитивно-поведенческой терапии.

6 **Социальная значимость:** большинство специализированных учреждений одобрят прохождение данного тренинга (а также, возможно, рекомендуют прохождение подобного обучения другим учреждениям). 1 2 3 4 5 6

Следующие 12 вопросов касаются Ваших впечатлений от обучения и его результатов. Насколько полно, по Вашему мнению, было раскрыто содержание, и было ли данное обучение полезным?

Для каждого вопроса выберите ответ, который наиболее отражает Ваши впечатления.

ПОЖАЛУЙСТА, ВЫБЕРИТЕ, ОДИН ОТВЕТ:

7 **Обучение улучшило Ваше понимание методов когнитивно-поведенческой терапии?**
Нисколько Немного Достаточно Очень

8 **Обучение помогало Вам развить навыки, необходимые для проведения когнитивно-поведенческой терапии?**
Нисколько Немного Достаточно Очень

9 **Чувствуете ли Вы себя более уверенно как специалист когнитивно-поведенческой терапии после прохождения обучения?**
Нисколько Немного Достаточно Очень

10 **Считаете ли Вы, что сможете использовать полученные в рамках обучения знания в своей клинической практике?**

Нисколько Немного Достаточно Очень

11 **Насколько компетентны были тренеры, проводившие обучение?**
Нисколько Немного Достаточно Очень

12 **Насколько Вы удовлетворены тренингом в целом?**
Нисколько Немного Достаточно Очень

13 **Были ли раскрыты предварительно заявленные темы в рамках данного обучения?**

Нисколько Немного Достаточно Очень

14 **Насколько эффективно взаимодействовали тренеры с группой (чувствовали ли Вы себя понятыми, комфортно)?**

Нисколько Немного Достаточно Очень

15 **Мотивировали ли Вас тренеры в процессе обучения (были ли они энергичными, внимательными и творческими)?**

Нисколько Немного Достаточно Очень

16 **Какая часть обучения была наиболее полезна для Вас лично?**

……..

……..

……..

17 **Какие изменения Вы рекомендовали бы внести, если таковые имеются (например, в содержание тренинга или методы обучения)?**

……..

……..

……..

18 **Пожалуйста, сделайте любые другие комментарии, которые, на Ваш взгляд, будут полезны.**

……..

……..

……..

Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much.	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
Column Sum				

Scoring - Sum each column. Then sum the column totals to achieve a grand score. Write that score here _____ .

Interpretation

A grand sum between **0 – 21** indicates very low anxiety. That is usually a good thing. However, it is possible that you might be unrealistic in either your assessment which would be denial or that you have learned to "mask" the symptoms commonly associated with anxiety. Too little "anxiety" could indicate that you are detached from yourself, others, or your environment.

A grand sum between ***22 – 35*** indicates moderate anxiety. Your body is trying to tell you something. Look for patterns as to when and why you experience the symptoms described above. For example, if it occurs prior to public speaking and your job requires a lot of presentations you may want to find ways to calm yourself before speaking or let others do some of the presentations. You may have some conflict issues that need to be resolved. Clearly, it is not "panic" time but you want to find ways to manage the stress you feel.

A grand sum that **exceeds 36** is a potential cause for concern. Again, look for patterns or times when you tend to feel the symptoms you have circled. Persistent and high anxiety is not a sign of personal weakness or failure. It is, however, something that needs to be proactively treated or there could be significant impacts to you mentally and physically. You may want to consult a physician or counselor if the feelings persist.

ШКАЛА ТРЕВОГИ ВЕСК

Инструкция: Данный список содержит наиболее распространенные симптомы тревоги. Пожалуйста, тщательно изучите каждый пункт. Отметьте, насколько Вас беспокоил каждый из этих симптомов в течение ПОСЛЕДНЕЙ НЕДЕЛИ, включая сегодняшний день, поставив крестик в соответствующей колонке справа.

	Совсем не беспокоил 0	**Слегка.** Не слишком меня беспокоил 1	**Умеренно.** Это было неприятно, но я мог это переносить 2	**Очень сильно.** Я с трудом мог это выносить**.** **3**
1. Ощущение онемения или покалывания в теле				
2. Ощущение жара				
3. Дрожь в ногах				
4. Неспособность расслабиться				
5. Страх, что произойдет самое плохое				
6. Головокружение или ощущение легкости в голове				
7. Ускоренное сердцебиение				
8.Неустойчивость				
9. Ощущение ужаса				
10. Нервозность				
11. Дрожь в руках				
12. Ощущение удушья				
13. Шаткость походки				
14. Страх утраты контроля				
15. Затрудненность дыхания				
16. Страх смерти				
17. Испуг				
18. Желудочно-кишечные расстройства				
19. Обмороки				
20. Прилив крови к лицу				
21. Усиленное потоотделение (не связанное с жарой)				

Beck Depression Inventory

Choose one statement from among the group of four statements in each question that best describes how you have been feeling during the **past few days**. Circle the number beside your choice.

1	**0** I do not feel sad. **1** I feel sad. **2** I am sad all the time and I can't snap out of it. **3** I am so sad or unhappy that I can't stand it.	8	**0** I don't feel I am any worse than anybody else. **1** I am critical of myself for my weaknesses or mistakes. **2** I blame myself all the time for my faults. **3** I blame myself for everything bad that happens.
2	**0** I am not particularly discouraged about the future. **1** I feel discouraged about the future. **2** I feel I have nothing to look forward to. **3** I feel that the future is hopeless and that things cannot improve.	9	**0** I don't have any thoughts of killing myself. **1** I have thoughts of killing myself, but I would not carry them out. **2** I would like to kill myself. **3** I would kill myself if I had the chance.
3	**0** I do not feel like a failure. **1** I feel I have failed more than the average person. **2** As I look back on my life, all I can see is a lot of failure. **3** I feel I am a complete failure as a person.	10	**0** I don't cry any more than usual. **1** I cry more now than I used to. **2** I cry all the time now. **3** I used to be able to cry, but now I can't cry even though I want to.
4	**0** I get as much satisfaction out of things as I used to. **1** I don't enjoy things the way I used to. **2** I don't get any real satisfaction out of anything anymore. **3** I am dissatisfied or bored with everything.	11	**0** I am no more irritated by things than I ever am. **1** I am slightly more irritated now than usual. **2** I am quite annoyed or irritated a good deal of the time. **3** I feel irritated all the time now.
5	**0** I don't feel particularly guilty. **1** I feel guilty a good part of the time. **2** I feel quite guilty most of the time. **3** I feel guilty all of the time.	12	**0** I have not lost interest in other people. **1** I am less interested in other people than I used to be. **2** I have lost most of my interest in other people. **3** I have lost all of my interest in other people.
6	**0** I don't feel I am being punished. **1** I feel I may be punished. **2** I expect to be punished. **3** I feel I am being punished.	13	**0** I make decisions about as well as I ever could. **1** I put off making decisions more than I used to. **2** I have greater difficulty in making decisions than before. **3** I can't make decisions at all anymore.
7	**0** I don't feel disappointed in myself. **1** I am disappointed in myself. **2** I am disgusted with myself. **3** I hate myself.	14	**0** I don't feel that I look any worse than I used to. **1** I am worried that I am looking old or unattractive. **2** I feel that there are permanent changes in my appearance that make me look unattractive. **3** I believe that I look ugly.

15	**0** I can work about as well as before. **1** It takes an extra effort to get started at doing something. **2** I have to push myself very hard to do anything. **3** I can't do any work at all.	19	**0** I haven't lost much weight, if any, lately. **1** I have lost more than five pounds. **2** I have lost more than ten pounds. **3** I have lost more than fifteen pounds. (Score 0 if you have been purposely trying to lose weight.)
16	**0** I can sleep as well as usual. **1** I don't sleep as well as I used to. **2** I wake up 1-2 hours earlier than usual and find it hard to get back to sleep. **3** I wake up several hours earlier than I used to and cannot get back to sleep.	20	**0** I am no more worried about my health than usual. **1** I am worried about physical problems such as aches and pains, or upset stomach, or constipation. **2** I am very worried about physical problems, and it's hard to think of much else. **3** I am so worried about my physical problems that I cannot think about anything else.
17	**0** I don't get more tired than usual. **1** I get tired more easily than I used to. **2** I get tired from doing almost anything. **3** I am too tired to do anything.	21	**0** I have not noticed any recent change in my interest in sex. **1** I am less interested in sex than I used to be. **2** I am much less interested in sex now. **3** I have lost interest in sex completely.
18	**0** My appetite is no worse than usual. **1** My appetite is not as good as it used to be. **2** My appetite is much worse now. **3** I have no appetite at all anymore.		

SCORING

1 – 10: These ups and downs are considered normal.
11 – 16: Mild mood disturbance
17 – 20: Borderline clinical depression
21 – 30: Moderate depression
31 – 40: Severe depression
over 40: Extreme depression

ШКАЛА ДЕПРЕССИИ БЕСК

Инструкция: Этот опросник состоит из 21 пункта, каждый из которых содержит несколько высказываний. Пожалуйста, после тщательного прочтения выберите в каждом пункте одно высказывание, которое лучше всего описывает Ваше самочувствие в течение последних двух недель, включая сегодняшний день. Обведите кружком номер выбранного Вами высказывания. Если в одном пункте Вам в равной степени подходят несколько высказываний, поместите в кружок высказывание с наибольшим номером. Убедитесь, что Вы выбрали не более одного высказывания для каждого пункта, включая пункт 16 (изменения сна) и пункт 18 (изменения аппетита)

ТОСКА
0. Я не испытываю тоски
1. Я испытываю тоску значительную часть времени
2. Я все время испытываю тоску
3. Я настолько несчастлив и испытываю такую тоску, что боюсь не выдержать этого.

ЧУВСТВО НАКАЗАННОСТИ
0. Я не чувствую, что заслужил наказание
1. Я чувствую, что могу быть наказан
2. Я заслуживаю наказания
3. Я чувствую, что меня заслуженно наказывают

ПЕССИМИЗМ
0. Я не ожидаю плохого от будущего
1. Я ожидаю от будущего больше неприятностей, чем обычно
2. Я не жду, что в будущем у меня все сложится хорошо
3. Я чувствую, что мое будущее безнадежно, и изменения могут быть только в худшую сторону

ПРОШЛЫЕ НЕУДАЧИ
0. Я не чувствую себя неудачником
1. Я мог бы допустить меньше неудач
2. Оглядываясь назад, я вижу множество неудач
3. Я чувствую себя полным неудачником

ОТВРАЩЕНИЕ.К СЕБЕ
0. Я отношусь к себе так же, как всегда
1. Я утратил уверенность в себе
2. Я разочарован в себе
3. Я себя терпеть не могу

УТРАТА УДОВОЛЬСТВИЯ
0. Я получаю максимум удовольствия от вещей, которые всегда меня радовали
1. Меня не радует то, что обычно радовало
2. Я получаю очень мало удовольствия от вещей, которые обычно меня радовали
3. Я не могу получить удовольствие от того, что обычно меня радовало

САМООБВИНЕНИЯ
0. Я критикую или обвиняю себя не более, чем обычно
1. Я более критичен к себе, чем обычно
2. Я критикую себя за все свои ошибки
3. Я обвиняю себя во всем плохом, что происходит

ЧУВСТВО ВИНЫ
0. Я не чувствую себя особенно виноватым
1. Я испытываю чувство вины за многое, сделанное мною
2. Я испытываю чувство вины большую часть времени
3. Я испытываю чувство вины постоянно

СУИЦИДАЛЬНЫЕ МЫСЛИ ИЛИ ЖЕЛАНИЯ
0. У меня нет мыслей о самоубийстве
1. У меня есть мысли о самоубийстве, но я не приведу их и действие
2. Я хотел бы покончить с собой
3. Я бы покончил с собой при подходящей возможности

БЕСПОКОЙСТВО
0. Я не более беспокоен или возбужден, чем обычно
1. Я испытываю большее беспокойство и возбуждение, чем обычно
2. Я испытываю такое беспокойство и возбуждение, что тяжело сидеть спокойно
3. Я испытываю такое беспокойство и возбуждение, что вынужден двигаться или что-то делать

ПЛАЧ
0. Я плачу не больше, чем обычно
1. Я плачу больше, чем обычно
2. Я плачу по каждому незначительному поводу
3. Я хочу плакать, но не могу

УТРАТА ИНТЕРЕСОВ
0. Я не утратил интересов к другим людям и занятиям
1. Я испытываю меньший интерес к другим людям и занятиям, чем обычно
2. Я D значительной степени утратил интерес к другим людям и занятиям
3. Меня трудно чем-либо заинтересовать

РАЗДРАЖИТЕЛЬНОСТЬ
0. Я не более раздражителен, чем обычно
1. Я более раздражителен, чем обычно
2. Я значительно более раздражителен, чем обычно
3. Я испытываю раздражение постоянно

НЕРЕШИТЕЛЬНОСТЬ
0. Я принимаю решения так же легко, как всегда
1. Мне значительно труднее, чем обычно, принимать решения
2. Принятие любого решения - проблема для меня

ИЗМЕНЕНИЯ АППЕТИТА
0. Мой аппетит не изменился
1а. Мой аппетит несколько снижен, по сравнению с обычным.
1б. мой аппетит несколько повышен, по сравнению с обычным.
2а Мой аппетит значительно снижен, по сравнению с прежним
2б Мой аппетит значительно повышен, по сравнению с прежним
За У меня совсем нет аппетита
3б Я постоянно хочу есть

ЧУВСТВО НИКЧЕМНОСТИ
0 я не чувствую себя никчемным
1 Я не чувствую себя таким же ценным и полезным, как всегда
2 Я чувствую себя менее ценным, чем другие
3 Я чувствую себя полностью никчемным

ТРУДНОСТИ СОСРЕДОТОЧЕНИЯ
0 Я так же хорошо могу сосредоточиться, как всегда
1 Я не могу так же хорошо сосредоточиться, как обычно
2 Мне трудно долго удерживать внимание на чем либо
3 Я не могу сосредоточиться ни на чем

ПОТЕРЯ ЭНЕРГИИ
0 Я так же энергичен как обычно
1 У меня меньше энергии, чем обычно
2 У меня недостаточно энергии, чтобы сделать много
3 У меня нет сил ни на что

УСТАЛОСТЬ
0. Я устаю не больше, чем обычно
1. Я устаю скорее, чем обычно
2. Из-за усталости я не могу выполнять многие привычные для меня дела
3. Из-за усталости я не могу выполнить большинство привычных дел

ИЗМЕНЕНИЯ СНА
0..Я сплю так же, как всегда
1а Я сплю несколько больше, чем обычно
16 Я сплю несколько меньше, чем обычно 2а Я сплю значительно больше, чем обычно
26 Я сплю значительно меньше, чем обычно
За Я сплю большую часть дня
3б Я просыпаюсь на 1-2 часа раньше, и потом не могу заснуть

УТРАТА ИНТЕРЕСА К СЕКСУ
0. Я по замечаю никаких изменений в моем интересе к сексу
1. Я испытываю меньший интерес к сексу, чем обычно
2. Мой интерес к сексу значительно снизился сейчас
3. Я полностью утратил интерес к сексу

Appendix 1.6e Agoraphobic Cognitions Questionnaire

Agoraphobic Cognitions Questionnaire

Client ID ..... Date .....

Below are some thoughts or ideas that may pass through your mind when you are nervous or frightened. Please indicate how often each thought occurs when you are nervous. rate from 1-5 using the scale below:

1	2	3	4	5
thought **never** occurs	thought **rarely** occurs	thought occurs **during half of the times**	thought **usually** occurs	thought **always** occurs

.....when I am nervous

Please rate all items.

1. I am going to throw up	1	2	3	4	5
2. I am going to pass out	1	2	3	4	5
3. I must have a brain tumor	1	2	3	4	5
4. I will have a heart attack	1	2	3	4	5
5. I will choke to death	1	2	3	4	5
6. I am going to act foolish	1	2	3	4	5
7. I am going blind	1	2	3	4	5
8. I will not be able to control myself	1	2	3	4	5
9. I will hurt someone	1	2	3	4	5
10. I am going to have a stroke	1	2	3	4	5
11. I am going crazy	1	2	3	4	5
12. I am going to scream	1	2	3	4	5
13. I am going to babble or talk funny	1	2	3	4	5
14. I am going to be paralyzed by fear	1	2	3	4	5
15. other ideas not listed (please describe and rate them)					
.....	1	2	3	4	5
.....	1	2	3	4	5
.....	1	2	3	4	5

Agoraphobic Cognitions Questionnaire
Russian Adaptation

Инструкция. Пожалуйста, укажите, как часто следующие мысли приходят Вам в голову, **когда Вы беспокоитесь**. Оцените частоту этих мыслей, используя следующие соответствия:

1 = Такая мысль никогда не возникает

2 = Такая мысль бывает редко

3 = Такая мысль возникает примерно в половине случаев

4 = Такая мысль возникает в большинстве случаев

5 = Такая мысль возникает всегда

Я думаю, что :

1. _____ Меня стошнит
2. _____ Я потеряю сознание
3. _____ У меня опухоль мозга
4. _____ У меня будет сердечный приступ
5. _____ Я задохнусь
6. _____ Я поведу себя глупо
7. _____ Я слепну
8. _____ Я не смогу себя контролировать
9. _____ Я кого-нибудь изобью
10. _____ У меня будет инсульт
11. _____ Я сойду с ума
12. _____ Я не смогу сдержаться и закричу
13. _____ Я буду говорить глупо или несвязно
14. _____ Я буду парализован страхом

Client ID ..... Date .....

1. Please indicate the degree to which you avoid the following places or situations because of discomfort or anxiety. Rate your amount of avoidance when you are with a trusted companion and when you are alone. Do this by using the following scale:

1	2	3	4	5
never avoid	rarely avoid	avoid about half of the time	avoid most of the time	always avoid

Circle the number for each situation or place under both conditions: when accompanied and when alone. Leave blank situations that do not apply to you.

Places	When accompanied					When alone				
Theaters	1	2	3	4	5	1	2	3	4	5
Supermarkets	1	2	3	4	5	1	2	3	4	5
Shopping malls	1	2	3	4	5	1	2	3	4	5
Classrooms	1	2	3	4	5	1	2	3	4	5
Department stores	1	2	3	4	5	1	2	3	4	5
Restaurants	1	2	3	4	5	1	2	3	4	5
Museums	1	2	3	4	5	1	2	3	4	5
Elevators	1	2	3	4	5	1	2	3	4	5
Auditoriums or stadiums	1	2	3	4	5	1	2	3	4	5
Garages	1	2	3	4	5	1	2	3	4	5
High places	1	2	3	4	5	1	2	3	4	5
Please tell how high		____					____			
Enclosed places	1	2	3	4	5	1	2	3	4	5

Open spaces	When accompanied					When alone				
Outside (for example: fields, wide streets, courtyards)	1	2	3	4	5	1	2	3	4	5
Inside (for example: large rooms, lobbies)	1	2	3	4	5	1	2	3	4	5

Riding in	When accompanied					When alone				
Buses	1	2	3	4	5	1	2	3	4	5
Trains	1	2	3	4	5	1	2	3	4	5
Subways	1	2	3	4	5	1	2	3	4	5
Airplanes	1	2	3	4	5	1	2	3	4	5
Boats	1	2	3	4	5	1	2	3	4	5

Driving or riding in car	When accompanied					When alone				
A. at anytime	1	2	3	4	5	1	2	3	4	5
B. on expressways	1	2	3	4	5	1	2	3	4	5

Situations	When accompanied					When alone				
Standing in lines.....	1	2	3	4	5	1	2	3	4	5
Crossing bridges.....	1	2	3	4	5	1	2	3	4	5
Parties or social gatherings .	1	2	3	4	5	1	2	3	4	5
Walking on the street	1	2	3	4	5	1	2	3	4	5
Staying at home alone.....						1	2	3	4	5
Being far away from home	1	2	3	4	5	1	2	3	4	5
Other (specify): _____	1	2	3	4	5	1	2	3	4	5

2. After completing the first step, circle the five items with which you are most concerned. Of the items listed, these are the five situations or places where avoidance/anxiety most affects your life in a negative way.

Panic attacks

3. We define a panic attack as:
   1. A high level of anxiety accompanied by...
   2. strong body reactions (heart palpitations, sweating, muscle tremors, dizziness, nausea) with...
   3. the temporary loss of the ability to plan, think, or reason and...
   4. the intense desire to escape or flee the situation. (Note: This is different from high anxiety or fear alone).

Please indicate the total number of panic attacks you have had in the last 7 days: [ ]

In the last 3 weeks: [ ]

How severe or intense have the panic attacks been? (Place an X on the line below):

very mild	mild	moderately severe	very severe	extremely severe
1	2	3	4	5

Safety zone

4. Many people are able to travel alone freely in an area (usually around their home) called their safety zone. Do you have such a zone? If yes, please describe:

a. its location: [ ]

b. its size (e.g. radius from home): [ ]

Mobility Inventory for Agoraphobia
Russian Adaptation

Инструкция. Пожалуйста, укажите, как часто Вы избегаете следующих мест или ситуаций **из-за дискомфорта или беспокойства**. Оцените частоту такого избегания, когда Вы один. Используйте следующие показатели:

1 = Никогда не избегаю
2 = Редко избегаю
3 = Избегаю приблизительно в половине случаев
4 = Избегаю большую часть времени
5 = Избегаю всегда

1. _____ Театры
2. _____ Продуктовые магазины
3. _____ Классы или аудитории
4. _____ Универмаги
5. _____ Рестораны
6. _____ Музеи
7. _____ Лифты
8. _____ Стадионы
9. _____ Гаражи или стоянки
10. _____ Высоты
11. _____ Замкнутые пространства (Например, туннели)
12. _____ Открытые пространства вне помещений (Например, поля, широкие улицы)
13. _____ Открытые пространства внутри помещений (Например, большие комнаты, залы)

Поездки в:

14. _____ Автобусах, троллейбусах
15. _____ Поездах
16. _____ Метро
17. _____ Самолетах
18. _____ Кораблях или лодках
19. _____ Машинах, всегда
20. _____ Машинах, на скоростных автомагистралях

Ситуации:

21. _____ Стоять в очередях
22. _____ Переходить мосты
23. _____ Вечеринки или сборища
24. _____ Идти по улице
25. _____ Быть дома одному
26. _____ Находиться далеко от дом
27. _____ Кинотеатры
28. _____ Рынки
29 _____ Подземные переходы

Паническая атака – это сильный приступ страха. Подвергшиеся ей ощущают внезапный страх и иногда не могут объяснить, чего они, собственно, боятся. В процессе этой атаки возникают такие отчетливо выраженные симптомы как стесненное дыхание, сердцебиения, дрожь, потение и головокружение, вызывающие нередко страх неизбежной смерти. Может наступить временная утрата способности анализировать ситуацию и планировать свои действия. На время может возникнуть путаница в мыслях, вызывающая страх сойти с ума или потерять контроль над собой. Часто все это приводит к сильному желанию избегать каких-либо ситуаций или просто убегать из определенных мест.
Если такие приступы бывают у Вас, укажите, пожалуйста, их количество за последние **7 ДНЕЙ:** _____

TRAINING ACCEPTABILITY RATING SCALE (TARS): CBT training

Name:……..

Date:…….

Instructions: Based on the training that you received, please rate your agreement with the following statements on this scale:

1 = strongly disagree
2 = moderately disagree
3 = slightly disagree
4 = slightly agree
5 = moderately agree
6 = strongly agree

The first six statements concern the appropriateness or acceptability of the workshop's content: do you think that the material was 'socially valid'?

		CIRCLE YOUR LEVEL OF AGREEMENT
1	**General acceptability:** this approach to CBT training would be appropriate for a variety of mental health service providers.	1 2 3 4 5 6
2	**Effectiveness:** the CBT training will be beneficial for mental health service providers who receive it	1 2 3 4 5 6
3	**No negative side-effects:** the CBT training will **not** result in therapy that leads to harm to clients	1 2 3 4 5 6
4	**Appropriateness:** most participants would accept that this CBT training programme provided an appropriate approach to training in cognitive behavioural therapy	1 2 3 4 5 6
5	**Consistency:** the CBT training was consistent with common sense and good practice in helping mental health service providers to provide CBT treatments	1 2 3 4 5 6
6	**Social validity:** most mental health service providers would approve of training in this therapy method (e.g. would recommend it to	1 2 3 4 5 6

others)

The next 12 questions focus on your impressions of the teaching process and outcomes (i.e. how competently you think the training was conducted, and whether it was helpful or not).
For each question please circle the statement that best expresses your opinion.

PLEASE CIRCLE ONE ANSWER:

7 **Did the training improve your understanding of CBT treatments?**
Not at all A little Quite a lot A great deal

8 **Did the training help you to develop CBT skills?**
Not at all A little Quite a lot A great deal

9 **Has the training made you more confident as a CBT therapist?**
Not at all A little Quite a lot A great deal

10 **Do you expect to make use of what you learnt in the training in your clinical practice?**
Not at all A little Quite a lot A great deal

11 **How competent were the presenters/ supervisors?**
Not at all A little Quite a lot A great deal

12 **In an overall, general sense, how satisfied are you with the training?**
Not at all A little Quite a lot A great deal

13 **Did the training cover the topics it set out to cover?**
Not at all A little Quite a lot A great deal

14 **Did the presenters/ supervisors relate to the group effectively?**
(e.g. made you feel comfortable and understood)
Not at all A little Quite a lot A great deal

15 **Were the presenters/ supervisors motivating?** (e.g. energetic, attentive and creative)
Not at all A little Quite a lot A great deal

16 **How much were you able to implement the training in your practice?**
Not at all A little Quite a lot A great deal

17 **What was the most helpful part of the training for you personally?**
……..

……..

18 **What change, if any, would you recommend?** (e.g. to the content or training methods)

……..

……..

19 **Please make any other comments that you would like to offer.**

……..

……..

20 **Did the supervision improve your understanding of CBT treatments?**
Not at all A little Quite a lot A great deal

21 **Did the supervision help you to develop CBT skills?**
Not at all A little Quite a lot A great deal

22 **Has the supervision made you more confident as a CBT therapist?**
Not at all A little Quite a lot A great deal

23 **In an overall, general sense, how satisfied are you with the supervision?**
Not at all A little Quite a lot A great deal

D. Milne
DM/KM/11th October, 2007, DCP pilot of EBS manual

(Part I from Davis, J.R, Rawana, E.P & Capponi, D.R. (1989).
Acceptability of behavioural staff management techniques.
Beh Res Treatment, 4, 23-44,
Part II from Milne & Noone 1996; CFF Project, HATQ).

ОЦЕНКА ЭФФЕКТИВНОСТИ ТРЕНИНГА (ОЭТ)

ФИО:……

Дата:……

Инструкции для заполнения: Оцените обучение когнитивно-поведенческой терапии, которое Вы получили в рамках этого проекта.

1 = полностью не согласен / не согласна
2 = не вполне согласен / согласна
3 = скорее не согласен / не согласна
4 = скорее согласен / согласна
5 = вполне согласен / согласна
6 = полностью согласен / согласна

Утверждения 1-6 касаются применимости / полезности данного тренинга. Считаете ли Вы, что полученное обучение является социально-значимым?

		Оцените, насколько Вы согласны с нижеприведенными утверждениями					
1	**Общая применимость:** обучение когнитивно-поведенческой терапии будет интересно многим учреждениям и консультантам, предоставляющим услуги в области ментального здоровья.	1	2	3	4	5	6
2	**Эффективность:** прохождение данного обучения, вероятно, будет полезно для вышеупомянутых учреждений и консультантов.	1	2	3	4	5	6
3	**Отсутствие отрицательных побочных эффектов:** использование когнитивно-поведенческой терапии, вероятно, не причинит вред клиентам.	1	2	3	4	5	6
4	**Уместность:** большинство участников признало бы, что обучение обеспечило уместный подход к обучению когнитивно-поведенческой терапии.	1	2	3	4	5	6
5	**Последовательность:** в обучении последовательно совмещались как здравый смысл (понимание процессов), так и практика для обеспечения лучшей помощи учреждениям в предоставлении услуг	1	2	3	4	5	6

когнитивно-поведенческой терапии.

6 **Социальная значимость:** большинство специализированных учреждений одобрят прохождение данного тренинга (а также, возможно, рекомендуют прохождение подобного обучения другим учреждениям). 1 2 3 4 5 6

Следующие 12 вопросов касаются Ваших впечатлений от обучения и его результатов. Насколько полно, по Вашему мнению, было раскрыто содержание, и было ли данное обучение полезным?

Для каждого вопроса выберите ответ, который наиболее отражает Ваши впечатления.

ПОЖАЛУЙСТА, ВЫБЕРИТЕ, ОДИН ОТВЕТ:

7 **Веб-обучение улучшило Ваше понимание методов когнитивно-поведенческой терапии?**
Нисколько Немного Достаточно Очень

8 **Веб-обучение помогало Вам развить навыки, необходимые для проведения когнитивно-поведенческой терапии?**
Нисколько Немного Достаточно Очень

9 **Чувствуете ли Вы себя более уверенно как специалист когнитивно-поведенческой терапии после прохождения веб-обучение?**
Нисколько Немного Достаточно Очень

10 **Считаете ли Вы, что сможете использовать полученные в рамках веб-обучение знания в своей клинической практике?**
Нисколько Немного Достаточно Очень

11 **Насколько компетентны были тренеры, проводившие веб-обучение?**
Нисколько Немного Достаточно Очень

12 **Насколько Вы удовлетворены веб-тренингом в целом?**
Нисколько Немного Достаточно Очень

13 **Были ли раскрыты предварительно заявленные темы в рамках данного веб-обучение?**
Нисколько Немного Достаточно Очень

14 **Мотивировали ли Вас тренеры в процессе веб-обучение (были ли они энергичными, внимательными и творческими)?**

Нисколько Немного Достаточно Очень

15 **Какая часть обучения была наиболее полезна для Вас лично?**

……..

……..

16 **Какие изменения Вы рекомендовали бы внести, если таковые имеются (например, в содержание тренинга или методы обучения)?**

……..

……..

17 **Пожалуйста, сделайте любые другие комментарии, которые, на Ваш взгляд, будут полезны.**

……..

……..

СЛЕДУЮЩИЕ ВОПРОСЫ КАСАЮТСЯ ВАШЕГО ОПЫТА СО СУПЕРВИЗИЯ

18. **Пожалуйста, укажите форму супервизии, которые Вы получали в рамках этого проекта:**

☐ супервизия по скайпу от опытного КБТ терапевта

☐ «само-супервизия» через ежемесячное заполнение консультационного листа

ПОЖАЛУЙСТА, ВЫБЕРИТЕ, ОДИН ОТВЕТ:

19. **Супервизия улучшила Ваше понимание методов когнитивно-поведенческой терапии?**

Нисколько Немного Достаточно Очень

20. **Супервизия помогла Вам развить навыки, необходимые для проведения когнитивно-поведенческой терапии?**

Нисколько Немного Достаточно Очень

21. **Чувствуете ли Вы себя более уверенно как специалист когнитивно-поведенческой терапии после прохождения супервизии?**

Нисколько Немного Достаточно Очень

22. **Насколько Вы удовлетворены супервизией в целом?**

Нисколько Немного Достаточно Очень

Appendix 2: Trial Specific Measures

General information:

a. Name:

b. How many years experience as a qualified therapist did you have when you started the Diploma/ MSc in Advanced Cognitive Therapy Studies? *Please fill in the appropriate number:*

_____ years

c. For admittance to the course, you were all required to either be already BABCP accredited as CBT therapists, or to have sufficient training and experience to warrant accreditation by the BABCP should you so desire.

Are you now BABCP accredited as a CBT *therapist*? If so, when did you achieve accreditation? *Please check the appropriate answer*

___Yes Date of accreditation: _____

___No

Are you now BABCP accredited as a CBT *supervisor*? If so, when did you achieve accreditation? *Please check the appropriate answer*

___Yes Date of accreditation: _____

___No

Are you now BABCP accredited as a CBT *trainer*? If so, when did you achieve accreditation? *Please check the appropriate answer*

___Yes Date of accreditation: _____

___No

d. Prior to starting the Diploma/ MSc in Advanced Cognitive Therapy Studies, what was your total **general** therapy experience (including CBT and non-CBT cases):

Please circle the appropriate answer

0-10 cases 11-20 cases 21-50 cases 50+cases

e. Prior to starting the Diploma/ MSc in Advanced Cognitive Therapy Studies, what was your total **CBT** therapy experience (CBT cases only):

Please circle the appropriate answer

0-10 cases 11-20 cases 21-50 cases 50+cases

f. Prior to starting the Diploma/ MSc in Advanced Cognitive Therapy Studies, how much training in CBT did you have (workshops, etc.)?

*Please fill in the approximate number of **days** of CBT training*

_____days

g. Prior to starting the Diploma/ MSc in Advanced Cognitive Therapy Studies, for **approximately** what **duration of time** (if any) had you received supervision from a CBT specialist: *e.g., "I had received CBT supervision for 4 years prior to starting the course."*

1. In general, how frequent was your CBT specialist supervision*? Please circle one.*

bimonthly monthly biweekly weekly other:_____

. **Prior** to starting the Diploma/ MSc in Advanced Cognitive Therapy Studies, **approximately** how **many total hours** of supervision from a CBT specialist had you received? *e.g., for about one year, I had weekly CBT supervision. For another 5 years, I had monthly CBT supervision.*

. **How many total hours** of CBT supervision did you have **during the duration** of the course, but **not provided by** the Diploma/ MSc in Advanced Cognitive Therapy Studies? *If you still have your CBT activity log, this should be of help at this point.*

*Please fill in the approximate total time period, e.g., during the first year of the of the course, I had monthly CBT supervision through my local service; therefore I had 1 hour*12 months* 1 year=* ***12 hours***
_____= _____ hours

Course assessment:

1. How would you rate you level of CBT competence (as a therapist) prior to starting the Diploma/ MSc in Advanced Cognitive Therapy Studies? *please circle one number*

0----------1----------2----------3----------4----------5
no ability minimal ability some ability moderate ability considerable ability complete mastery

2. How would you rate your CBT competence (as a therapist) upon completing the Diploma/ MSc in Advanced Cognitive Therapy Studies? *please circle one number*

0----------1----------2----------3----------4----------5
no ability minimal ability some ability moderate ability considerable ability complete mastery

3. How much impact do you think the following components of the course had on any increase (or decrease) in your level of CBT competence? *Please circle the item that best describes the amount of impact you think each component had.*

COMPONENTS OF TRAINING	**Amount of impact** *please circle the appropriate description for each item*					
Clinical Updates:						
1. Reading CT literature on your own in preparation for clinical updates	none	minimal	somewhat	moderate	sizable	very large
2. Theoretical input from clinical updates	none	minimal	somewhat	moderate	sizable	very large
3. Clinical material within clinical updates	none	minimal	somewhat	moderate	sizable	very large
4. Experiential exercises within clinical updates: *In general*	none	minimal	somewhat	moderate	sizable	very large
5. Experiential exercises within clinical updates: *Role plays*	none	minimal	somewhat	moderate	sizable	very large
6. Experiential exercises within clinical updates: *Group exercises*	none	minimal	somewhat	moderate	sizable	very large
7. Experiential exercises within clinical updates: *Practising behavioural experiments*	none	minimal	somewhat	moderate	sizable	very large
8. Reflection on application of materials presented in clinical updates to your current practice	none	minimal	somewhat	moderate	sizable	very large
9. Using CBT methods on yourself (e.g., daily thought records)	none	minimal	somewhat	moderate	sizable	very large
10. Discussion with peers while preparing for clinical updates	none	minimal	somewhat	moderate	sizable	very large
11. Other experiential elements during clinical updates (please describe): _____	none	minimal	somewhat	moderate	sizable	very large
12. Review of clinical update Power Point handouts and notes	none	minimal	somewhat	moderate	sizable	very large
13. Hearing feedback and questions from peers during teaching sessions	none	minimal	somewhat	moderate	sizable	very large
14. Informal discussions with peers during breaks	none	minimal	somewhat	moderate	sizable	very large

COMPONENTS OF TRAINING	Amount of impact *please circle the appropriate description for each item*					
15. Informal discussions with tutors during breaks	none	minimal	somewhat	moderate	sizable	very large
Written work:						
16. Preparing and writing case reports	none	minimal	somewhat	moderate	sizable	very large
17. Feedback on case reports	none	minimal	somewhat	moderate	sizable	very large
Supervision practicals (clinical cases):	*For these questions, we are interested the impact you think the supervision you received for your **clinical work with patients** had on your CBT competence as a **therapist**.*					
18. Supervision of clinical work (in general)	none	minimal	somewhat	moderate	sizable	very large
19. Process of preparing for supervision (preparing case presentation and questions)	none	minimal	somewhat	moderate	sizable	very large
20. Peer feedback on recordings of clinical work with patients	none	minimal	somewhat	moderate	sizable	very large
21. Role plays of clinical scenarios during supervision practicals	none	minimal	somewhat	moderate	sizable	very large
22. Observation of peers' discussion of clinical work during supervision practicals	none	minimal	somewhat	moderate	sizable	very large
23. Tutors' CTS ratings and comments on submitted recordings of clinical work	none	minimal	somewhat	moderate	sizable	very large
24. Listening to your own clinical tapes and rating them on the CTS	none	minimal	somewhat	moderate	sizable	very large
Supervision practicals (supervisory skills):	*For these questions, we are interested in the impact you think the supervision you received for your **supervision of other therapists** had on your competence as a **disseminator**.*					
25. General feedback and instruction regarding supervisory skills from tutors during supervision practicals	none	minimal	somewhat	moderate	sizable	very large
26. General feedback from peers regarding supervisory skills during supervision practicals	none	minimal	somewhat	moderate	sizable	very large
27. Observation of peers' discussion of supervisory work during supervision practicials	none	minimal	somewhat	moderate	sizable	very large

COMPONENTS OF TRAINING	**Amount of impact** *please circle the appropriate description for each item*					
28. Tutors' rating on the "Therapist Competence Scale" and comments on submitted recordings of supervisory work	none	minimal	somewhat	moderate	sizable	very large
29.Listening to your own supervisory recording and rating them on the "Therapist Competency Scale"	none	minimal	somewhat	moderate	sizable	very large
30. Other (*any additional component not listed above)*: _____	none	minimal	somewhat	moderate	sizable	very large

4. Reasons for seeking training through the Diploma/ MSc in Advanced Cognitive Studies course?

Please circle one number for each item to describe its importance in your decision to seek training.

a. Advancement in professional career within the NHS or current occupational setting

0	***1***	***2***	***3***	***4***	***5***
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

b. Enhanced opportunities for future private practice

0	***1***	***2***	***3***	***4***	***5***
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

c. Desire to enhance competence as a CBT practitioner

0	***1***	***2***	***3***	***4***	***5***
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

d. Desire to enhance competence as a CBT trainer and supervisor

0	***1***	***2***	***3***	***4***	***5***
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

e. Agreement with the cognitive model

0	1	2	3	4	5
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

f. Sense of incompetence at times when providing therapy or disseminating CBT

0	1	2	3	4	5
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

g. Funding for a post-qualification course became available through NHS CBT initiatives or employer

0	1	2	3	4	5
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

h. Desire to obtain BABCP accreditation as a CBT therapist

0	1	2	3	4	5
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

i. Desire to obtain BABCP accreditation as a CBT supervisor or trainer

0	1	2	3	4	5
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

j. For use of CBT in future research

0	1	2	3	4	5
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

k. For the purposes of personal growth

0	1	2	3	4	5
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

l. Desire to seek a peer group of like-minded practitioners

0	1	2	3	4	5
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

m. Pressure to enhance CBT competence or practice from current/ future employers

0	***1***	***2***	***3***	***4***	***5***
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

n. Other (*any additional motivation not listed above)*:_____

0	***1***	***2***	***3***	***4***	***5***
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

Many thanks for your time and effort in completing this survey!

General information:

a. Name:

b. Age:

c. Gender:

d. Profession:

e. How many years experience as a qualified therapist did you have when you started the CBT diploma course? *please fill in the appropriate amount:*

_____ years

f. Are you BABCP accredited? *please check the appropriate answer*

____yes
____no

g. If not, do you think it is likely that you would meet the BABCP accreditation as a therapist? *please check the appropriate answer*

____yes
____no
____not sure

h. Prior to starting the CBT diploma course, what was your total **general** therapy experience (including CBT and non-CBT cases):

please circle the appropriate answer

0-10 cases 11-20 cases 21-50 cases 50+cases

i. Prior to starting the CBT diploma course, what was your total **CBT** therapy experience (CBT cases only):

please circle the appropriate answer

0-10 cases 11-20 cases 21-50 cases 50+cases

j. Prior to starting the CBT diploma course, how much training in CBT did you have (workshops, etc.)?

*please fill in the approximate number of **days** of CBT training*

_____days

k. Prior to starting the CBT diploma course, approximately **how many total hours** of supervision from a CBT specialist had you received?

*Please fill in the approximate total time period, eg: for 2 years I had once-weekly supervision; therefore, I had 1 hour*48 weeks*2 years= **96 hours** in all.*

_____= _____ hours

. In total, the amount of additional CBT supervision received during the CBT diploma course:
please fill in the appropriate amount
_____ number of months during the duration of the course
_____total number of hours of additional CBT supervision during the diploma course

Course assessment:

1. How would you rate initial (pre-course) level of CBT competence: *please circle one number*

0----------1----------2----------3----------4----------5
no ability minimal ability some ability moderate ability considerable ability complete mastery

2. How would you rate your current level of CBT competence? *please circle one number*

0----------1----------2----------3----------4----------5
no ability minimal ability some ability moderate ability considerable ability complete mastery

3. How much impact did the following components in the course have on any increase (or decrease) in your level of CBT competence? *Please circle the item that best describes the amount of impact you think each component had.*

Component of training	**Amount of impact** *please circle the appropriate description for each item*					
1. individual reading of CBT literature	none	minimal	somewhat	moderate	sizable	very large
2. theoretical section of lectures	none	minimal	somewhat	moderate	sizable	very large
3. clinical material within lectures	none	minimal	somewhat	moderate	sizable	very large
4. experiential exercises within lectures (in general)	none	minimal	somewhat	moderate	sizable	very large
5. experiential exercises within lectures: role plays	none	minimal	somewhat	moderate	sizable	very large
6. experiential exercises within lectures: group exercises	none	minimal	somewhat	moderate	sizable	very large
7. experiential exercises within lectures: practicing behavioral experiments	none	minimal	somewhat	moderate	sizable	very large
8. reflection on application of materials to your current practice	none	minimal	somewhat	moderate	sizable	very large
9. using CBT methods on yourself (ie: daily thought records)	none	minimal	somewhat	moderate	sizable	very large
10. any other experiential elements during lectures: _____	none	minimal	somewhat	moderate	sizable	very large

Component of training	**Amount of impact** *please circle the appropriate description for each item*					
11. preparing and writing of essays/ dissertation	none	minimal	somewhat	moderate	sizable	very large
12. preparing and writing of case reports	none	minimal	somewhat	moderate	sizable	very large
13. peer therapy (in general)	none	minimal	somewhat	moderate	sizable	very large
14. peer therapy: experience as a client (practicing on self)	none	minimal	somewhat	moderate	sizable	very large
15. peer therapy: feedback from a peer on their client-experience with you as the therapist	none	minimal	somewhat	moderate	sizable	very large
16. peer therapy : any other aspect_____	none	minimal	somewhat	moderate	sizable	very large
17. informal discussions with peers during breaks	none	minimal	somewhat	moderate	sizable	very large
18. informal discussions with presenters during breaks	none	minimal	somewhat	moderate	sizable	very large
19. review of power point handouts and notes	none	minimal	somewhat	moderate	sizable	very large
20. reflecting at the end of the day on materials covered and how it can be applied to my own practice	none	minimal	somewhat	moderate	sizable	very large
21. hearing feedback and questions from peers during lectures	none	minimal	somewhat	moderate	sizable	very large
22. supervision (in general)	none	minimal	somewhat	moderate	sizable	very large
23. supervision: general feedback and instruction from supervisor	none	minimal	somewhat	moderate	sizable	very large
24. supervision: general feedback from peers	none	minimal	somewhat	moderate	sizable	very large
25. process of preparing for supervision (preparing case presentation and question)	none	minimal	somewhat	moderate	sizable	very large
26. supervisor feedback on session tapes during supervision	none	minimal	somewhat	moderate	sizable	very large
27. peer feedback on session tapes during supervision	none	minimal	somewhat	moderate	sizable	very large

Component of training	Amount of impact *please circle the appropriate description for each item*					
28. supervisor CTS rating and comments on submitted tapes	none	minimal	somewhat	moderate	sizable	very large
29. listening to own tapes and rating on CTS	none	minimal	somewhat	moderate	sizable	very large
30. role plays within supervision	none	minimal	somewhat	moderate	sizable	very large
31. observation of peers' supervisory interactions	none	minimal	somewhat	moderate	sizable	very large
32. Other (*any additional component not listed above)*: _____	none	minimal	somewhat	moderate	sizable	very large

4. Reasons for seeking training at this point in your practice?
Please circle one number for each item to describe its importance in your decision to seek training.

a. Advancement in professional career within the nhs

0 ----------***1*** ----------***2***----------***3***----------***4***----------***5***
not a motivation *slight consideration* *somewhat important* *considerable motivation* *very important* *a primary motivation*

b. Opportunity for future private practice

0 ----------***1*** ----------***2***----------***3***----------***4***----------***5***
not a motivation *slight consideration* *somewhat important* *considerable motivation* *very important* *a primary motivation*

c. Desire to be a competent CBT practitioner

0 ----------***1*** ----------***2***----------***3***----------***4***----------***5***
not a motivation *slight consideration* *somewhat important* *considerable motivation* *very important* *a primary motivation*

d. Agreement with the cognitive model

0 ----------***1*** ----------***2***----------***3***----------***4***----------***5***
not a motivation *slight consideration* *somewhat important* *considerable motivation* *very important* *a primary motivation*

e. Sense of incompetence at times when providing therapy

0 ----------***1*** ----------***2***----------***3***----------***4***----------***5***
not a motivation *slight consideration* *somewhat important* *considerable motivation* *very important* *a primary motivation*

f. Opportunity with current nhs CBT initiatives to get funding/ support from service where you are currently employed

0	1	2	3	4	5
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

g. Desire to obtain BABCP accreditation

0	1	2	3	4	5
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

h. For use of CBT in future research

0	1	2	3	4	5
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

i. For the purposes of personal growth

0	1	2	3	4	5
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

j. Desire to seek a peer group of like-minded practitioners

0	1	2	3	4	5
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

k. Pressure to be CBT competent or compliant from current/ future employers

0	1	2	3	4	5
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

l. Other (*any additional motivation not listed above)*:_____

0	1	2	3	4	5
not a motivation	*slight consideration*	*somewhat important*	*considerable motivation*	*very important*	*a primary motivation*

Many thanks for your time and effort in completing this survey!

Cognitive Behavioural Therapy Theory and Assessment Skills Scale (C-TASS)

Tape number : _____ Date of Rating_____

Directions: For each recording, assess the therapist on the 0 to 6 scale below, and record the rating on the line next to the item number. Descriptions are provided for even-numbered scale points. If you believe the therapist falls between two of the descriptors, select the intervening odd number (1, 3, 5). For example, if the therapist set a very good agenda but did not establish priorities, assign a rating of a 5 rather than a 4 or 6.

If the descriptions for a given item occasionally do not seem to apply to the session you are rating, feel free to disregard them and use the more general scale below:

0	1	2	3	4	5	6
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

Please do not leave any item blank. For all items, focus on the skill of the therapist, taking into account how difficult the patient seems to be.

Part I. GENERAL THERAPEUTIC SKILLS

____1. SETTING THE SCENE

0 Therapist did not explain assessment or make any attempt to set the patient at ease.

2 Therapist was friendly and acknowledged the context of the initial interview, but only in passing.

4 Therapist tried to set the patient at ease, and **explained the process and goals of assessment** (i.e., that this sessions does not include treatment, but is a chance for the therapist to understand the patient's current concerns and difficulties).

6 Therapist displayed optimal warmth and sensitivity in the initial interaction with the patient. Process and goals of the assessment were outlined in a way that set the tone for collaboration (e.g., therapist expressed the desire to more thoroughly understand the patient's difficulties, encouraged patient to give feedback if questions became too uncomfortable, or seem irrelevant.).

____2. FEEDBACK

0 Therapist did not ask for feedback to determine patient's understanding of, or response to, the session.

2 Therapist elicited some feedback from the patient, but did not ask enough questions to be sure the patient understood the therapist's line of reasoning during the session or to ascertain whether the patient was satisfied with the session.

4 Therapist asked **enough** questions to be sure that the patient understood the therapist's *line of reasoning throughout* the session and to determine the *patient's reactions to the session.* The therapist adjusted his-her behaviour in response to the feedback, when appropriate.

6 Therapist was especially adept at eliciting and responding to verbal and non-verbal feedback throughout the session (e.g., elicited reactions to session, regularly checked for understanding, helped summarise main points at end of session).

____3. UNDERSTANDING

0 Therapist repeatedly failed to understand what the patient explicitly said and thus consistently missed the point. Poor empathic skills.

2 Therapist was usually able to reflect or rephrase what the patient explicitly said, but repeatedly failed to respond to more subtle communication. Limited ability to listen and empathise.

4 Therapist generally seemed to grasp the patient's "internal reality" as reflected by *both what the explicitly said and what the patient communicated in more subtle ways.* Good ability to listen and empathise.

6 Therapist seemed to understand the patient's "internal reality" thoroughly and was adept at communicating this understanding through appropriate verbal and non- verbal responses to the patient (e.g., the tone of the therapist's response conveyed a sympathetic understanding of the patient's "message"). Excellent listening and empathic skills.

____4. INTERPERSONAL EFFECTIVENESS

0 Therapist had poor interpersonal skills. Seemed hostile, demeaning, or in some other way destructive to the patient.

2 Therapist did not seem destructive, but had significant interpersonal problems. At times, therapist appeared unnecessarily impatient, aloof, insincere or had difficulty conveying confidence and competence. The assessment process seemed like an *impersonal interview* designed primarily to gather data.

4 Therapist displayed a satisfactory degree of warmth, concern, confidence, genuineness, and professionalism. Patient engagement in the assessment process was productively negotiated. No significant interpersonal problems.

6 Therapist displayed optimal levels of warmth, concern, confidence, genuineness, and professionalism, appropriate for this particular patient/session. Questions were posed with sincere curiosity, and the therapist responded with compassion and sensitivity to patient disclosure.

____5. COLLABORATION

0 Therapist did not attempt to set up collaboration with patient.

2 Therapist attempted to collaborate with patient, but had difficulty either negotiating patient engagement in the assessment process or establishing rapport.

4 Therapist was able to collaborate with patient, obtain patient engagement in the assessment process, and establish rapport. The therapist checked back with the patient about what had been understood.

6 Collaboration seemed excellent; therapist encouraged patient as much as possible to take an active role during the session (e.g., by explaining rationale for different areas of questioning and checking for patient understanding and consent) so they could function as a "team". Therapist provided frequent *'capsule summaries'* following the patient's responses, and made more comprehensive summaries before shifting the focus of questioning (e.g., summarized presenting problem before moving on to past history and predisposing factors).

____6. SESSION MANAGEMENT

0 Therapist made no attempt to structure therapy time. Session seemed aimless.

2 Session had some direction, but the therapist had significant problems with structuring or pacing (e.g., too little structure, inflexible about structure, too slowly paced, too rapidly paced, or failed to manage unproductive digressions.

4 Therapist was reasonably successful at using time efficiently. Therapist maintained appropriate control over flow of discussion and pacing.

6 Therapist used time efficiently by tactfully limiting peripheral and unproductive discussion, and by pacing the session as rapidly as was appropriate for the patient. Was able to prioritise session time for assessing topics essential to creating a CBT treatment-guiding formulation (i.e., maintaining cycles).

Part II. CBT ASSESSMENT SKILLS

____7. GUIDED DISCOVERY

0 Therapist relied primarily on debate, persuasion, or "lecturing". Therapist seemed to be "cross-examining" patient, putting the patient on the defensive, or didactically pointing out links in the patient's maintaining cycles.

2 Therapist relied too heavily on persuasion and debate, rather than on guided discovery, , or the therapist's questioning seemed aimless. However, therapist's style was supportive enough that patient did not seem to feel attacked of defensive.

4 Therapist, for the most part, helped patient see new perspectives through guided discovery (e.g., considering the links between behaviour, thoughts, feelings and physiology) rather than through didactic explanation. *Used questioning appropriately (ie: used of downward arrowing in a productive manner).*

6 Therapist was especially adept at using guided discovery during the session to explore problems and help patient draw
his/her own conclusions. Achieved an excellent balance between psychoeducation and skilful questioning.

____8. ASSESSMENT OF THE PRESENTING PROBLEM

0 Therapist did not attempt to elicit specific information regarding thoughts, feelings, images, meanings, behaviours, physiological changes, triggers or modifiers in discussing the patient's current difficulties, or therapist did not inquire directly about thoughts, assumptions, meanings, or beliefs.

2 Therapist used appropriate techniques to elicit some thoughts AND behaviours; however, therapist had difficulty finding a focus or focused on thoughts/behaviours/ other maintaining factors that were irrelevant to the patient's key problems.

4 Therapist *asked about a recent example* and elicited information on specific thoughts, beliefs and coping behaviours relevant to the presenting problem. However, the therapist could have focused on more central thoughts or maintaining processes (i.e., safety behaviours) that offered greater promise for progress. The therapist did not elicit enough information in all domains crucial for formulation (i.e., thoughts, feelings, behaviour and physiological change).

6 Therapist asks about a recent example and very skilfully addressed the four domains necessary for formulation (thoughts, feelings, behaviours and physiological changes), with a focus on the key thoughts/ assumptions, and safety behaviours most relevant to understanding and treating the problem area The therapist also asks about triggers and modifiers.

____9. ASSESSMENT OF CONSEQUENCES

0 Therapist did not attempt to assess the impact the patient's difficulties have on their lives.

2 Therapist asked *generally* about the patient's current level of occupational or social functioning, but did not inquire about specific relationships (e.g., spouse, children, family, boss, friends) or life satisfaction.

4 Therapist assessed the impact of the patient's problem on their own occupational and social functioning, and on the lives and relationships with important others (i.e. spouse, children, family, boss, friends). *The therapist tuned into expressions of hopelessness*, and asked relevant follow-up questions..

6 Therapist thoroughly assessed the consequences of the presenting problem on the patient's own life, and inquired about its impact on the lives of important others. The therapist's questioning was titrated to the patient's responses, and more attention was given to understanding the areas that might be part of a systemic formulation, or that caused the patient significant distress. If hopelessness is expressed, the therapist asked follow-up questions to determine immediate risk.

____10. PAST HISTORY AND PRECIPITATING EVENTS

0 Therapist did not attempt to assess vulnerability factors or precipitating events. .

2 Therapist asked about *either* early experience or precipitating events, *but not both*, or therapist spent too much time on this topic to the detriment of other areas of assessment.

4 Therapist asked about *both* topics: early experience, and precipitating events. Therapist asked about thoughts, conclusions and meaning when discussing the *development of the problem.*

6 Therapist elicited optimal information on vulnerability factors, and precipitating events. When one of the topics seemed to be worthy of more attention than would usually be given for this patient's presenting problem, the therapist acknowledged this, and either requested permission either to move on and return to the subject later, or to include the subject as an immediate focus of clinical attention.

____11. EXPLAINING THE CBT MODEL

0 Therapist is unable to explain the CBT model (e.g., leaves out a crucial element such as cognition, or does not mention links between the domains).

2 Therapist had significant difficulties explaining the CBT model. Professional jargon was used, or the explanation was incomprehensible, or contained factual or theoretical errors (e.g., that physiology causes mood).

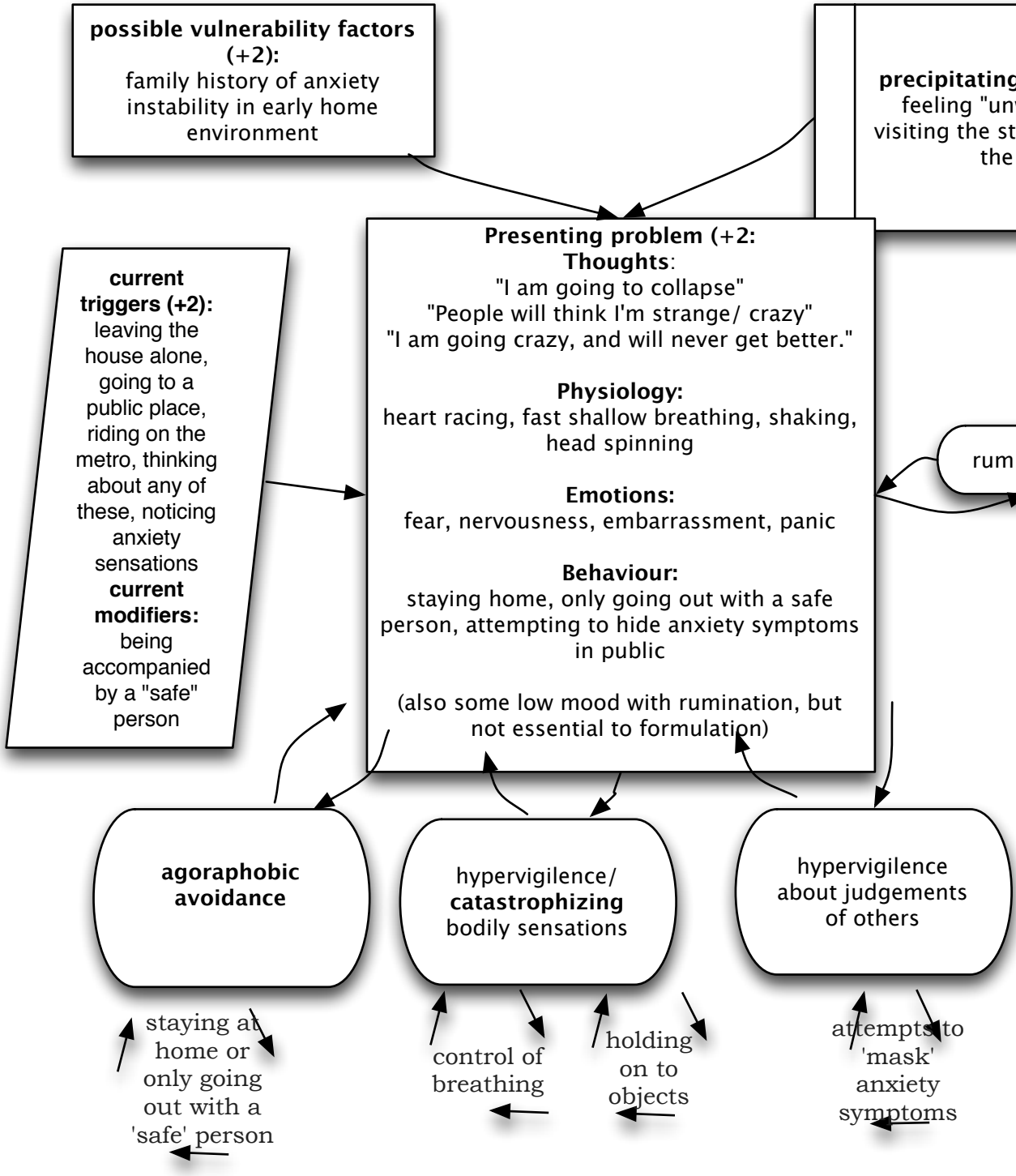
4 Therapist related the explanation to the *patient's presenting problem* and engaged the patient in *some Socratic questioning* to highlight some links between domains.

6 The therapist used Socratic questioning to help the patient understand the CBT model and its relation to the presenting problem. The explanation was clear and accessible and referenced some of the ways in which the patient's current cognitions and coping strategies may be working to exacerbate each other.

Part IV. OVERALL RATINGS AND COMMENTS

12. How would you rate the clinician overall in this session, as a cognitive therapist?

0	1	2	3	4	5	6
Not CBT	Poor	Barely Adequate	Mediocre	Satisfactory	Good	Excellent



SCORING FOR EACH COMPONENT:

0 = Information missing or not justifiable

1 = Some relevant information present, but not all

2 = All relevant information is present

ADDITIONAL SCORING:

+1 Clearly presented

-1 Faulty links or reasoning

MAXIMUM POSSIBLE SCORE = 15

Maintaining cycles (+2 for each one for a total of +6)

Therapist's name: _____

Patient's ID #:_____

Date of assessment: _____

Please answer the questions below for the patient you are treating:

Age: _____

Sex:
- ☐ Male
- ☐ Female

Marital Status:
- ☐ Married
- ☐ Living with somebody as if married
- ☐ Widowed
- ☐ Divorced or annulled
- ☐ Separated
- ☐ Never married

What age was the patient when he/ she finished full time education (i.e. school/college/university)? _____ years old

Please rate highest educational achievement

1. Doctor of Science
2. Candidate of Science
3. MBA
4. Second diploma
5. University degree
6. College degree
7. Technical degree
8. Other (specify)

_____

What is his/her current employment?

1. Full time employment
2. Part time employment
3. Self-employed
4. On sick leave
5. On disability
6. Retired
7. Unemployed

Please provide your current job title/role:

_____

Is the patient *currently* taking any medication for psychological difficulties (e.g. anxiety or depression medication such as Amitriptyline or Fluoxetine)?

☐ Yes (Please state what type of drug If known)

_____

☐ No

Has the patient ever *in the past* taken any medication for psychological difficulties (e.g. anxiety or depression medication such as amitriptyline or Fluoxetine)?

☐ Yes (Please state what type of drug If known)

_____

☐ No

Have the patient ever taken part in any psychological treatment for psychological difficulties (e.g., group/individual talking therapies such as counselling)?

☐ Yes (Please state what type of treatment If known)

_____

☐ No

Main presenting problem: (please tick only one)

☐ Depression
☐ Panic disorder/ agoraphobia
☐ Specific phobia
☐ Social phobia
☐ Obsessive-compulsive disorder
☐ Posttraumatic stress disorder
☐ Generalised anxiety disorder
☐ Health anxiety
☐ Eating disorder
☐ Personality disorder
☐ Adjustment disorder
☐ Chronic pain
☐ Medically unexplained symptoms (e.g. IBS, tinnitus etc.)
☐ Substance or alcohol use problem
☐ Psychotic illness
☐ Bipolar disorder

☐ Other (please state) _____

Any secondary or co-morbid: (please tick all that apply)

☐ Depression
☐ Panic disorder/ agoraphobia
☐ Specific phobia
☐ Social phobia
☐ Obsessive-compulsive disorder
☐ Posttraumatic stress disorder
☐ Generalised anxiety disorder
☐ Health anxiety
☐ Eating disorder
☐ Personality disorder
☐ Adjustment disorder
☐ Chronic pain
☐ Medically unexplained symptoms (e.g. IBS, tinnitus etc.)
☐ Substance of alcohol use problem
☐ Psychotic illness
☐ Bipolar disorder

☐ Other (please state) _____

Appendix 3: Chapter Five Trial Materials

WARNEFORD HOSPITAL
OXFORD

UNIVERSITY OF OXFORD
DEPARTMENT OF PSYCHIATRY

INFORMATION FOR PARTICIPANTS

The impact of web-based CBT training

Purpose of study: To evaluate the efficacy of online cognitive behavioural therapy (CBT) training in effecting change in clinical skill.

Invitation
You are invited to participate in this research study. Before agreeing to volunteer, it is important that you understand why the research is being done and what it will involve. Please do not hesitate to ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?
This research is aimed at understanding more about the effects of online training in CBT on the clinical CBT skills of fifth year psychology students; we are particularly interested whether factors such as individual learning style, or previous instruction in CBT have a relationship with the change in CBT clinical skills

Why have I been invited?
Your have been invited because you are a fifth year student studying clinical psychology-this learning group will be the focus on the experiment.

This study is NOT suitable for the following people: those who are studying CBT independently at this time (not as part of your University's academic programme) through a training course or through clinical supervision.

Do I have to take part?
It is up to you to decide whether or not to take part. If you decide to participate you would be given this information sheet and asked to sign a consent form. If you decide to take part, you are still free to withdraw without penalty at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part will not affect your studies or academic status in any way.

What will happen to me if I take part?
You will be asked to complete a short questionnaire with questions about your learning style. It should take about 10 minutes to complete. After this, you will be randomly assigned either to a group that will have immediate access to the online CBT training programme, or to a group that will be given access to these training materials in six weeks' time. All participants will be sent by e-mail a short case description of a fictitious patient. During the following week, an experienced clinician will telephone you and role-play a clinical scenario involving this fictitious patient, for approximately 20 minutes. This conversation will be recorded for assessment purposes. At the end of the conversation, we will ask you to construct a CBT conceptualization of this patient's problem.
After this, if you are in the immediate training group, you will receive a user name and password to access the online materials created by the Oxford Cognitive Therapy Centre. The training

programme covers basic CBT theory, formulation and assessment and has been translated into Russian. You will have four weeks to watch these training materials. In all, you will need about 3 hours to complete the training programme. At the end of four weeks, you will receive a second phone call and will repeat the same scenario as at the beginning of the trial. In total, the study will take about four hours.
If you are in the delayed training group, you will complete the two role-play assessments at the same time as the first group, but will receive access to the training programme after the second phone call is completed.

What are the possible risks and benefits of taking part?
There are no known risks involved with any of the tasks we will use. Should you feel uncomfortable for any reason during the study please notify the researcher who will pause or terminate the experiment as appropriate. Your participation is entirely voluntary and you may withdraw at any time, without giving a reason.

Benefits include a chance to receive CBT training from highly-regarded instructors. When both phone calls have been completed and you have finished the training programme, we will issue certificates of participation from the Oxford Cognitive Therapy Centre. In addition, you will be given access to two additional modules addressing basic clinical CBT skills, and the treatment of panic disorder and obsessive-compulsive disorder, also translated into Russian.

Will my taking part be kept confidential?
Participation and all information collected will be kept confidentially in anonymous form. Only the research team will have access to the data, which will be held in accordance with the data protection act and destroyed after 10 years. Procedures adhere to the British Psychological Society (BPS) and Oxford Good Practice in Research guidelines.

What will happen to the results of the research?
Anonymised results will be pooled with those of other participants, analysed and subsequently published and/or reported. No written work will identify any individual.

How can I raise a concern?
If you have a concern about any aspect of this project, please speak to the researcher concerned (sasha.rakovshik@psych.ox.ac.uk or +7 903 798 2951) who will do her best to answer your query. If you remain unhappy and wish to make a formal complaint, please contact Miss C. Green (ethics@medsci.ox.ac.uk) who will then direct your complaint to the appropriate body.

Further information about this research
The study is being carried out for the Doctorate in Psychiatry offered by the Department of Psychiatry at Oxford University. It has been approved by the University of Oxford, Central University Research Ethics committee. If you have any further questions, in the first instance please contact:

- Sarah Rakovshik (principal investigator), sasha.rakovshik@psych.ox.ac.uk
- Dr. Freda McManus (supervisor), Freda.McManus@psych.ox.ac.uk

Thank you for considering participation

ОКСФОРДСКИЙ УНИВЕРСИТЕТ
ОТДЕЛЕНИЕ ПСИХИАТРИИ

КЛИНИКА ВАРНЕФОРД
ОКСФОРД

ИНФОРМАЦИЯ ДЛЯ УЧАСТНИКОВ

Влияние электронной версии тренинга когнитивно-поведенческой терапии

Цель исследования
Оценить уровень эффективности электронной версии тренинга когнитивно-поведенческой терапии в развитии клинических навыков.

Приглашение
Вы приглашены для участия в исследовании. До подтверждения Вашего добровольного согласия, важно понимать, почему это исследование проводится и в чем оно заключается. Вы можете задавать любые вопросы и получить дополнительную информацию, если Вам что-то неясно. Подумайте, действительно ли Вы хотите принять участие. Благодарим Вас за ознакомление с этой информацией.

Какова цель исследования?
Целью данного исследования является дополнительное изучение эффективности электронной версии тренинга когнитивно-поведенческой терапии на клинические навыки студентов пятого курса, в частности, влияние таких факторов, как индивидуальный стиль обучения или ранее пройденные тренинги когнитивно-поведенческой терапии на развитие клинических навыков.

Почему меня пригласили?
Вы были приглашены, так как Вы являетесь студентом пятого курса факультета клинической психологии, т.е. являетесь фокус-группой этого исследования.

В этом исследовании НЕ могут принимать участие студенты, изучающие когнитивно-поведенческую терапию индивидуально (вне академической программы университета), на тренингах или посредством индивидуального обучения.

Должен ли я принимать участие в исследовании?
Принимать ли участие в данном исследовании является исключительно Вашим волеизъявлением. В случае если Вы решите участвовать, Вам будет предложено подписать заявление о согласии с участием в исследовании. Вы сможете прервать свое участие без каких-либо штрафных санкций и объяснения причин. Решение прекратить участие в исследовании или решение не принимать в нем участие ни в коей мере не повлияет на процесс обучения или Ваш академический статус.

Что предполагает мое участие?
Вам будет предложено ответить на несколько вопросов, касающихся Вашего стиля обучения. Это займет примерно 10 минут. После этого по принципу случайной выборки Вы будете объединены с группой студентов, которым будет незамедлительно предоставлен доступ к электронной версии тренинга когнитивно-поведенческой терапии, или к группе студентов, которым будут предоставлены материалы тренинга через 6 недель. Все студенты получат по электронной почте описание состояния вымышленного пациента. После этого в течение ближайшей недели у Вас состоится 20-минутное телефонное интервью с опытным клиническим консультантом для обсуждения случая данного вымышленного пациента. Ваше общение с консультантом будет записано для последующего анализа. В конце разговора Вам предложат

концептуально сформулировать подход к лечению данного пациента посредством когнитивно-поведенческой терапии.
После этого студенты 1-ой группы получат доступ (логин и пароль) к материалам Оксфордского центра когнитивно-поведенческой терапии. Программа тренинга покрывает общую теорию когнитивно-поведенческой терапии, формулировки и оценки, переведенные на русский язык. У Вас будет 4 недели для ознакомления с данными материалами. В целом, Вам понадобиться около 3 часов, чтобы пройти это обучение. По истечении 4-недельного срока, у Вас состоится 2-ой телефонный разговор с тем же сценарием, что и в первый раз. Таким образом, все исследование займет около 4 часов.
Если Вы принадлежите ко 2-ой группе студентов, Вам будет предоставлен доступ к материалам тренинга после 2-ого интервью.

Каковы предполагаемые риски и преимущества от участия в данном исследовании?
Риски, связанные с заданиями, которые Вам будут предложены, не выявлены. В случае если Вы ощутите некий дискомфорт по какой-либо причине, пожалуйста, сообщите об этом консультанту, который приостановит или прервет исследование надлежащим образом. Участие является добровольным, и Вы можете прервать его без объяснения причины.

Преимуществом участия в данном исследовании является прохождение обучения когнитивно-поведенческой терапии у тренеров высокой квалификации. После прохождения тренинга Вам будут вручены сертификаты о прохождении данного обучения. Помимо этого Вам будет предложен доступ к 2-ум дополнительным модулям обучения когнитивно-поведенческой терапии для развития клинических навыков лечения панического расстройства также переведенных на русский язык.

Будет ли мое участие конфиденциальным?
Ваше участие будет анонимным, а вся полученная информация конфиденциальной. Доступ к данным будет только у команды исследователей, данные будут сохранены установленным образом и уничтожены через 10 лет. Все процедуры соответствуют стандартам Британского психологического общества и Оксфордского центра лучших исследовательских практик.

Как будут использованы результаты исследования?
Анонимные результаты участников будут объединены, проанализированы и сформированы в отчет. Ни в каких письменных документах не будут упоминаться имена участников.

Каким образом я могу выразить сомнение?
Если у Вас возникли сомнения или вопросы касательно какой-либо части проекта, пожалуйста, свяжитесь с исследователем по электронной почте rakovsh@post,harvard.edu или по тел. +7 903 798 2951. Если у Вас останется чувство неудовлетворенности и Вы захотите выразить жалобу, пожалуйста, свяжитесь с С. Грин (ethics@medsci.ox.ac.uk), которая направит Вашу жалобу соответствующему ответственному сотруднику.

Дополнительная информация об исследовании
Данное исследование проводится в рамках докторской работы по психиатрии в Оксфордском университете и одобрено Оксфордским университетом и комитетом по этике Центрального исследовательского университета. По любым вопросам просим связываться с:

- Сарой Раковщик (главный исследователь) - rakovsh@post.harvard.edu
- Доктором Фредой МакМанус (супервизор) - Freda.McManus@psych.ox.ac.uk

Благодарим за внимание к данному исследованию

UNIVERSITY OF OXFORD
DEPARTMENT OF PSYCHIATRY

WARNEFORD HOSPITAL
OXFORD
OX3 7JX

TEL: (01865) 613 143
FAX: (01865) 793101

CONSENT FORM

Online CBT training for Russian students

- Principal Investigators: Sarah G. Rakovshik (principal investigator), sasha.rakovshik@psych.ox.ac.uk
- Dr. Freda McManus (supervisor), Freda.McManus@psych.ox.ac.uk

This study has been approved by the University of Oxford Central University Research Ethics Committee
Ref № MSD/IDREC/C1/2010/9

Please initial box

I confirm that I have read and understand the information sheet dated (Jan. 22,2010) (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had any questions I asked answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without any penalty. ☐

I agree to the research assessments being audio taped ☐

I understand that personal data will be identified using only by a number code, will be accessed only by members of the research team and will be destroyed after a period of 10 years. ☐

I understand that all information will be kept strictly confidential within the limits of the law and except in the rare circumstances in which it is judged that I or someone else is at immediate risk of serious harm ☐

I agree to take part in the above study. ☐

_____	_____	_____
Name of Student	Date	Signature
_____	_____	_____
Researcher	Date	Signature

2 COPIES TO BE COMPLETED: ONE FOR RESEARCH FILE AND ONE FOR PARTICIPANT

ОКСФОРДСКИЙ УНИВЕРСИТЕТ
ОТДЕЛЕНИЕ ПСИХИАТРИИ

КЛИНИКА ВАРНЕФОРД
ОКСФОРД
OX3 7JX

ТЕЛ.: (01865) 613 143
ФАКС: (01865) 793101

ЗАЯВЛЕНИЕ О СОГЛАСИИ

с участием в
электронной версии тренинга когнитивно-поведенческой терапии для русских студентов

Главные исследователи:
- Сара Г. Раковщик (главный исследователь), rakovsh@post.harvard.edu
- Доктор Фреда МакМанус (супервизор), Freda.McManus@psych.ox.ac.uk

Данное исследование одобрено Оксфордским университетом и комитетом по этике Центрального исследовательского университета

Идентификационный № MSD/IDREC/C1/2010/9

Пожалуйста, подтвердите Ваше согласие:

☐ Я подтверждаю, что ознакомился / ознакомилась с информацией об исследовании , проводимом 2010-01-28 (версия 1) и понимаю суть вышеупомянутого исследования. У меня была возможность, как изучить информацию, так и задать вопросы и получить на них удовлетворительные ответы.

☐ Я понимаю, что мое участие является моим добровольным волеизъявлением, и я могу прервать его без объяснения причины и каких-либо штрафных санкций.

☐ Я согласен / согласна с тем, что во время исследования будут производиться аудиозаписи.

☐ Я понимаю, что мои личные данные будут идентифицироваться только посредством кода, будут использованы только группой исследователей и будут уничтожены через 10 лет.

☐ Я понимаю, что вся информация будет строго конфиденциальной в рамках закона. В редких случаях серьезной угрозы здоровья и жизни эта информация может быть обнародована.

☐ Я согласен / согласна принять участие в вышеупомянутом исследовании.

_____	_____	_____
Ф.И.О. студента	Дата	Подпись
____Sarah Rakovshik _____	___28.01.11_____	_____
Исследователь	Дата	Подпись

2 КОПИИ ДЛЯ ЗАПОЛНЕНИЯ: 1-АЯ ДЛЯ ИССЛЕДОВАТЕЛЯ, 2-АЯ ДЛЯ УЧАСТНИКА

Instructions for role-playing the patient ("Anna"):

For the first 15 minutes:
Please respond to therapist's questions concerning your current problem, its development, and relevant parts of your life history. Below you will find the answers you should give.

Please wait to be asked about all of this information. When you are asked, do not offer all of the information at once, but only one to three sentences that specifically answer the question asked.

At the 15 minute mark, please ask the therapist how cognitive behavioural therapy works. You may ask one or two follow-up questions if time permits.

At 20 minutes, you may interrupt the therapist and say, "Our time is up. Thank you for your help. I look forward to talking to you again".

Additional information on Anna:
You have been given a description of Anna's current problem and the events leading up to its development in the short case description. Below you will find additional information on Anna's family, psychiatric history, and current living situation. You will also find a more detailed description of a recent episode of panic: Anna's current thoughts, feelings and behaviours when she is anxious.

Family history:
Anna was raised by her mother, who is still living and retired. Anna's parents were divorced when she was four, due to her father's alcohol problems. She doesn't remember her father very well. He moved back to Vladivostok after the divorce, and they have had very little contact.

Mother was a "worrier", but Anna doesn't remember this interfering with her mother's ability to work or take care of the children. Her mother (Lyudmila) helps Anna with her daughter and now accompanies Anna outside the house and helps with Katya.

Anna has a brother (2 years older than she). He occasionally seems to feel down, but she can't remember him being very depressed or anxious. He is married, works as a computer programmer, and has two children. He sometimes drinks, but mostly on holidays with friends or family.

Current social and professional:
Anna has always lived in Moscow. She lived at home while attending institute. She studied accounting and has worked as an accountant for the last 10 years. She likes her job, and doesn't find it particularly stressful.

She moved to her husband's apartment when she got married at the age of 27. He husband's name is Sergei. They met through mutual friends when they were in their early 20s. They live in a 3-room apartment with their daughter. She reports that her marriage is good. Her husband doesn't really understand her current problems, but

tries to be supportive. He accompanies her on weekend when she needs to go out, and drives her in his car when he can so that she doesn't have to take the metro.

Psychiatric history:
Anna says she is like her mother in that she tends to worry, but has never felt it interfered with her ability to function. She is afraid of spiders, but reports no other specific phobias. She does not remember feeling depressed for any length of time.

Current problem:
Anna is seeking treatment for panic attacks and agoraphobia. Even in her own home she is experiencing panic attacks several times a week. She has now on sick leave from her job, and is relying on help from family for essential tasks such as shopping. She has also started feeling very low now that she feels she can't manage the simplest tasks in life. The panic attacks at home are triggered when she thinks about trying to go out by herself. To cope with them, she lies down and tries to breathe deeply. They usually subside within 5 to 10 minutes.

Precipitating events:
Anna developed panic attacks about six months previously after she had a period of illness (flu) and was off work for a few days. After a few days in bed, Anna felt somewhat recovered from the flu and decided to go to the supermarket for supplies.

In the supermarket she began to feel very unwell (light-headed, short of breath). She held onto her shopping cart and tried to breath deeply. When she felt well enough to let go, she left her cart returned home without any groceries.

She noticed that she experienced similar feelings the next time that she went to the supermarket and thus began to avoid supermarkets. Similar feelings began to happen in the metro. Anna stopped travelling by metro and only went to crowded places if accompanied by a 'safe' person. Her symptoms gradually worsened until she felt that she was no longer able to leave the house unaccompanied.

Description of recent episode of panic:

Initial situation: Walking from her husband's car into the clinic before this appointment (ie: just about 15 minutes ago).

First noticed: Felt light-headed as she was walking up to steps to the clinic entrance. Also noticed that it seemed harder to breathe.

Thoughts: "I'm going to collapse before I get to the office." "I should have asked Sergei to accompany me into the building."

Feelings: anxiety, panic

Physiological sensations: light-headedness, could feel heart beat increasing, harder to breath.

How she responded: held onto the banister, tried to breathe more deeply, ducked her head and looked at the ground so that no one could see she was having trouble.

If the therapist asks what happened next:

Anna was feeling more anxious and it felt even harder to breath. She held onto the banister with her other hand as well and pretended to be looking in her purse for something, so that no one passing by would know she wasn't feeling well. Before driving away, her husband had noticed that she had stopped on the stairs. He got out of the car, and put his arm around her shoulders for about 3 minutes until she was feeling better; he then walked with her into the office. He is now in the waiting room so that he can take her home when the session is over.

If the therapist asks what the worst thing is about the anxiety:

"I'm afraid I'll lose control and collapse."

If the therapist asks what the worst thing would be about this:

"It's very hard to even think about… I guess people would think that I'm crazy, or at least that I am very strange."

If the therapist asks what is the worst about this:

"I guess I'm afraid that it is true. I think I might be going crazy because I can't even go out anymore. I'm afraid I'll end up in a psychiatric hospital, or that my family will have to take care of me for the rest of my life. Sergei already had to miss a half a day of work in order to bring me here."

Anna's thoughts when she is feeling low:
"I'm worthless" "I can't do anything anymore." "I'll never get better."

* Anna does not have any thoughts about hurting herself. She states she can't even consider hurting her family in this way.

Case Vignette

Please read the case vignette outlined below. We will be asking you to do a brief role-play of an initial interview with this patient. In this role-play you will be the therapist, and a clinician will call you to role-play the patient. After the role-play, please write-out on a CBT conceptualization of the patient's presenting problem.

Case

Anna is 35, and is seeking treatment for panic attacks and agoraphobia. She developed panic attacks about six months previously after she had a period of illness (flu) and was off work for a few days. After a few days in bed, Anna felt somewhat recovered from the flu and decided to go to the supermarket for supplies. In the supermarket she began to feel very unwell and had to leave and return home. She noticed that she experienced similar feelings the next time that she went to the supermarket and thus began to avoid supermarkets, and only go to crowded places if accompanied by a 'safe' person. Her symptoms gradually worsened until she felt that she was no longer able to leave the house unaccompanied. Even in her own home she is experiencing panic attacks several times a week. She has now on sick leave from her job, and is relying on help from family for essential tasks such as shopping. She is married and has one daughter (Katya, age 6).

Use your knowledge of cognitive therapy theory and practice to elicit the information needed to construct a CBT conceptualization of Anna's problem. We are aware that you have a very short time to do this and are not expecting to obtain as much information as you could in a full-length session. The people playing the patients have been instructed to be cooperative and responsive to your questions and how you structure the session.

Please start by asking about the information you think is most important to understanding Anna's problem- this could either be a longitudinal formulation, or a current maintenance cycle. After fifteen minutes, Anna will ask you to explain how cognitive therapy can be used to solve problems such as hers. At this point, please briefly explain the cognitive model to Anna.

Кейс «Виньетка»

Пожалуйста, ознакомьтесь с изложенной ниже информацией. Вам будет предложено разыграть небольшую ролевую игру интервью с пациентом. В этой игре Вы будете терапевтом, а руководить процессом будет клинический психолог. После игры сформулируйте, пожалуйста, концептуальный подход к решению существующей проблемы пациента с помощью когнитивно-поведенческой терапии.

Кейс

Пациент Анна 35-ти лет обратилась с жалобами на приступы панических атак и агорафобию. Первые приступы появились примерно шесть месяцев назад, после того как она перенесла заболевание (грипп), проведя несколько дней дома. Через несколько после начала болезни Анне стало немного лучше, и она решила сходить за продуктами. В супермаркете она почувствовала себя очень плохо и была вынуждена вернуться домой. Она заметила, что испытала подобные чувства и в следующий раз, когда она пошла в супермаркет, и поэтому стала их избегать, а также стала появляться в людных местах только с человеком, который мог ее «защитить». Постепенно ее состояние ухудшалось, пока она не почувствовала, что больше не может выходить из дома без сопровождения. В настоящее время, даже не покидая дом, Анна испытывает несколько приступов панических атак в неделю. Она сейчас на больничном и нуждается в поддержке семьи и близких даже в удовлетворении таких элементарных нужд, как покупки в магазине. Анна замужем, имеет дочь (Катя, 6 лет).

Используя свои знания теории и практики когнитивной терапии, получите информацию, необходимую для разработки концептуального подхода к решению проблемы Анны. Мы понимаем, что у вас очень мало времени для этого и не ожидаем, что Вы сможете получить столько информации, сколько Вы могли бы получить во время полной консультации. Людям, играющим пациентов, было поручено сотрудничать с Вами и реагировать на ваши вопросы и то, как вы структурируете сессию.

Пожалуйста, начните с получения информации, которая наиболее важна для понимания проблемы Анны, - это может быть информация, касающаяся как прошлого, так и текущего жизненного цикла пациента Через пятнадцать минут Анна просит Вас объяснить, как когнитивная терапия может быть использована для решения таких проблем, как у нее. На данном этапе, пожалуйста, вкратце опишите модель когнитивной терапии Анне.

Appendix 4: Chapter Six Trial Materials

UNIVERSITY OF OXFORD
DEPARTMENT OF PSYCHIATRY
Reference: MSD/IDREC/C1/2010/28

INFORMATION FOR PARTICIPANTS

The impact of web-based CBT training and online supervision

Purpose of study: To evaluate the efficacy of web-based cognitive behavioural therapy (CBT) training and online group supervision in improving CBT skills.

Invitation
You are invited to participate in this research study. Before agreeing to participate, it is important that you understand why the research is being done and what it will involve. Please do not hesitate to ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?
This research is aimed at understanding more about the effects of web-based training in CBT on the clinical CBT skills of practicing mental health providers; we are particularly interested whether factors such as the addition of supervision, individual learning style, or previous instruction in CBT have a relationship with the effects of web-based training in CBT.

Why have I been invited?
Your have been invited because you are a practicing mental health professional with the opportunity and desire to provide CBT treatments to your patients - this group is the focus of the research.

This study is NOT suitable for the following people: those who are studying CBT independently at this time through a training course or through clinical supervision, and therapists without opportunity to provide CBT treatments to patients during the course of the trial or those who are not already qualified to offer psychological treatments

Do I have to take part?
It is up to you to decide whether or not to take part. If you decide to participate you would be given this information sheet and asked to sign a consent form. If you decide to take part, you are still free to withdraw without penalty at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part will not affect your professional or vocational status in any way.

What will happen to me if I take part?
You will be asked to submit an audio-recording of one of your therapeutic sessions with a current patient and to provide a CBT conceptualization of the case. Once we have received these, you will be asked to complete two short questionnaires with questions about your learning style and a brief survey on your previous professional training and practice. It should take about 15 minutes to complete both. After this, you will be randomly assigned to one of three groups:

(i) access to the web-based CBT training programme with monthly group supervision by Skype
(ii) access to the web-based CBT training programme with guided self-supervision, or
(iii) a delayed-training control group. Those people who are initially allocated to the delayed training group will be randomized into one of the two active training groups once 3 months have elapsed and you have submitted three therapy tapes with case conceptualizations.

The training will involve viewing materials created by the Oxford Cognitive Therapy Centre. You will be given a username and password to access the materials from any computer when it is time for you to

begin the training. The training programme covers basic CBT theory, formulation and assessment, collaborative skills, Socratic method, and CBT treatment for panic and obsessive compulsive disorder. The presentations are in English, and have Russian subtitles. The presentations are divided into 3 modules (each lasting approximately 4 hours). You will have one month to watch each module, and to participate in a supervision activity. After the second module, you will be asked again to submit an audio-recording of a therapeutic session and a CBT case conceptualization. When these materials have been received, you will obtain access to the final module, after which you will again submit a recording of a clinical session and a case conceptualization. In all, it will take about 20 hours to complete the training programme.

In addition, you will be asked to provide basic demographic and diagnostic information for each consenting patient, and to give your patients four brief self-report questionnaires every month to assess their clinical progress during therapy. You will be given information and consent forms for your patients explaining the purpose of gathering this data, and that the results will be given to the research team without any identifying information (i.e., name). Examples of these consent forms are included in this informational packet.

What are the possible risks and benefits of taking part?
There are no known risks involved with any of the tasks we will use. Should you feel uncomfortable for any reason during the study please notify the researcher who will pause or terminate the experiment as appropriate. Your participation is entirely voluntary and you may withdraw at any time, without giving a reason.

Benefits include a chance to receive CBT training from highly regarded instructors and a trained CBT supervisor. Once you have submitted the final assessment materials, you will gain access to two additional CBT training modules (without Russian translation), and will be awarded a certificate of participation by the Oxford Cognitive Therapy Center.

Will my taking part be kept confidential?
Participation and all information collected will be kept confidentially in anonymous form. Only the research team will have access to the data, which will be held in accordance with the data protection act and destroyed once research is completed. Procedures adhere to the British Psychological Society (BPS) and Oxford Good Practice in Research guidelines.

What will happen to the results of the research?
Anonymised results will be pooled with those of other participants, analysed and subsequently published and/or reported. No written work will identify any individual.

How can I raise a concern?
If you have a concern about any aspect of this project, please speak to the researcher concerned (sasha.rakovshik@psych.ox.ac.uk or +7 903 798 2951) or her supervisor (Dr Freda McManus freda.mcmanus@psych.ox.ac.uk) who will do her best to answer your query. If you remain unhappy and wish to make a formal complaint, please contact Miss C. Green (ethics@medsci.ox.ac.uk) who will then direct your complaint to the appropriate body.

Further information about this research
The study is being carried out for the Doctorate in Psychiatry offered by the Department of Psychiatry at Oxford University. It has been approved by the University of Oxford, Central University Research Ethics committee. If you have any further questions, in the first instance please contact:

- Sarah Rakovshik (principal investigator), sasha.rakovshik@psych.ox.ac.uk
- Dr. Freda McManus (supervisor), Freda.McManus@psych.ox.ac.uk

Thank you for considering participation

[NB This information sheet and all relevant materials will be translated into Russian for use]

КЛИНИКА ВАРНЕФОРД
ОКСФОРД

ОКСФОРДСКИЙ УНИВЕРСИТЕТ
ОТДЕЛЕНИЕ ПСИХИАТРИИ

Информационный код**:** MSD/IDREC/C1/2010/28

ИНФОРМАЦИЯ ДЛЯ УЧАСТНИКОВ

Влияние электронной версии тренинга когнитивно-поведенческой терапии

Цель исследования
Оценить уровень эффективности электронной версии тренинга когнитивно-поведенческой терапии в развитии клинических навыков.

Приглашение
Вы приглашены для участия в исследовании. До подтверждения Вашего добровольного согласия, важно понимать, почему это исследование проводится и в чем оно заключается. Вы можете задавать любые вопросы и получить дополнительную информацию, если Вам что-то неясно. Подумайте, действительно ли Вы хотите принять участие. Благодарим Вас за ознакомление с этой информацией.

Какова цель исследования?
Целью данного исследования является дополнительное изучение эффективности электронной версии тренинга когнитивно-поведенческой терапии на развитие клинических навыков практикующих терапевтов, в частности, взаимосвязь данного тренинга с дополнительным индивидуальным консультированием терапевтов, их индивидуальным стилем обучения или ранее пройденными тренингами когнитивно-поведенческой терапии.

Почему меня пригласили?
Вы были приглашены, так как Вы являетесь практикующим терапевтом, в перспективе использующим навыки когнитивно-поведенческой терапии в своей практике, т.е. являетесь фокус-группой этого исследования.

В этом исследовании НЕ могут принимать участие изучающие когнитивно-поведенческую терапию на тренингах или посредством индивидуального обучения, терапевты, не планирующие применять получаемые навыки во время обучения, а также те терапевты, которые уже получили соответствующие квалификации.

Должен ли я принимать участие в исследовании?
Принимать ли участие в данном исследовании является исключительно Вашим волеизъявлением. В случае если Вы решите участвовать, Вам будет предложено подписать заявление о согласии с участием в исследовании. Вы сможете прервать свое участие без каких-либо штрафных санкций и объяснения причин. Решение прекратить участие в исследовании или решение не принимать в нем участие ни в коей мере не повлияет на Ваш профессиональный статус.

Что предполагает мое участие?

Вам будет необходимо предоставить аудио-запись одной из Ваших консультаций и концептуально изложить подход к лечению пациента посредством когнитивно-поведенческой терапии. После этого Вам будет предложено заполнить 2 анкеты, касающиеся Вашего стиля обучения и предыдущего профессионального опыта. Это займет примерно 15 минут. После этого по принципу случайной выборки Вы будете объединены с одной их 3 групп:

i) Группа с доступом к электронной версии тренинга когнитивно-поведенческой терапии, с дополнительным ежемесячным консультированием посредством Skype
ii) Группа с доступом к электронной версии тренинга когнитивно-поведенческой терапии с дополнительными ежемесячными упражнениями для самостоятельного проведения
iii) Контрольная группа, которая приступит к исследованию через 3 месяца. При окончания своего участия в контрольной группе, участники будут снова разделенными случайным образом на 2 группы (перечисленные выше) с доступом к электронной версии тренинга когнитивно-поведенческой терапии и с условиями описанными ниже.

Всем участникам будут предоставлены материалы, разработанные Оксфордским центром когнитивно-поведенческой терапии, а также доступ к электронной версии тренинга с любого компьютера с момента начала Вашего обучения. Программа обучения охватывает общую теорию когнитивно-поведенческой терапии, формулировки и методы оценки, навыки совместной работы с пациентом, метод Сократа и техники когнитивно-поведенческой терапии для панических и обсессивно-компульсивных расстройств. Презентационные материалы представлены на английском (с субтитрами на русском) и разделены на 3 части, каждая из которых длится примерно 4 часа. Каждая часть доступна для просмотра и для обсуждения в течение месяца. По мере прохождения 2-ой части Вам также будет необходимо предоставить аудио-запись консультации и концептуально-сформулированный подход к лечению. После предоставления всех вышеупомянутых материалов Вам будет открыт доступ к финальной части обучения, после которого Вам также будет необходимо предоставить аудио-запись и концептуальное описание лечения пациента. В общем, процесс обучения занимает примерно 20 часов.

Вам также будет необходимо предоставить общую информацию о каждом Вашем пациенте, а также заполненные пациентами опросные листы, которые им необходимо заполнять каждый месяц во время лечения. Вам будет предоставлена вся необходимая для пациентов информация с подробным объяснением цели сбора данной информации и указанием на то, что персональная информация будет конфиденциальной (бланки опросных форм Вы можете найти в Ваших раздаточных материалах).

Каковы предполагаемые риски и преимущества от участия в данном исследовании?
Риски, связанные с заданиями, которые Вам будут предложены, не выявлены. В случае если Вы ощутите некий дискомфорт по какой-либо причине, пожалуйста, сообщите об этом консультанту, который приостановит или прервет исследование надлежащим образом. Участие является добровольным, и Вы можете прервать его без объяснения причины.

Преимуществом участия в данном исследовании является прохождение обучения когнитивно-поведенческой терапии у тренеров высокой квалификации. После прохождения тренинга Вам будут вручены сертификаты Оксфордского Когнитивного

Центра о прохождении данного обучения. Помимо этого Вам будет предложен доступ к 2-ум дополнительным модулям обучения когнитивно-поведенческой терапии для развития клинических навыков (не переведенных на русский язык) и вручен сертификат о прохождении соответствующего обучения.

Будет ли мое участие конфиденциальным?
Ваше участие будет анонимным, а вся полученная информация конфиденциальной. Доступ к данным будет только у команды исследователей, данные будут сохранены установленным образом и уничтожены по окончанию проекта. Все процедуры соответствуют стандартам Британского психологического общества и Оксфордского центра лучших исследовательских практик.

Как будут использованы результаты исследования?
Анонимные результаты участников будут объединены, проанализированы и сформированы в отчет. Ни в каких письменных документах не будут упоминаться имена участников.

Каким образом я могу выразить сомнение?
Если у Вас возникли сомнения или вопросы касательно какой-либо части проекта, пожалуйста, свяжитесь с исследователем по электронной почте sasha.rakovshik@psych.ox.ac.uk или по тел. +7 903 798 2951. Если после этого у Вас останется чувство неудовлетворенности и Вы захотите выразить жалобу, пожалуйста, свяжитесь с С. Грин (ethics@medsci.ox.ac.uk), которая направит Вашу жалобу соответствующему ответственному сотруднику.

Дополнительная информация об исследовании
Данное исследование проводится в рамках докторской работы по психиатрии в Оксфордском университете и одобрено Оксфордским университетом и комитетом по этике Центрального исследовательского университета. По любым вопросам просим связываться с:

- Сарой Раковщик (главный исследователь) – rakovsh@post.harvard.edu
- Доктором Фредой МакМанус (супервизор) - Freda.McManus@psych.ox.ac.uk

Благодарим за внимание к данному исследованию

UNIVERSITY OF OXFORD
DEPARTMENT OF PSYCHIATRY

Information sheet for people being treated by a mental health professional undertaking training in cognitive behavioural therapy

You are being asked to read this information sheet in order to ask you to give your consent to material from your treatment being used by the therapist, for the purposes of their completing a training course provided by Oxford University's Department of Psychiatry and the Oxford Cognitive Therapy Centre.

Your therapist is a mental health professional who is receiving training in a talking therapy called 'cognitive behaviour therapy'. The course is being run for mental health professionals only and uses a web-based training programme developed by the Oxford Cognitive Therapy Centre.

As part of their training, mental health professionals undertaking this course are asked to audiotape sessions with their clients. These tapes will be listened to by members of the research team to assess the impact of the training programme. On some occasions therapists will receive feedback on the therapy they are providing to help them improve their practice of cognitive behaviour therapy. We think that this is an important and effective way of training people to improve their skills in delivering therapy.

Everything that is heard and discussed as part of the training programme is confidential and will not be shared with anyone else. Across the course of the three-month training programme, each therapist is required to submit 3 tapes to the research team. These tapes will be kept by the research team, stored in an encrypted and password-protected file on a back-up hard disk, and will be destroyed when the research is completed.

Even after you have given consent for your sessions to be taped, you are free to withdraw this at any time, and if you would rather that any specific session was not taped then just let your therapist know that. Your therapist will check every session whether you agree for the session to be recorded.

Your therapist will provide us with some general information about you, for example: your age, profession, and why you have sought treatment. In addition, your therapist is also required to submit information on how you are feeling at different points during your therapeutic treatment. You will be asked to fill-in four questionnaires about your thoughts, feelings and physical state at several points during your treatment. This information will be given by your therapist to the research team using only a number to identify the person to whom it pertains. No identifying information (e.g., name) is submitted or stored with this clinical information.

Consent form

Reference: MSD/IDREC/C1/2010/28

I have read and understood the information sheet for people being treated by a mental health professional undertaking the University of Oxford's and Oxford Cognitive Therapy Centre's web-based training in cognitive behavioural therapy.

	Yes	No
I give my consent for therapy sessions to be recorded.	☐	☐

I understand that my therapist will check each meeting if this is still OK, and will ask for my verbal consent on each tape as well.

	Yes	No
I give consent for the results of questionnaire assessments with no identifying information to be submitted to the research team.	☐	☐

NAME OF PATIENT:

SIGNATURE: DATE:

NAME OF THERAPIST:

SIGNATURE: DATE:

2 copies –1 for the patient, 1 for the therapist

ОКСФОРДСКИЙ УНИВЕРСИТЕТ
ОТДЕЛЕНИЕ ПСИХИАТРИИ

Информация для пациентов, проходящих лечение у специалистов когнитивно-поведенческой терапии

Просим Вас ознакомиться с предоставленной информацией с тем, чтобы получить Ваше согласие на предоставление материалов касательно Вашего лечения терапевтом отделению психиатрии Оксфордского университета и Оксфордскому центру когнитивно-поведенческой терапии.

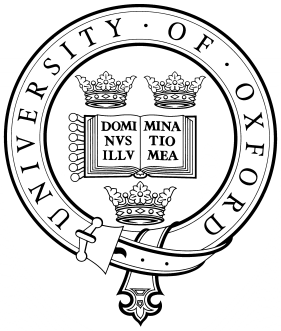
Ваш терапевт проходит курс обучения под названием «когнитивно-поведенческая терапия». Этот курс разработан Оксфордским центром когнитивно-поведенческой терапии и проводится исключительно профессионалами в области ментального здоровья с использованием электронных ресурсов.

В рамках этого обучения, терапевты должны записывать на аудио-носители консультации со своими пациентами с тем, чтобы представители исследовательской группы могли оценить эффективность преподаваемого курса. В некоторых случаях терапевты будут получать обратную связь касательно проводимого ими лечения, с целью улучшения их навыков когнитивно-поведенческой терапии. Мы думаем, что это – важный и эффективный способ улучшения навыков терапевтов когнитивно-поведенческой терапии.

Все, что будет услышано, а также будет обсуждаться в рамках курса, является конфиденциальным и не будет озвучено третьим лицам. В течение курса, который длится 3 месяца, каждый терапевт должен предоставить 3 аудио-записи исследовательской команде, которые будут храниться в виде зашифрованных, защищенных паролем файлов на резервном жестком диске, а по мере завершения исследования будут уничтожены.

Даже после того, как Вы дали свое согласия на запись Ваших консультаций с терапевтом, Вы в праве прервать это в любое время, также как и не дать свое согласие на запись определенных консультаций, которые Вы не хотели бы передавать третьим лицам. Ваш терапевт будет уточнять, согласны ли Вы на запись каждой конкретной консультации.

Ваш терапевт предоставит также некоторую информацию о Вас общего характера, например, Ваш возраст, профессию, и причину, по которой Вы получаете лечение. Помимо этого терапевту будет необходимо предоставить информацию о Вашем самочувствии в различные периоды лечения. Вам будет предложено заполнить 4 опросных листа о Ваших мыслях, чувствах и физическом состоянии в разные периоды времени. Вся эта информация будет предоставлена исследовательской команде только с Вашим идентификационным номером. Никакой другой информации (например, Ваше имя) предоставлено не будет.



Заявление о согласии

Информационный код: MSD/IDREC/C1/2010/28

Я ознакомлен / ознакомлена с информацией для получающих лечение пациентов у терапевтов, проходящих обучение в Оксфордском университете и Оксфордском центре когнитивно-поведенческой терапии с использованием электронных ресурсов.

Я согласен / согласна с тем, что мои консультации с терапевтом будут записаны на аудио-носители. **Да** ☐ **Нет** ☐

Я понимаю, что терапевт получит также мое дополнительное устное согласие на запись каждой конкретной консультации. **Да** ☐ **Нет** ☐

Я согласен / согласна с тем, что результаты опросных листов будут предоставлены исследовательской команде без прямого указания на мои личные данные. **Да** ☐ **Нет** ☐

ИМЯ ПАЦИЕНТА:

ПОДПИСЬ: ДАТА:

ИМЯ ТЕРАПЕВТА:

ПОДПИСЬ: ДАТА:

2 копии - одна для пациента, другая для терапевта

UNIVERSITY OF OXFORD
DEPARTMENT OF PSYCHIATRY

WARNEFORD HOSPITAL
OXFORD
OX3 7JX

TEL: (01865) 613 143
FAX: (01865) 793101

CONSENT FORM

Online CBT training for Russian and Ukrainian therapists

- Principal Investigators: Sarah G. Rakovshik (principal investigator), sasha.rakovshik@psych.ox.ac.uk
- Dr. Freda McManus (supervisor), Freda.McManus@psych.ox.ac.uk

This study has been approved by the University of Oxford Central University Research Ethics Committee
Ref no MSD/IDREC/C1/2010/28

Please initial box

I confirm that I have read and understand the information sheet dated (February17, 2010) (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had any questions I asked answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without any penalty. ☐

I agree to the obtain appropriate consent from patients for recording of sessions, and for submission of recordings and completed questionnaires for assessment by the research team. ☐

I understand that the CBT supervision I may receive as part of the training program in this trial does ***not*** replace the clinical responsibility I and my local clinical supervisor carry for patient care. ☐

I understand that personal data will be identified using only by a number code, will be accessed only by members of the research team and will be destroyed after research is complete. ☐

I understand that all information will be kept strictly confidential within the limits of the law and except in the rare circumstances in which it is judged that I or someone else is at immediate risk of serious harm. ☐

I agree to take part in the above study. ☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

2 COPIES TO BE COMPLETED: ONE FOR RESEARCH FILE AND ONE FOR PARTICIPANT

ОКСФОРДСКИЙ УНИВЕРСИТЕТ
ОТДЕЛЕНИЕ ПСИХИАТРИИ

КЛИНИКА ВАРНЕФОРД
ОКСФОРД
OX3 7JX

ТЕЛ.: (01865) 613 143
ФАКС: (01865) 793101

ЗАЯВЛЕНИЕ О СОГЛАСИИ

с участием в

электронной версии тренинга когнитивно-поведенческой терапии для русских и украинских специалистов

Главные исследователи:
- Сара Г. Раковщик (главный исследователь), rakovsh@post.harvard.edu
- Доктор Фреда МакМанус (супервизор), Freda.McManus@psych.ox.ac.uk

Данное исследование одобрено Оксфордским университетом и комитетом по этике Центрального исследовательского университета
Идентификационный № MSD/IDREC/C1/2010/28

Пожалуйста, подтвердите Ваше согласие

☐ Я подтверждаю, что ознакомился / ознакомилась с информацией об исследовании , проводимом 2010-02-17 (версия 1) и понимаю суть вышеупомянутого исследования. У меня была возможность, как изучить информацию, так и задать вопросы и получить на них удовлетворительные ответы.

☐ Я понимаю, что распределение по группам происходит случайным образом, и что если я попаду в контрольную группу, то в течении 3-х месяцев я присылаю ту же ежемесячную информацию, но не получаю доступ к обучению. Я так же понимаю, что в конце этого срока меня снова распределят в одну из групп с доступ к обучению.

☐ Я понимаю, что мое участие является моим добровольным волеизъявлением, и я могу прервать его без объяснения причины и каких-либо штрафных санкций.

☐ Я согласен / согласна с тем, что во время исследования будут производиться аудиозаписи, а также на предоставление этих записей и материалов касательно моего лечения исследовательской команде с целью оценки эффективности проводимого курса.

☐ Я понимаю, что индивидуальное консультирование, которое я могу получить в рамках обучения когнитивно-поведенческой терапии, не снимает с меня и с моего непосредственного местного руководителя клинической ответственности за здоровье пациента.

☐ Я понимаю, что мои личные данные будут идентифицироваться только посредством кода, будут использованы только группой исследователей и будут уничтожены после того, как исследование завершиться.

☐ Я понимаю, что вся информация будет строго конфиденциальной в рамках закона. В редких случаях серьезной угрозы здоровья и жизни эта информация может быть обнародована.

☐ Я согласен / согласна принять участие в вышеупомянутом исследовании.

_____	_____	_____
Ф.И.О участника	Дата	Подпись
_Раковщик Сара_____	____21.02.1_____	___S. Rakovshik_____
Исследователь	Дата	Подпись

2 КОПИИ ДЛЯ ЗАПОЛНЕНИЯ: 1-АЯ ДЛЯ ИССЛЕДОВАТЕЛЯ, 2-АЯ ДЛЯ УЧАСТНИКА Версия 17/02/10

Consultation Worksheet

My Consultation Question:_____

(1) Have you and your client constructed a conceptualization model for understanding and treating this issue? If so, write or draw it here. If not, collaborate with client to construct it.

(2) Do you have a treatment plan which fits the conceptualization? If so, write it here. If not, consider what evidenced-based interventions might apply and summarize them here.

(3) Is therapy following the conceptualization and treatment plan? If not, is there a good reason? Would an alternative conceptualization or treatment plan be better? Why? Does the client agree?

(4) Do you have the knowledge and skill to properly implement the CT treatment? If not, how could you apply what you have already learned during the training to this case?"

(5) Is the therapeutic response following expected patterns? If not, formulate hypotheses about why client response is different from expected. Consider client beliefs, skill deficits, emotional responses, interpersonal patterns, life circumstances, and developmental history. Also consider the factors in #6 below.

(6) What else might be interfering with success? Include hypotheses about:

The therapist (beliefs, skill deficits, emotional responses, interpersonal patterns, life circumstances, developmental history):

The therapy relationship (e.g., is it positive and collaborative?):

The cognitive conceptualization (e.g., is something missing or inaccurate?):

The treatment plan (e.g., are there additional approaches which might help?):

Adapted from Padesky, C. A. (1996)

РАБОЧИЙ ЛИСТ КОНСУЛЬТАЦИИ

Основной запрос консультации:_____

(1) Сформулировали ли Вы с клиентом концептуальную модель его / ее проблемы и работы над ней. Если «да», то опишите или нарисуйте модель решения запроса клиента. Если «нет», пообщайтесь с клиентом с тем, чтобы сформулировать проблему и решение.

(2) Есть ли у Вас план решения данной проблемы, концептуально соответствующий запросу? Если «да», напишите здесь концептуальный план решения запроса клиента. Если «нет», опишите, какие очевидные факты могут иметь значение для выработки плана решения, обобщенно сформулируйте их и запишите здесь.

(3) Соответствует ли терапия концептуальной модели решения проблемы и плану лечения? Если «нет», есть для этого веские основания? Есть ли альтернативная, более подходящая модель решения проблемы и план выздоровления? Поясните, почему? Согласен ли клиент с альтернативным вариантом?

(4) Достаточно ли у Вас знаний и навыков для применения когнитивно-поведенческой терапии? Если «нет», можете ли Вы применить имеющиеся у Вас навыки и знания для решения проблемы клиента?

(5) Откликается ли клиент на терапию определенным образом? Если «нет», предположите, почему клиент откликается не так, как ожидалось. Примите во внимание убеждения, недостаток навыков, эмоциональные реакции, модели взаимодействия с людьми, жизненные обстоятельства и историю жизни клиента. Также примите во внимание следующий пункт (№6)

(6) Что еще может способствовать успеху? Сделайте гипотетические предположения касательно:
Терапевта (убеждения, недостаток навыков, эмоциональные реакции, модели взаимодействия с людьми, жизненные обстоятельства, историю жизни):

Отношений в рамках терапии (позитивные, конструктивные, клиент настроен на общение?):

Когнитивной концептуализации (чего-то не хватает или неправильно?):

Плана лечения (есть ли другие подходы, которые могут быть полезны?):

Appendix 5: Recruitment Materials

UNIVERSITY OF OXFORD
DEPARTMENT OF PSYCHIATRY

WARNEFORD HOSPITAL
OXFORD
OX3 7JX

TEL: (01865) 223902
FAX: (01865) 793101
EMAIL: Freda.mcmanus@
psych.ox.ac.uk

Dr Freda McManus
Clinical Research Fellow &
Consultant Clinical Psychologist

16th June 2011

Dear Diploma students,

Re: End of training questionnaire

The current governmental focus on increasing access to evidence-based treatments, and in particular CBT, has led to a rapid expansion of CBT training. While CBT itself has many decades of research and evaluation to generate the evidence base for it, we currently know very little about how therapists can be trained to effectively provide these treatments in routine clinical practice.

In light of this opportunity to disseminate CBT more widely, we think it is a priority to begin to develop an evidence base for effective CBT training practices. Hence, we are asking you to complete the attached questionnaire which is part of a broader study examining therapists' accuracy in assessing their own CBT skills, and on what elements of a training experience contribute to gains in CBT competence.

As you are just finishing an intensive CBT training course, you have a unique perspective on which elements of training have, or have not, contributed to any changes in your competence as a cognitive therapist. The attached survey asks you to reflect on your experience over this past year during the diploma course, and to rate the influence various components of the course have had on your current CBT abilities. In addition, we are interested in your reasons for seeking training, and details about your current professional setting.

All information will be stored anonymously and will be used primarily for the purposes of audit i.e., to enhance the effectiveness of Diploma training in CBT.

We appreciate your time and effort in completing this survey.

Best wishes & many thanks for your help with this,

Freda McManus

SURVEY FOR DIPLOMA/MSc IN ADVANCED COGNITIVE THERAPY STUDIES

OXFORD COGNITIVE THERAPY CENTRE

Warneford Hospital
Headington
OXFORD
OX3 7JX
Tel : (01865) 223986
Fax : (01865) 226331
E-mail:octc@obmh.nhs.uk

Dear «Name»,

SURVEY: PERCEPTION OF EFFECTIVE ELEMENTS OF TRAINING (DIPLOMA/MSc IN ADVANCED COGNITIVE THERAPY STUDIES)

We are writing to ask for your help in completing the enclosed survey.

As you are no doubt very well aware, the current focus on increasing access to evidence-based treatments, and in particular CBT, has led to a huge expansion in training in CBT. Yet, it is not entirely clear what aspects of training contribute most to its efficacy. The enclosed survey invites therapists to draw on personal experience in identifying what they believe contributes most to the efficacy of CBT training, *specifically in relation to year development as a clinician or supervisor*, rather than the other elements of the Diploma/ MSc in Advanced Cognitive Therapy Studies (i.e., research skills, training skills, organizational development). We hope that it will help us to refine further our own training programmes at OCTC .

The attached survey, devised by Sarah Rakovshik, a DPhil student in the University Department of Psychiatry, under the supervision of Freda McManus, invites you to reflect on your experience of the Diploma/MSc in Advanced Cognitive Therapy Studies, as it impacted on your development as a CBT practitioner, and to rate the influence of various components of the course on your current competence as a therapist and disseminator. In addition, we are interested in the reasons you sought training, and details of your current professional setting. Sarah can be contacted by e-mail with any questions you may have concerning the survey: rakovsh@post.harvard,edu.

We appreciate that, as senior practitioners your time is precious. We would nonetheless very much appreciate your taking the time and effort to complete the survey, as the information you provide will be valuable to us. All responses will be anonymised once they are entered; the identities of the responders will not be evident to the course directors. We are interested in knowing your identities for the response on the 'long-term feedback' form. Please fill in your name and the date you began the course if you are willing to be identified for this question. We wish you well in your continuing work with CBT.

Warm regards,

Yours sincerely,

Dr Helen Kennerley
Co-Director, Diploma/MSc in
Advanced Cognitive Therapy Studies

Dr Melanie Fennell
Co-Director, Diploma/MSc in
Advanced Cognitive Therapy Studies

UNIVERSITY OF OXFORD

DEPARTMENT OF PSYCHIATRY

Dr. Freda McManus
Clinical Research Fellow &
Consultant Clinical Psychologist

Sarah G. Rakovshik
DPhil Candidate & Cognitive Therapist

DEPARTMENT OF PSYCHIATRY
WARNEFORD HOSPITAL
OXFORD
OX3 7JX

EMAIL: rakovsh@post.harvard.edu

Dear Professor Khomogorova,

Re: Training in Cognitive-behavioural therapy for Russian psychology students

The University of Oxford's Department of Psychiatry, in collaboration with the Oxford Cognitive Therapy Centre, is currently conducting research into the evaluation of training methods, therapist-competence and the development of clinical skill in the dissemination of Cognitive Behavioural Therapy (CBT). Our focus concerns the effectiveness of CBT training for therapists from a wide-range of clinical backgrounds. Hence, phase two of our research involves the dissemination of CBT treatment protocols to psychology students in Russia.

Due to Moscow State Psychological and Pedagogical University's commitment to psychological practice, we would like to offer the possibility of collaboration within your existing academic programme. We intend to conduct our trials during the 2009-2010 academic year, and are therefore eager to begin discussions on such a collaboration. We believe that we can offer opportunities that could be of benefit to the faculty and students of your department, and that your programme could be an appropriate setting for our current research.

As we will be deciding the parameters of our research within the next month, we request that you contact us if you would be interested in considering our proposal. Sarah Rakovshik can be reached by telephone at +7 903 798 2951, or by e-mail at rakovsh@post.harvard.edu. She is a fluent Russian speaker, and will be in Moscow during the current academic year to coordinate this research. We will try to reach you as well within the coming week.

Thank you for your consideration. We look forward to hearing from you.

Best regards,

Dr Freda McManus
Clinical Research Fellow &
Consultant Clinical Psychologist

Sarah Gray Rakovshik
DPhil Candidate &
Cognitive Therapist

UNIVERSITY OF OXFORD
DEPARTMENT OF PSYCHIATRY

Dr. Freda McManus
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Sarah G. Rakovshik
DPhil Candidate & Cognitive Therapist

DEPARTMENT OF PSYCHIATRY
WARNEFORD HOSPITAL
OXFORD
OX3 7JX

EMAIL:
sasha.rakovshik@psych.ox.ac.uk

Обучение Когнитивно-Поведенческой терапии для психиатров, психологов и психотерапевтов.

Уважаемая_____!

Отдел Оксфордского университета Психиатрии, в сотрудничестве с Оксфордским Центром Когнитивной Психотерапии, в настоящее время проводит исследование относительно оценки учебных методов, компетентности терапевта и развития клинических навыков в распространении Когнитивно-Поведенческой Терапии (КПТ). Наше внимание касается эффективности обучения КПТ для специалистов из широкого диапазона клинических фонов. В связи с этим, вторая фаза в нашем исследовании вовлекает распространение протоколов лечения КПТ практикующим специалистам в России и на Украине.

Мы обращаемся к Вам с предложением участия специалистов Вашего центра. Мы полагаем, что мы можем предложить возможности, которые могут быть выгодны и сотрудникам и пациентам Вашего центра. Некоторые специалисты, участвовавшие в нашем испытании, предоставили очень позитивные отклики об эффективности обучения, оказанного на их терапевтические навыки. Мы будем продолжать принимать новых специалистов к испытанию, пока не достигнем необходимого числа участников для нашего исследования.

Если Вашему центру или, возможно, отдельным сотрудникам хотелось бы получить дополнительную информацию о нашем проекте, пожалуйста, свяжитесь с Сарой Раковщик по телефону +7 903 798 2951 или по электронной почте sasha.rakovshik@psych.ox.ac.uk Сара хорошо говорит по-русски и будет в Москве в течение текущего учебного года, чтобы скоординировать это исследование.

Спасибо за Ваше внимание. Будем признательны за Ваш ответ.

С уважением,

Dr Freda McManus
Clinical Research Fellow &
Consultant Clinical Psychologist

Sarah Gray Rakovshik
DPhil Candidate &
Cognitive Therapist

PART II: COMPETENCY AS A SUPERVISOR

OXFORD DIPLOMA/MSc IN ADVANCED COGNITIVE THERAPY STUDIES

SUPERVISOR COMPETENCY SCALE

Evaluation of recorded session of supervision

GUIDELINES WHEN USING THE SCS

The purpose of supervision is to foster good practice, as defined by professional guidelines, so as to meet client/patient needs. This rating form has been devised to structure the process of evaluating supervision competency, making use of both specific and general items. It reflects the 2008 supervision competencies of Pilling and Roth, and general guidelines for good supervision practice (see Kennerley and Clohessy (2010) for a review) whilst striving to be as short and simple as possible.

It aims to:

1. Enable raters to communicate a standard of practice
2. To help supervisors reflect on and develop their practice
3. To indicate the degree to which a particular supervision session fulfils the purpose outlined above

It can be used both as an instrument to give detailed feedback and / or an evaluation tool for deciding whether or not supervisee performance is adequate.

It comprises three sections:

Section I: the scale used by raters to evaluate a supervisor's performance. This addresses six areas of practice: structuring of sessions; enhancing learning; the supervisory relationship; other process issues; reflective practice. Items within each of these areas of practice are rated on a 5-point scale. Raters also comment on the general strengths of the supervisor, make suggestions for improvement and consider the appropriateness of the supervisor's reflection on supervision (see section II).

Section II: a reflection on supervision form to be completed by the supervisor. This encourages self-reflective practice and enables the rater to decide if the self-reflection is adequate or appropriate and if supervisee feedback (see section III) has been considered.

Section III: As recipients of supervision, supervisees' feedback is valuable, if properly attended to by the supervisor. Thus supervisees are asked to give their supervisors feedback on the session and this should be submitted with the session recording. If the

supervisor wishes to s/he can specify the details of feedback and the assessor can comment upon the appropriateness of the supervisor's choice of questions.

Items to be submitted:

1. Each student should submit a recording of a supervision session made within the last 3 months. This should be approximately 1 hour long for an individual supervision session and no longer than 1 ½ hours for a group session.
2. Students must provide feedback from the recipients of the supervision session submitted for evaluation, preferably in written form. The supervisor is responsible for gathering relevant feedback and assessors can comment on the appropriateness of it. Feedback from all group supervision members should be provided together with the recording.
3. Students must submit a completed **Reflection on Supervision** form (see section III of the SCS, overleaf).

Note: Students **must** secure supervisee consent for the recording to be viewed by the assessor and must ensure that their supervisees have gained clients' consent for their own work to be supervised.

INSTRUCTIONS TO RATERS

As a rater, you are expected to use your professional judgment in completing this form and to comment (briefly) on your ratings. If possible, illustrate the basis for more general judgments, so as to clarify your decision and enable the student learn from the evaluation. There are 7 parts to the SCS: within each there is scope for rating particular items such as contracting use of time, promoting reflective practice, being respectful etc. Items in Parts 1-5 are rated using the following scale:

Rate supervisor's performance on the following scale:

1	2	3	4	5
Absence of feature or highly incompetent or major problems evident	Evidence of competence, but many problems and/or lack of consistency	Competent, but some problems and /or inconsistencies	Good features Minor problems and or inconsistencies	Expert performance or very good even in the face of difficulties

Items within Part 6 are rated using a simple 5-point scale, while items in Part 7 concern general feedback and require written statements.
This is intended to form the basis of detailed feedback which will help the supervisee improve her/his practice. Not all of the items within part 1-6 will be applicable for the recording under scrutiny and it is acceptable to rate these as 'not applicable' (N/A). For example addressing problems within the supervisory relationship might not be relevant in the session which is being assessed.

Performance requirements:
At the end of end of Parts 1-6, raters are asked to judge whether or not the supervisee has shown competent practice (see level 3 on the above rating scale). This does not necessarily reflect an average score for that part of the SCS (as some items will have been deemed not applicable) but the rather the rater's overall view of performance in that particular aspect of supervision. For overall performance in a particular area to be considered competent, none of the scored items should fall below '2' and the majority should score '3' or above. In order to fulfil course requirements, a supervisee must be deemed competent (ie achieve a 'pass') in all six areas.

NOTES FOR RATERS

Section I

Part 1: Structuring the session

1. Contracts use of time: this should be done collaboratively. Time allocation should reflect the demands of supervision and time available. Supervisors should ensure time is allocated to review the past session and current session as appropriate.
2. Adheres to agreed agenda: the supervisor is expected to pace the session appropriately, remain focused on the agenda and only digress following discussion and renegotiation of the agenda with the supervisee.
3. Selects specific and appropriate topics / goals for session : the topics and goals should be arrived at collaboratively, should reflect both the needs of the supervisee and of the client(s) and should reflect the supervision contract which will have been drawn up prior to beginning the course of supervision.
4. Paces session (i) appropriate to the needs of the supervisee, and (ii) uses time efficiently.

Part 2: Enhancing Learning

1. Gathers information to illustrate supervisee's clinical practice using Socratic methods, 'live' supervision, role play and case discussion.
2. Uses a variety of methods to appraise and evaluate the skills and knowledge of the supervisee: for example through role play or by rating therapy tapes.
3. Shows sensitivity to the learning needs of the supervisee : is aware of the developmental needs and optimum learning style of the supervisee and is able to create a stimulating learning environment that does not over stress the supervisee. …
4. Balances use of methods likely to foster supervisee learning (e.g. Socratic Method, use of recordings, information giving, experiential methods etc) throughout the session and uses learning approaches appropriately. For example, experiential approaches to skills development.
5. Makes available relevant and appropriate materials (e.g. references, measures, recordings etc)
6. Gives feedback to supervisee which is sensitive and constructive. Feedback should be clear, specific, framed as the supervisor's opinion and should both challenge and support the supervisee. Feedback should be given frequently enough to be useful and the supervisee should be prompted to reflect on it in the session. Supervisee feedback should be elicited at the end of each session.

7. Makes theory-practice links, helping the supervisee combine cognitive theory and psychological principles with sound clinical work.
8. Promotes reflective practice by regularly prompting the supervisee to critically appraise and learn from their work, and by encouraging supervisees to record and review their therapy sessions.
9. In a *group setting* facilitates group learning by attending to the input of all group members and by encouraging vicarious learning.

Part 3: Supervisory Relationship

1. Collaborative and engaging: there should be evidence of 'team work' on shared, agreed goals.
2. Respectful, supportive, sensitive: the supervisor's practice should communicate a respectful awareness of the learning needs of the supervisee.
3. Creates safe environment for supervisee to be open: the supervisor should create a setting which is supportive, emotionally containing and which is non-judgemental of the person.
4. Boundaried: the SR reflects a working alliance not a friendship or therapy. Supervision is primarily educative. It should be relevant and free of interruption and unnecessary digression.
5. Open: honest mutual feedback should be exchanged regularly to ensure that there is shared understanding, that clinical goals are being met, that agreed tasks are being carried out, that practice is ethical and that learning needs are met. Supervisors should express reservations in a timely and respectful fashion.
6. Problems within the SR are addressed if this is necessary. Supervisors should be open and honest if they have concerns about the SR and if problems arise the supervisor should address them in a timely and respectful fashion

Part 4: Other process issues

To score highly in this section the supervisor must:

- Create a setting which facilitates the exploration of process issues. Even though there will be times when detailed attention to process issues is not necessary it is crucial to make exploration possible. The supervisor will be given credit for creating a setting which allows for this possibility.
- Show an awareness and appreciation of a systemic perspective of the supervision process which embraces not only therapist, supervisor and client but also the relevant systems within which they operate (e.g. domestic, occupational, institutional).
- Target key areas if they need to be addressed.

The relevance of process issues might need to be inferred by the rater if the issue is not identified and discussed by the supervisor – in which case the reasons for this inference should be clearly noted under general comments.

Supervisees will be penalised for failing to appreciate key process issues or if process issues are recognised but not addressed properly. The key areas for consideration are:-

1. IP issues within the therapeutic relationship
2. IP issues between the supervisor and client or wider system
3. Process issues within the client's wider system
4. Process issues within the supervisee's wider system

5. In a *group setting* the supervisor should recognise and manage group processes appropriately: this means using helpful group processes (e.g. de-stigmatizing, the instillation of hope and peer guidance) to augment the supervision experience whilst minimising unhelpful group processes (e.g. scapegoating, dependency, splitting).

Part 5: Professional and ethical practice

1. Practises within limits of own knowledge and skill: supervisors should restrict their supervisory practice to their areas of knowledge and expertise and be open about the limitations of their skill and awareness.
2. Fosters competence in working with difference: the supervisor should encourage a non-judgemental and sensitive approach, which is enabling of clients from a broad range of backgrounds. This may have to be inferred from the supervisor's attitude towards the patient under discussion and the supervisee(s) in the session. If this is the case, the reasons for the inference should be clearly noted under general comments.
3. Respects confidentiality: the supervisor should protect patient confidentiality and ensure that supervisees do the same. Encouraging or permitting supervisees to disclose the full name of a patient will result in this item being failed.
4. Promotes safe CBT practice (including risk assessment where appropriate). Risk awareness is *crucial* to good supervision and ethical practice. Supervisors should also ensure that supervisees create appropriate therapy boundaries and practise ethically (for example fostering *appropriate* therapist-patient alliance, etc).
5. Encourages realistic and safe case management such that the supervisee is neither over-loaded nor under-stimulated. The supervisor should also ensure that the supervisee(s) practices within the limits of their knowledge and skill and should support the supervisee in recognising and bridging gaps in their practice.

Part 6: Reflective practice

These items are rated on a 5 point rating scale: scores of 3 and over are acceptable for competent practice.

1. Supervisor elicited appropriate feedback: this reflects the feedback gathered verbally at the end of the supervision session and the written feedback collected from the supervisee(s). The purpose of the feedback is to inform the supervisor's practice and to give information which will improve the supervision experience for the supervisee.

2. Responses to supervisee's feedback were appropriate: the supervisor should show that s/he has properly reviewed and considered supervisee feedback and has identified learning opportunities.

3. Supervisor's next supervision goal(s) is appropriate: the supervisor should build on reflection by translating new ideas / insights into action in the form of supervision goals, which should be 'SMART'. These might involve seeking supervision of supervision, organising further CPD, modifying performance in supervision sessions, for example. Whatever the goals, they should reflect the learning opportunities of the recorded session.

Part 7: General feedback

In this section raters should give a summary of:

1. The supervisor's main strength (as demonstrated in the submitted recording) along with,
2. Suggestions for improvement of supervisory practice

Comments should be constructive, specific and where possible readily translated in to tasks which can be reviewed.

Supervisor Competency Scale contributors: Helen Kennerley, Gillian Butler, and Sue Clohessy (OCTC)

OXFORD DIPLOMA/MSc IN ADVANCED COGNITIVE THERAPY STUDIES

II. SUPERVISOR COMPETENCY SCALE

Recording 1 / Recording 2

Supervisor:…….. Date of session: …….....
Rater: ……. Date of rating: ……..
Supervision format (e.g. group, peer etc): ……

Items submitted for rating

1. One recording Yes No
2. Feedback from recipient(s) of supervision Yes No
3. Completed Reflection on supervision form Yes No

Rate supervisor's performance on the following scale:

1	2	3	4	5
Absence of feature or highly incompetent or major problems evident	Evidence of competence, but many problems and/or lack of consistency	Competent, but some problems and /or inconsistencies	Good features Minor problems and or inconsistencies	Expert performance or very good even in the face of difficulties

Part 1: Structuring the session

1. Contracts use of time …
2. Adheres to agreed agenda …
3. Selects specific and appropriate topics / goals for session …
4. Paces session (i) appropriate to the needs of the supervisee(s) …
   (ii) uses time efficiently …

General Comments:

Part 1: Considered competent: Yes No

Part 2: Enhancing Learning

1. Gathers information to illustrate supervisee's clinical practice …
2. Uses a variety of methods to appraise and evaluate the skills and knowledge of the supervisee …
3. Shows sensitivity to the learning needs of the supervisee …
4. Balances use of methods likely to foster supervisee learning (e.g. Socratic method, use of recordings, information giving, experiential methods etc) …
5. Makes available relevant and appropriate materials (e.g. references, measures, recordings etc) …
6. Gives feedback to supervisee which is sensitive and constructive …
7. Makes theory-practice links …
8. Promotes reflective practice ...
9. In a *group setting* facilitates group learning …

General Comments:

Part 2: Considered competent: Yes No

Part 3: Supervisory Relationship

1. Collaborative and engaging …
2. Respectful, supportive, sensitive …
3. Creates safe environment for supervisee to be open …
4. Boundaried: the SR reflects a working alliance not a friendship or therapy …
5. Open: honest mutual feedback …
6. Problems within the SR are addressed …

General Comments:

Part 3: Considered competent: Yes No

Part 4: Other process issues

1. Shows sensitivity to IP issues within the therapeutic relationship ...
2. Shows sensitivity to IP issues between the supervisor and client or wider system …
3. Shows sensitivity to process issues within the client's wider system ...
4. Shows sensitivity to process issues within the supervisee's wider system ...
5. In a *group setting* recognises and manages group processes appropriately ...

General Comments:

Part 4: Considered competent: Yes No

Part 5: Professional and ethical practice

1. Practises within limits of own knowledge and skill ...
2. Fosters competence in working with difference ...
3. Respects confidentiality ...
4. Promotes safe CBT practice (including risk assessment where appropriate) ...
5. Encourages appropriate case management ...

General Comments:

Part 5: Considered competent: Yes No

Part 6: Reflective practice

	Not at all				Absolutely
1. Supervisor elicited appropriate feedback	1	2	3	4	5
2. Responses to supervisee's feedback were appropriate	1	2	3	4	5
3. Supervisor's next supervision goal is appropriate	1	2	3	4	5

General Comments:

Part 6: Considered competent: Yes No

Part 7: General feedback

3. Supervisor's main strength as demonstrated in this recording

4. Suggestions for improvement

III. REFLECTION ON SUPERVISION FORM

1. Background information

Give a brief description of the supervisee(s), their level of experience, the number of times you have met etc

2. General reflection

(i) Comment on what you are pleased with and less pleased with in this session: consider content, procedure and process. You might also want to consider your assumptions, shared responsibilities and shared expertise.

(ii) What is your response to the feedback from your supervisee(s)?

(iii) In the light of (i) and (ii), what is your next goal(s) as a supervisor?

(iv) Does this session reflect your usual practice? Was there anything unusual about this session – if so, how did you manage this?

SECTION III

SUPERVISEE FEEDBACK *

Supervisor:…….. Date of session: …….....

As a supervisee, what did you find particularly helpful or less helpful about this session? What, if anything, would suggest to improve the session?

* Supervisors may request more detailed feedback

Word count:

Approximately 50,000 words