



**(BABCP)**

[www.babcp.com](http://www.babcp.com)

## **Core Curriculum Reference Document**

British Association for Behavioural & Cognitive Psychotherapies





## FOREWORD

BABCP is pleased to be able to provide the following document for your use and reference.

The main purpose of it is to provide information about a proportion of the CONTENT that might be expected to be included in the training received by an Accredited Cognitive Behavioural Practitioner. To date all that has been available is a statement of QUANTITY of training.

As a reference document, there will not be any attempt by the Accreditation Teams formally to evaluate the content of an individuals training, and as such, it will not alter the standards or procedure for applying for Accreditation.

There are of course many other potential uses for the document.

The proposal originated within the Practitioner Accreditation and Registration Committee, and was agreed as a project at a meeting of all the Accreditation Committees in 2009. We are grateful to Nick Hool of the University of Chester, for taking on the development of the bulk of the project work on behalf of the Association. The document was approved by the Board in September 2010 and the National Committees Forum in November 2010.

A range of organisations and individuals have contributed, and it has been written in a spirit of inclusivity, to reflect the Aims and Objectives of the Association.

The curriculum contains two sections, each with five parts, but it is worth noting that much of the listing is provided as INDICATIVE CONTENT; that is, it makes suggestions rather than prescriptions as to what might be included under the sub-headings.

Finally, some appendices to the document will be available in due course, covering Learning Objectives, Formal Assessment, and what might be expected within Minimum Supervised Practise. These might be most useful for those intending to set up new courses.

We hope that you find the document helpful and would welcome suggestions or comments on it to the office over the forthcoming year.

Please send any comments etc to:  
BABCP Core Curriculum Reference Feedback  
FREEPOST RSHG-HYHY-LSHJ  
Imperial House  
Hornby Street  
Bury BL9 5BN

# **BABCP CORE CURRICULUM REFERENCE DOCUMENT**

## **Background**

BABCP Minimum Training Standards (MTS) provide guidance on the quantity of training required to become an accredited cognitive behavioural practitioner, but do not specify the content of the training. Within the context of the increasingly diverse range of cognitive behavioural therapies and CBT training programmes, there is a need to specify the core content of the academic and skills training a practitioner should undertake in order to be eligible for practitioner accreditation.

## **Aim**

To specify the core curriculum content of the CBT training which all practitioners must successfully undertake in order to become eligible for BABCP practitioner accreditation. This should be taken in conjunction with 'Standards of Proficiency for Psychological Therapists'.

## **Key Recommendations**

- CBT includes a diverse range of therapies and BABCP represents the interests of practitioners at either end of the behavioural – cognitive continuum. Behaviour therapists and cognitive therapists each tend to engage in similar interventions, but utilise a different rationale. These differences have been taken into account when developing the curriculum. It is recommended that BABCP remains inclusive to practitioners and training providers who identify themselves as “pure” behaviourists or cognitive therapists.
- Many practitioners train and operate within specialist areas. Once accredited, practitioners use their own discretion in declaring the areas they are competent to practice in. Due to the current generic nature of accreditation it is recommended that all practitioners develop and demonstrate a specified core set of competences.
- The core curriculum aims to enable practitioners to develop core knowledge and clinical competence (a) in the areas where the evidence base of CBT is strongest, and (b) that can be adapted to many of the specialist areas of practice. Therefore the curriculum focuses primarily on the science, theory, and practice of CBT with common mental health disorders.
- In order to achieve its aims the core curriculum should represent at least 100 hours of the directed study in theory and skills stipulated in the minimum training standards and the development of clinical competence.

## **CBT CORE CURRICULUM REFERENCE**

### **Curriculum Aims**

The curriculum should enable practitioners to develop and demonstrate:

1. A critical understanding of the scientific and theoretical underpinnings of Behavioural and Cognitive Therapies for common mental health disorders across the specialisms
2. The core clinical competences required to practise CBT with common mental health disorders across the specialisms

### **Curriculum Content**

The following section comprises the core content of a CBT training programme, but should not be viewed as a strict course guide. Although it would be beneficial for aspects of the curriculum to be covered within dedicated lectures (e.g. disorder specific protocols), certain aspects of the curriculum would more usefully be covered within session plans or lecture notes (e.g. critical treatment skills), or may be woven throughout the course.

### **Summary of Content**

1. The Scientific and Theoretical underpinnings
  - (a) Phenomenology
  - (b) Behavioural Theories
  - (c) Cognitive Theories
  - (d) Efficacy Research
  - (e) The scientist practitioner
2. The CBT Core Competences
  - (a) Competency Measurement
  - (b) Professional and Therapeutic Competences
  - (c) Assessment Competences
  - (d) Intervention Competences
  - (e) Treatment Process Competences

# **1. The Scientific and Theoretical underpinnings of Behavioural and Cognitive Therapies for Common Mental Health Disorders:**

## **(a) Phenomenology, diagnostic classification and epidemiological characteristics of common mental health disorders across the specialisms:**

- Definitions of psychopathology, including social, ethical, and cultural issues
- Depression
- Anxiety Disorders (and Hypochondriasis)

## **(b) Behavioural theories of common mental health disorders:**

- Behavioural theories of learning: Classical, Operant and Vicarious.
- Behavioural theories of the development and maintenance of depression
- Behavioural theories of the development and maintenance of anxiety disorders
- Behavioural theories linked to treatment methods
- Empirical support for behavioural theories

## **(c) Cognitive theories of common mental health disorders:**

- Cognitive theories of emotional disorder
- Cognitive theories of development and maintenance of depression
- Cognitive theories of development and maintenance anxiety disorders
- Cognitive theories linked to treatment methods
- Empirical support for cognitive theories

## **(d) Research regarding the effectiveness of CBT:**

- Efficacy of behavioural approaches for common mental health disorders
- Efficacy of cognitive approaches for common mental health disorders
- Efficacy of combined cognitive behavioural approaches for common mental health disorders
- Psycho-pharmacotherapy for depression and anxiety and medication concordance

- Factors impacting upon the efficacy of CBT for common mental health disorders
- Efficacy and evidence of CBT for specialist areas of pathology
- Eating disorders
- Substance misuse
- Psychosis
- Bi-polar disorders
- Personality disorders
- Physical health problems
- Child and adolescent disorders
- Intellectual disabilities
- NICE Guidance

**(e) The scientist practitioner model – conducting empirically grounded interventions in routine clinical practice**

**2. Development of CBT Core Clinical Competences:**

**(a) Identification and measurement of Clinical Competence:**

- Models of competence development (e.g. Dreyfus)
- Models of learning (e.g. Kolb)
- CBT competence frameworks (e.g. Roth and Pilling)
- Measurement of therapist competence\*

\*Note: The Cognitive Therapy Scale-Revised has been adopted widely as the central measure of in-session competence. However there is a need for courses to flexibly adopt a broader range of measures which are suited to the skills being demonstrated (e.g. behavioural activation) and the population served (e.g. CTS-Psy).

**(b) Development of CBT Professional and Therapeutic Competences**

**i. CBT Professional Competences**

Indicative Content:

1. BABCP Standards of Conduct, Performance and Ethics
2. Demonstrating empathy, genuineness and acceptance toward clients when practising CBT

3. Managing personal involvement when practising CBT
4. Operating as a scientist-practitioner
5. Reflecting upon and evaluating personal values, clinical competence and limitations as a CBT practitioner
6. Practising CBT with individuals from diverse and minority backgrounds
7. Effective clinical communication including CBT assessment and treatment reports/letters
8. Effective management of complex/high-risk clinical situations when practising CBT
9. Effective working with professionals, family members and other support networks
10. Management of emotional expression by clients

## **ii. Using CBT Supervision**

Indicative Content:

1. Working in accordance with terms of supervision contract
2. Appropriate seeking of guidance between clinical supervision sessions
3. Prioritising material for discussion within supervision
4. Succinctly presenting case information
5. Receiving and providing feedback within supervision
6. Working productively with clinical supervisor to manage difficulties within the supervisory relationship
7. Implementing action plans agreed within supervision
8. Direct observation and/or audio/video recording clinical sessions for viewing within supervision
9. Self-rating and peer-rating of in-session competence
10. Accurate, thorough, and up-to-date completion of clinical practice portfolio



### **iii. Collaborative Therapeutic Alliances**

Indicative Content:

1. Forming and maintaining appropriate therapeutic alliances
2. Collaborating with clients and facilitating joint active participation throughout treatment
3. Managing client's psychological and emotional needs within treatment
4. Managing client non-compliance or testing of therapeutic boundaries
5. Managing between-session client contacts
6. Understanding and managing therapeutic ruptures
7. Managing therapeutic endings.

### **iv. CBT Interpersonal Skills**

Indicative Content:

1. Learning the "when" and "how" of interpersonal communication
2. Demonstrating emotional warmth
3. Awareness of body language
4. Use of verbal encouragers
5. Use of questions
6. Accurate listening
7. Use of summaries
8. Use of two-way feedback
9. Noticing and responding to subtle client behaviours (e.g. affect shifts)
10. Understanding the implicit communications of clients
11. Using appropriate self-disclosure
12. Providing information
13. Providing direction
14. Interrupting clients and redirecting the conversation
15. Engaging in empathic confrontation
16. Boundary Setting

## **(c) Development of CBT Assessment Competences**

### **v. Semi-Structured Assessment**

Indicative Content:

1. Eliciting preliminary problem relevant data (e.g. what, where, when, with whom, why)
2. Identifying the frequency, duration and intensity of problem episodes
3. Identifying behavioural excesses and deficits/avoidances
4. Conducting a cognitive/behavioural/functional analysis of a recent problem episode
5. Identifying the original onset of the problem and precipitating factors
6. Identifying modifiers of the problem (e.g. alcohol)
7. Conducting a mental state examination
8. Eliciting relevant historical data
9. Assessing and managing risk
10. Collecting baseline data (in-session and homework)
11. Assessing factors impacting upon treatment
12. Assessing suitability for CBT

### **vi. Diagnostic Classification of Common Mental Health Disorders**

Indicative Content:

1. Awareness of the process of differential diagnosis
2. Identifying common mental health disorders using DSM-IV-TR (APA, 2000)
3. Providing a clear justification when identifying common mental health disorder(s)
4. Considering and prioritising differential diagnoses; and making referrals to other professionals when required
5. Communicating disorder specific information to clients, family and professionals
6. Recognising parameters of personal competence with regard to identifying disorders
7. Using clinical experimentation and measurement to test diagnostic hypotheses

## **vii. Behavioural and/or Cognitive Case Formulation**

Indicative Content:

1. Developing specific problem statements and treatment goals
2. Developing behavioural (e.g. functional assessment) and/or cognitive (e.g. misinterpretation based) maintenance formulations
3. Developing a functional analysis and/or cognitive longitudinal explanatory formulations when required
4. Developing protocol specific formulations
5. Engaging in clinical experimentation to test formulation hypotheses

## **(d) Development of CBT Treatment Intervention Competences**

### **viii. Core Treatment Skills**

#### **1. Cognitive Restructuring**

Indicative Content:

- a. Identifying key automatic thoughts and images
- b. Using discussion techniques to help client examine and modify automatic thoughts and images
- c. Using behavioural experiments to help client reality test automatic thoughts and images
- d. Identifying and modifying conditional and unconditional schema

**And / Or**

#### **Contextual Approach to working with Cognitions**

Indicative Content:

- e. Identifying the context (antecedents) in which cognition occurs
- f. Identifying and differentiating respondent (automatic) and operant (e.g. rumination) private events
- g. Focusing on the function (consequences) of the cognitive process
- h. Helping the client to identify, and engage in, alternative positively reinforcing activities

## **2. Exposure**

Indicative Content:

- a. Providing psycho-education regarding the nature of the client's fears
- b. Providing a clear rationale and explanation of the principles of exposure
- c. Developing an exposure programme in collaboration with clients (including exposure hierarchy)
- d. Conducting therapist-aided (in-vivo, imaginal, and interoceptive) exposure exercises
- e. Ensuring exposure exercises are focused; appropriately graded; repeated; and prolonged
- f. Helping clients to endure high levels of arousal/distress
- g. Responding to obstacles to successful exposure
- h. Helping the client to review key learning points following the exposure exercise
- i. Planning, in collaboration with clients, self-directed homework exposure tasks
- j. Involving family members or relevant others when appropriate
- k. Monitoring the emotional processing of fear (activation of fear structure, habituation during exposure, habituation across exposure exercises)

**And / Or**

### **Cognitive Therapy of Anxiety Utilising In-Vivo Behavioural Experiments**

Indicative Content:

- l. Conceptualisation of the role of misinterpretation in maintaining anxiety disorders
- m. Conceptualisation of the role of selective attention and safety behaviours in maintaining misinterpretation of threat
- n. Developing an alternative conceptualisation regarding the client's fears
- o. Engaging in discussion techniques to weaken the client's degree of conviction in threat appraisals

- p. Planning and conducting in-vivo behavioural experiments to test alternative conceptualisation
- q. Examining and modifying assumptions influencing development of anxiety

### **3. Behavioural Activation**

Indicative Content:

- a. Psycho-educating clients regarding the relationship between situation, mood and behaviour
- b. Psycho-educating clients regarding the rationale for activation
- c. Helping clients to identify short-term, medium, and long-term goals
- d. Helping clients to monitor and identify situations, behaviours, and aspects of routine most strongly associated with negative affect
- e. Helping clients conduct a functional assessment (antecedents, behaviours and consequences)
- f. Helping clients to tolerate negative feelings whilst engaging in activities consistent with valued goals (“work from the outside in”)
- g. Helping clients establish a structured routine comprising stable and diverse sources of positive reinforcement for behaviours consistent with their life goals and reducing the effects of negative reinforcement
- h. Utilising graded task assignment to address avoidance behaviours
- i. Educating clients to observe the outcome of activation and persist in the use of activation strategies

**And / Or**

#### **Activity Monitoring and Scheduling**

Indicative Content:

- j. Helping clients to monitor and rate their activities, in terms of pleasure and mastery, using an activity chart
- k. Helping clients identify activities associated with increases in negative thoughts and depressed mood
- l. Helping clients to identify activities associated with higher levels of pleasure and/or mastery
- m. Scheduling pleasurable and previously avoided activities

- n. Using task assignments to identify and test out cognitions
- o. Enabling clients to test out their hypotheses regarding the degree of pleasure or mastery associated with specific activities

#### **4. Problem Solving**

Indicative Content:

- a. Providing psycho-education regarding problem-orientation and problem-solving
- b. Helping clients to identify a problem list
- c. Helping clients to identify a specific problem and corresponding goal
- d. Helping clients to generate and evaluate potential solutions
- e. Helping clients to select and plan implementation of a solution
- f. Helping clients to evaluation the outcome
- g. Helping clients to acquire key problem orientation and solving skills to facilitate generalisation

#### **5. Applied Behaviour Analysis**

- a. Helping clients change their behaviours in accordance with their life goals and improved quality of life
- b. Helping clients manage emotions in accordance with their life goals and improved quality of life

#### **ix. Treatment Protocols for Common Mental Health Disorders**

It is recommended that therapists receive AT LEAST a full teaching day's training in each of the following disorders. It is recommended that training should develop skills in a single protocol as opposed to "dipping into" a number of approaches. The following protocols are suggestions based on their strong empirical support. Any alternative approach used should be clearly specified and justified on the basis of the empirical literature and applicability to the whole range of specialist clinical populations.

##### **1. Depression**

- a. Cognitive therapy (Beck, Rush, Shaw and Emery, 1979)  
Or
- b. Behavioural activation (Martell, Addis and Jacobson, 2001)

## **2. Specific Phobia**

- a. Exposure therapy [and Cognitive Restructuring] (Craske, Antony and Barlow, 2006)

## **3. Panic Disorder**

- a. Cognitive therapy (Clark and Salkovskis, in press)  
Or
- b. Panic Control Therapy (Craske and Barlow, 2007)

## **4. Social Phobia**

- a. Cognitive therapy (Clark, in press)  
Or
- b. Cognitive Behavioural Therapy (Hope, Heimberg, and Turk, 2006)

## **5. Obsessive Compulsive Disorder**

- a. Exposure and Response Prevention (Kozak and Foa, 2005) or (Steketee, 1993)

## **6. Post Traumatic Stress Disorder**

- a. Prolonged Exposure Treatment (Foa, Hembree, and Rothbaum, 2005)  
Or
- b. Cognitive Processing Therapy (Resick and Schnicke, 1996)  
Or
- c. Cognitive Therapy (Ehlers, unpublished)

## **7. Generalised Anxiety Disorder**

- a. Cognitive Therapy and Self Control Desensitisation (Borkovec, Unpublished)  
Or
- b. CBT (Dugas and Robichaud, 2006)  
Or
- c. Mastery of Anxiety and Worry Program (Zinbarg, Craske and Barlow, 2006)

## **8. Hypochondriasis**

- a. Suggested text (Furer, Walker and Stein, 2007)

## **x. Critical Treatment Skills**

Indicative Content:

1. Selecting the most appropriate treatment intervention
2. Adapting treatment methods to meet individual client needs
3. Prioritising of treatment interventions
4. Adhering to collaborative empirical method of clinical practice
5. Using client engagement strategies
6. Recognising and responding to subtle client behaviours (including affect shifts)
7. Managing client distress and high arousal states
8. Ongoing assessment and management of risk
9. Identifying and responding to treatment obstacles
10. Using relapse prevention strategies

## **xi. Evaluation of Treatment**

Indicative Content:

1. Using measures to evaluate treatment progress
2. Using clinical experimentation to evaluate treatment progress
3. Making empirically supported clinical decisions based on treatment progress data
4. Evaluating the overall effectiveness of treatment programme
5. Identifying variables influencing treatment progress
6. Making post-treatment recommendations based upon evaluation
7. Drawing critical conclusions at completion of treatment re: implications for science, theory and practice of CBT

## **(e) Development of CBT Treatment Process Competences**

### **xii. Session Structure**

Indicative Content:

1. Collaboratively setting an agenda at the outset of each clinical session (inc. homework review; main focus and aims for session)



2. Adhering to the session agenda (including rescheduling of items not covered in session)
3. Engaging in two-way feedback at the end of each agenda item
4. Setting homework at the end of each session
5. Using time efficiently in clinical sessions

### **xiii. Treatment Structure**

Indicative Content:

1. Dividing treatment into discrete assessment; intervention; and evaluation phases
2. Ensuring continuity in the content of treatment sessions, consistent with achieving agreed treatment goals
3. Adhering to empirically supported treatment plans
4. Treating problems efficiently

### **xiv. Facilitation of Client Learning**

Indicative Content:

1. Using guided discovery questions
2. Providing psycho-education re: principles of CBT
3. Providing training in self-monitoring
4. Engaging in reflective examination of client problem episodes
5. Developing a shared conceptualisation of the client's problem experiences
6. Providing psycho-education re: the rationale for treatment procedures
7. Collaboratively planning corrective learning experiences
8. Facilitating corrective learning experiences
9. Guiding review and conceptualisation of corrective learning experiences
10. Providing training to conduct homework tasks
11. Guiding review of outcome of homework tasks
12. Providing exercises to aid generalisation and maintenance of new learning

## **xv. Use of Empirical Measures**

Indicative Content:

1. Selecting empirical measures including general; diagnosis specific; and personalised
2. Administering empirical measures
3. Interpreting data derived from empirical measures

**This document is the copyright of BABCP. It was developed by Nicholas Hool, University of Chester, 2010.**



**Contact BABCP**

Imperial House, Hornby Street, Bury BL9 5BN

[babcp@babcp.com](mailto:babcp@babcp.com)

0161 705 4304

[www.babcp.com](http://www.babcp.com)