Improving Access to Psychological Therapies

Postgraduate Diploma in High Intensity Psychological Interventions

Supervisor's Handbook

March 2021

Contents

Introduction
Supervision of High Intensity Psychological Intervention (HIPI) Training Therapists

This Handbook has been assembled to help you with the important role of establishing and managing the clinical service aspect of the HIPI PG Diploma, and in particular the role of the clinical supervision of trainees offered in the service and the responsibilities of the supervision role.

There is now a HIPI Supervisor Information web page on the University of Sheffield's website which you can use to find and download resources related to clinical supervision. Please find and save the following link:
https://www.sheffield.ac.uk/clinicalpsychology/programmes/iapt/cbtsupervisor

Thank you so much for taking up this role.

Your role is vital to the development of trainees' procedural and declarative knowledge, skills and experiences, enabling them to effectively practice in step 3 of IAPT clinical services.

During the PG Dip year, you will be providing one to one clinical supervision for HIPI trainees and group supervision will be provided at the University. It is vital that there are close links between the Service and University supervisors, so that the boundaries between the Service and University supervision can be established and any problems with the development of trainees quickly dealt with.

IAPT guidelines stipulate that clinical supervision for trainees should be at least **one hour per week** with the service supervisor.

Service supervisors carry clinical responsibility and manage the clinical risk for all the cases on the trainee's caseload. Therefore, service supervisors are encouraged to work with the trainee to identify cases that are relatively risk free and can be supervised by the University supervisor. These cases need not be less complex than those supervised in the service, but it would be unwise to allocate a case to University supervision that requires close monitoring of risk issues, simply due to distance from the case. Trainees are strictly informed not to take one case to both supervisors. The group supervision should be focussed to one or two cases at a time and heavily driven by access to live material.

Reports of trainee progress are initially sought via reporting mechanisms. If such reports indicate that there is a problem, the Programme Director and/or course team will organise a visit to the IAPT service. This could also occur if the mid-year supervisor's report highlights a major issue. The purpose of a service visit is to link the trainee, service manager and supervisor in order to review trainee performance and problem solve any integration issues. A training plan is a frequent outcome of

such a meeting, which states the problems evident and also charts changes that need to take place to ensure trainee progression.

KSA Portfolios

The University of Sheffield PG Diploma in CBP course is a BABCP Level 2 Accredited course. The Course is required to take responsibility for formally assessing trainees' suitability for training in CBP.

For trainees who do not have a recognised relevant Core Professional training or qualification, the course undertakes a formal and robust process of selection which considers the trainees' previous training and experience to assess suitability for the CBP training provided on the course.

These trainees are assessed through the core Knowledge, Skills and Attitudes (KSA) criteria, equivalent to a recognised Core Professional training or qualification.

KSA Trainees will have submitted and received feedback on their KSA portfolios during the selection process. The KSA must be completed and signed off before the training begins.

Information about the KSA process can be found at:
https://www.sheffield.ac.uk/clinicalpsychology/programmes/iapt/ksa

KSA Trainees are unable to pass and graduate from the course, until their KSA has been completed and signed off by one of the course KSA assessors.

PebblePad

Pebble Pad is the online program via which all Practice Portfolios are now submitted. You will receive a pass word and log on for your trainees' online portfolio. This allows you to sign off any required documents and compete the supervisors reports online. Appendix 1 shows a quick guide to accessing PebblePad. This will also be cover dint he supervisor event. Any queries about PebblePad can be sent to IAPTAdmin@sheffield.ac.uk

Fitness to Practise

Trainees are subject to the University's Fitness to Practise procedures in order for the course to effectively act as a gatekeeper concerning professional behaviour. Trainees must uphold appropriate standards of behaviour in all aspects of their training, as indicated below; this applies to the attitude and behaviour of the trainee in the service and at the University. Written information on Fitness to Practise procedures is provided to trainees on the first day of the course. If supervisors have any fitness to practise concerns, they should contact the Programme Director and associated actions will be actioned (e.g. initial meeting with the trainee to raise awareness).

Where HIPI trainees fail to meet FtP standards they will not be allowed to complete the course. The standards are as follows:

a) During their course, HIPI trainees must liaise in a positive and constructive way with many different people including patients, clinical supervisors, other NHS staff, course administrative and teaching staff, peers and others. Where fitness to practise concerns are raised in relation to this aspect, then interpersonal difficulties should be clearly demonstrated with a variety of different individuals and typically across several different settings.
b) Training requires individuals to acquire new skills and knowledge and take on new roles. It requires respect for others' opinions, an 'openness' to learning and an ability and willingness to use feedback constructively. Concerns relating to fitness to practise may involve an inability or unwillingness to acknowledge and use feedback on practice issues or interpersonal difficulties in a constructive way. Any feedback given and the responses of the trainee should be clearly documented.
c) Throughout their training trainees are required to demonstrate attitudes and behaviour in keeping with the statements of values and standards of respect, competence, responsibility and integrity.
d) In addition to (c) there are specific additional implementation issues in the training context. In particular, the domain of integrity requires that honesty must underpin all aspects of training in relation to documentation, assessed work and liaison with staff and supervisors.
e) Concerns may be raised about fitness to practise under any of the above areas. However, a series of more minor events may have occurred, usually across settings and with more than one person, which call into question the suitability of a candidate, through their attitudes or behaviour to continue their training.
f) As a condition of acceptance onto the course Trainees must undergo and have received a satisfactory DBS check. It is a condition of continued registration that any police cautions or criminal convictions occurring after offer of a place, but prior to termination of the course, are notified to the Programme Director within 7 days of occurrence. Failure to do so will be considered as a concern about fitness to practise. The content of any disclosure may lead to

University Fitness to Practise or Disciplinary Procedures being invoked (https://www.sheffield.ac.uk/sss/sas/conduct/ https://www.sheffield.ac.uk/sss/sas/progress).

g) The Course, wherever possible, attempts to ensure that candidates successfully complete their training. The Course Team is committed to helping trainees who encounter difficulties through (i) clear communication about the identification of problems and (ii) provision of support to a trainee in their attempts to meet the requirements of change.
h) Should concerns be raised about a trainee's fitness to practise, the procedures outlined in General Regulations relating to Student Fitness to Practise will be followed.
i) Where the University upholds concerns over Fitness to Practise, a trainee may be excluded from the course and their registration terminated.
j) The University has a duty of care to inform current and subsequent supervisors of any referrals for Fitness to Practise and their outcomes, since the NHS Trust is liable for the clinical work conducted by trainees.

Plagiarism

Issues around plagiarism are arising due to a culture of certain current and past trainees sharing their University assignments with their peers and colleagues. The IAPT teaching team now marks trainee work through an online system called Turnitin, through which every assignment is compared with a database of work across the country. This means we are made aware when a trainee's work is similar to that of a current or past trainee, who is/has studied at the University of Sheffield or an IAPT training programme at a university elsewhere.

While trainees are encouraged to talk to and support each other with their work, it is important that they do not hand out their written work, or read that of another trainee. We would appreciate your support in echoing this message, and being mindful of this issue when signing off each piece of work for your supervisees.

Any concerns regarding the fabrication of clinical sessions are escalated to the board of examiners. Such concerns are treated very seriously and the course adheres to the University's use of unfair means policy.

Professional Gate-keeping: Grading Trainee Competency

Clinical supervision is a key means by which the safety of trainee practitioners is examined. There are three mechanisms by which this happens:

a) mid-year progression with CBT competencies report
b) end of year achievement of competencies report

c) assessing competency of CBT sessions using the CTS-R (please note that in the final Practice Portfolio, there must be one session rated by the supervisor that receives a pass grade (i.e. >36 with a score of 3 on the change method item).

Supervisors are required to complete a mid and end of year report on the clinical performance and competency of the trainee. These forms are included in the appendices of this document and they are a fundamental aspect of the trainee Practice Portfolio. Trainees need to pass the Practice Portfolio in order to pass the course and supervisor reports are a constituent part of the Practice Portfolio. Therefore, it is vital for supervisors to be honest about their trainee's performance in the report, and also provide as much descriptive detail as possible to enable effective discussion at Internal and External Exam Boards. Should a supervisor want any additional support in terms of use of the CTS-R, a request should be made to the Course team.

Documenting Clinical Supervision

a) Service Supervisors need to keep a record of supervision to meet their employer's clinical governance arrangements
b) Supervisors may wish to use the University Clinical Supervision Record to keep their own record of supervision.
c) Trainees are required to evidence the time and content of each supervision session for their Practice Portfolios; supervisors need to sign each entry.

The core University course team is comprised of BABCP accredited Cognitive-Behavioural Psychotherapists, who have been selected due to their experience of working clinically for many years using cognitive behavioural psychotherapy. The University groups run on one day a week and have 3 trainees per group and last for 2 hours.

University Group Supervisor Contact Details

Name	Role	Email address	Working days
Abigail Bradbury	IAPT Tutor/ Teacher/ Supervisor	a.s.bradbury@sheffield.ac.uk	Tuesday and Wednesday
Dennis Convery	IAPT Tutor/ Teacher/ Supervisor	d.m.convery@sheffield.ac.uk	Tuesday and Wednesday
Jennie Hague	Programme Director/ IAPT Tutor/ Supervisor/ Teacher	Jennie.hague@sheffield.ac.uk	Tuesday to Friday
Eleanor Morton	IAPT Tutor/ Teacher/ Supervisor	e.k.morton@sheffield.ac.uk	Tuesday and Wednesday
Maggie Spark	Deputy HIPI Tutor/ Teacher/ Supervisor	h.m.spark@sheffield.ac.uk	Tuesday to Friday

Timetable of Assessment Deadlines

Assignment	Tutorial Date	Submission date	Internal Exam Board
Observed Structured Clinical Examination (OSCE)	MOCK OSCE Week 4 23.03.21 or 24.03.21	Week 5 30.03.21 or 31.03.21 Re-sit Week 8 22.04.21	Week 6 6.04.21 Re-sit Week 9 27.04.21
Literature Review/Case Study Assessment and Initial formulation	Week 7 14.04.21 AND Week 8 20.04.21	Week 12 19.05.21	Week 18 30.06.21
Service Learning Contract	N/A	Week 12 19.05.21	Week 18 30.06.21
Therapy Tape & Reflection 1 Tape can be either anxiety or depression	Week 16 15.06.21	Week 22 28.07.21	Week 29 14.09.21
Mid-Point Practice Portfolio	Week 16 15.06.21	Week 22 28.07.21	Week 29 14.09.21
Service Liaison Form	N/A	Week 22 28.07.21	Week 29 14.09.21
Formulation Case Study Assessment formulation and treatment	Week 24 10.08.21	Week 28 08.09.21	Week 34 19.10.21
Case Study 1 Case Study can be either anxiety or depression	Week 30 21.09.21	Week 36 03.11.21	Week 41 07.12.21

Therapy Tape & Reflection 2 Tape can be either anxiety or depression, depending on previous submission	Week 37 09.11.21	Week 41 08.12.21	Week 48
Case Study 2 Case Study can be either anxiety or depression, depending on previous submission	Week 39 23.11.21	Week 48 27.01.22	Week 52
Practice Portfolio	Week 37 09.11.21	Week 48 27.01.22	Week 52

Important information regarding the submissions

Please note the following:

- **a)** Within the fundamentals module, the case-based literature review and the formulation case study need to be from **differing** patients.
- **b)** The formulation case study patient **cannot** then be used as a depression or anxiety module case study.
- **c)** The case studies (one anxiety and one depression or one transdiagnostic) in the Practice Portfolio can be extensions of the work initially completed in the Case-Based Literature Review or the Formulation Case Study.
- **d)** The 8 focussed cases in the portfolio must include a variety of presentations (minimum of 3), including both behavioural and cognitive approaches for Depression. **One of these MUST be a PTSD case.**
- **e)** There is a group tutorial for each assessment

Submission of Case Studies: Anonymity and Honesty

Anonymity of client case material is of paramount importance. Trainees are required to submit four case studies as part of their assessed requirements (case-based literature review, formulation case study, depression case study and an anxiety case study). The HIPI course requires case study material to be strictly anonymised, or will be graded as a fail. The resubmitted work will be limited to a pass grade at 50% (if it is a pass). Anonymity means that the trainee cannot reveal themselves, the service they work in or the client's name. If for any reason this is not possible, informed consent must be sought by the trainee. HIPI supervisors are required to sign off the case studies to verify that the assignment is an authentic representation of the clinical work conducted. This form appears in the appendices. It might help to remind trainees about anonymity when you sign off the case studies.

Practice Portfolio Requirements

The final Practice Portfolio needs to contain the following:

Number of cases needed for the practice portfolio	8 cases
Ratio of closely supervised to supervised cases*	3 closely supervised – one of these MUST be a PTSD case 5 'case report' supervision
Minimum amount of supervision per practice portfolio case	5 hours
Minimum amount of close supervision per closely supervised case	3 hours

The means of closely supervising cases**	CTS-R
Two case summaries ***	Case reports

* This is the minimum standard and supervisors are encouraged to closely supervise as many cases as possible. Close supervision in defined as sitting in on a session or watching an audio-visual tape of a session. An example CTS-R feedback form and the CTS-R Scale and Manual are included in the appendices. University supervisors will ensure that all University cases are closely supervised. At least one of the assessed sessions needs to be passed (>36 CTS-R score) in the trainees Practice Portfolio. This session cannot be a final session or a review session.

** A CBT assessment rating form is included in the appendices to provide feedback on the competency of screening/assessment sessions completed by HIPI trainees and the rating form for the screening OSCE is also included.

*** The case summaries need to be completed cases of more than 6 sessions. These can be extensions of the Case Based Literature Review or the Formulation Case Study. They cannot be the submitted case studies in the Anxiety or Depression modules.

Criteria for HIPI Service Supervisors

Basic Criteria

a) Has current BABCP membership.
b) Complies with the Guidelines for Good Practice of the BABCP and demonstrates a working knowledge thereof.

CBP Experience

a) Is a BABCP accredited Cognitive-Behavioural Psychotherapist
b) Has demonstrated in CBT supervision a capacity for safe and effective CBT practice.
c) Can show evidence of continuing professional development.

Supervisor Experience

EITHER

1) Has satisfactorily completed a substantial structured training programme in supervision.

OR

2) Can show evidence that a programme of learning has been followed with a supervisor which ensures that the Guidelines for Good Practice of the BABCP is applied in his/her practice.

AND

a) Is currently practising as an IAPT service clinical supervisor.
b) Has had a minimum of two years' practice as a CB therapist.
c) Has completed a minimum of 30 contact hours with supervisees over a maximum of two years immediately prior to commencing as an IAPT clinical supervisor.
d) Can provide evidence of a range of supervisory experience (i.e. work with trainees and experienced CBT practitioners).
e) Evidence of CBT supervisory relationships being initiated, maintained and terminated appropriately.
f) Can provide evidence of the way in which he/she uses his/her authority as a clinical supervisor to promote the safety of the client.
g) Can provide evidence of the use of the Roth & Pilling (2008) competency framework models in his/her practice
h) Can demonstrate an awareness of the values, beliefs and assumptions, which underpin his/her work.
i) Can provide evidence of a capacity for self-regulation and reflection.

Role and Boundary Clarification

The **HIPI course team** undertakes:

a) to test the trainees acquisition of fundamental CBT skills prior to beginning clinical work in IAPT services and continue to monitor ongoing development and competence;
b) to communicate to service managers and service supervisors any concerns regarding the trainees which cannot be resolved with the trainee;
c) to offer service managers a consultative framework, including procedures for complaints against trainees or course staff.

The **IAPT Service** undertakes:

a) to offer, as far as possible, an agreed level of referrals of a type suitable for a HIPI trainee (i.e. clients suitable for cognitive behavioural interventions in step 3 of the stepped care model);
b) to provide trainees with a clear contract indicating responsibilities and duties of HIPI trainees;
c) the clinical supervisor will be trained to a level appropriate to working with HIPI trainees and will be prepared to evaluate the clinical performance of the trainee;
d) to provide a safe psychotherapeutic environment and a reasonable level of administrative support;
e) to collaboratively complete the interim and final reports for the Practice Portfolio.

The **HIPI Trainee** undertakes:

a) to work within the BABCP Code of Ethics and Practice;
b) to be clear about the practices and policies of the host Trust;
c) to provide an agreed level of psychotherapy hours by negotiation with service managers;
d) to use the clinical supervision as a means of monitoring his/her own development and fitness to practise;
e) to consult in an appropriate and ethical fashion with colleagues, managers and course staff regarding clients within the placement, especially when there are grounds for concern for clients' welfare.

Supervision contracts in HIPI trainee supervision

The main reasons for the use of contracts for HIPI supervision are:

a) prepare for a situation where supervisee and supervisor have different desires and expectations of supervision, with consequent fracturing of the supervisory alliance.
b) negotiate mutual expectations at the formative stages of supervision to help avoid problems later in supervision.
c) ensure the style of working in supervision is structured, collaborative and begins to establish a pattern of attention in supervision to process, content and relationship in order to be reflexive with the actual practice of CBT.
d) establish professional boundaries through making explicit the developmental, professional and legal functions of supervision.
e) create an underpinning foundation so that both supervisee and supervisor feel safe and supported.

To support your contracting around supervisory work then the following might serve as a suitable starting point for discussion and agreement:

a) Clarifying the type of supervision offered e.g. one to one.
b) Ground rules and policy regarding confidentiality.
c) Suitability of the type of supervision to the supervisees current needs.
d) The theoretical orientation, methods and techniques that will be used.
e) Emphasis of supervision e.g. process, content and relationship (or their relative weighting).
f) Practical considerations e.g. private quite room, frequency, duration, note taking, fees.
g) Goals, aims and objectives of supervision – making them SMART (Specific, Measurable, Attainable, Relevant and Time Limited).
h) Discussion of prior experiences of supervision, in order that supervision can be promoted as a positive developmental experience.
i) Work through the rights and responsibilities of both the supervisee and supervisor.
j) How the effectiveness of supervision will be measured/evaluated.
k) How any problems or fractures within the supervisory alliance will be handled from both the supervisee and supervisor perspectives.
l) How will issues that are outside the competence of the supervisor be handled?
m) How poor or incompetent practice (s) will be addressed from both a supervisee and supervisor perspective.
n) Process of review and renegotiations of the supervision contract.

Service Reports for High Intensity Trainees: University of Sheffield

Effective training in CBT is dependent on the trainee effectively integrating theory and practice. This means that, during training, IAPT high intensity trainees spend 2 days per week in the University learning theoretical competencies and 3 days per week in a clinical service learning CBT practice competencies. Effective liaison between the service and the University is essential and will ensure effective integration of learning. In the Course Handbook it states that by accepting a place on the Course the trainees accept the exchange of information between the service and university with regard to trainee progression. A major means of ensuring effective liaison and communication is the initial service report in which the service is asked to report any problems occurring with the trainee in their work context. The central aim of this report is to ensure effective and smooth trainee progression through the various landmarks of the course. If problems are identified, a service visit may be arranged in order to better understand the problem and also to produce an associated training plan. Often the academic tutor will perform the service visit.

Mid-Point Joint Supervisor Review Meeting

It is expected that a joint meeting between the trainee, the service supervisor, and the university supervisor will take place prior to the submission of the interim Practice Portfolio. The purpose of this meeting is to jointly discuss the trainee's progress in developing the CBT competencies, identify strengths and areas for improvement, highlight any areas of concern and consider how best to support the trainee's continued development in supervision for the remainder of the course.

It is anticipated that this meeting will take place remotely, via Googlemeet or similar, and it is the trainee's responsibility to ensure that the meeting is booked at a time convenient to all within the month prior to the mid-point submission.

Support Provided by the University for Service Supervisors

All service supervisors are strongly encouraged to attend the supervisor's workshop held at the University. This workshop provides information about supporting trainees throughout their training, the requirements of the course, use of the CTS-R, the role of the supervisor and the requirements of this role.

Supervisors can be invited to attend certain lectures on the course to support them in delivering supervision to the trainees on specific CBT protocols. The teaching sessions on the Unified Protocol for Emotional Disorders involve a day and a half workshop and is made available to all supervisors.

University tutors and supervisors are accessible via email for discussions with service supervisors regarding trainee issues.

Unfortunately, the University does not allow access to the online learning resources to those who are not registered students or staff, therefore we are unable to give supervisors access to this. With this in mind, the admin team are happy to provide teaching materials to supervisors on request.

The Service Learning Contract outlines what the University expects from services with regard to the support of trainees. It is important that supervisors are aware of the University's expectations in order to support trainees in adhering to them. Specific examples of when supervisor input may be required include ensuring that trainees are not providing therapy via any other modalities during the course of their training year, including PWP clinics. It is also important to ensure trainees are not responsible for supervision of other workers during their training year.

Appendices

Appendix 1

Supervisor access and completion of Pebblepad

Go to the Pebblepad website: www.pebblepad.co.uk

Click on the Blue Login button on the top right hand side

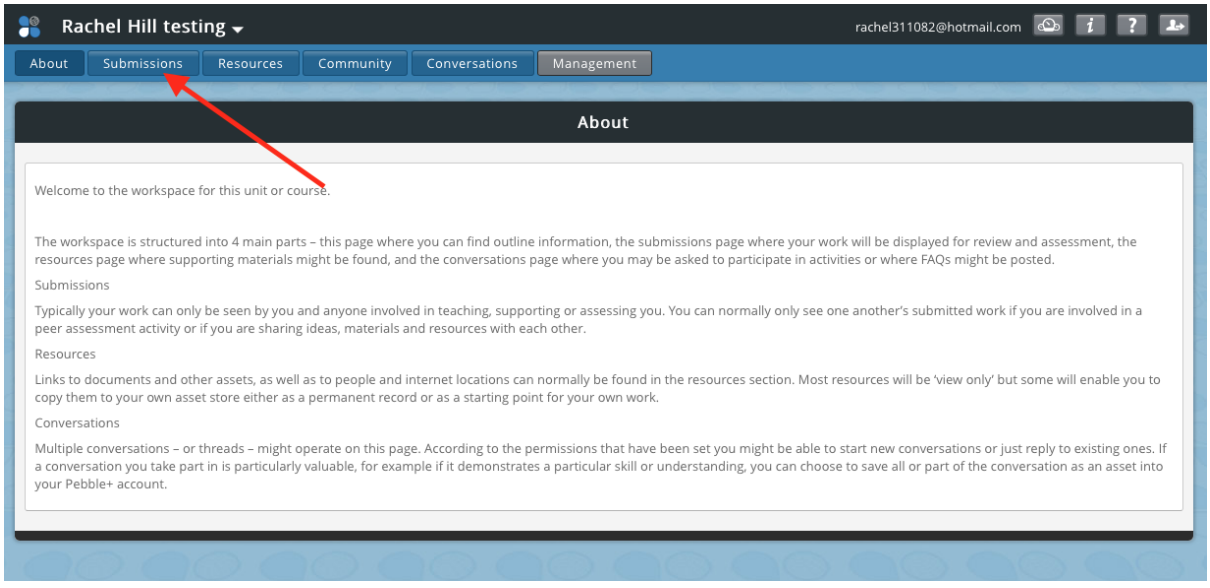
Choose the middle option of 'I use Pebblepad through my university/organisation' and then select University of Sheffield

Select 'I have a guest account for Pebblepad' and enter your username and password. (this should have been emailed to you when you were originally set up as a user). Click on Login to Pebblepad

This will show any workspaces that you have been allocated to and you will just need to choose the appropriate one.

(This will be based on the programme of study and intake(start date of the programme))

You will then see the following screen:



Choose submissions from the tabs along the top of the screen

This then takes you to any submissions made by your trainee

Choose whichever the relevant Portfolio is and click on the title, which will open the document for you.

You can then make your way along the top bar to view and complete all the pages, you should be able to complete assessor only fields.

When you have successfully input a comment you can save and the assessor only fields should have a stamp of your name and the date.

> The supervisor's handbook provides a guide of the required elements. It is your trainee's responsibility to ensure you have signed all the required elements.

Appendix 2: Service Learning Contract

University of Sheffield
HIPI Programme
Service Learning Contract:
Creating and Maintaining Effective Learning Environments

IAPT Trainee High Intensity Therapist posts require an unusually high level of cooperation and collaboration between the University and the IAPT service itself in order that the trainee learn the CBT competencies at the right rate and level. The training is brief, focussed and therefore demanding and the context in which the training takes place is therefore essential in terms of technical, managerial and supervisory support. Creating effective learning contexts is vital and partnership working is required to make sure that the training produces competent and safe practitioners with the skills and experience to meet the needs of IAPT patient groups.

This partnership agreement clarifies what service and University providers can expect from each other.

The agreement of all local partners is required for the partnership agreement to work: the following issues should be read and agreed by the student's on-site manager and supervisor:

Clinical supervision
Each trainee will receive weekly individual supervision from a suitably qualified, service-based BABCP accredited clinical supervisor, for at least one hour per week. If a trainee, is struggling, then the service will consider adding in extra supervision. Each HIPI trainee will also take part in a 2 hour weekly supervision group in the University. University supervision will focus in depth on one or two cases. Overall responsibility for the trainee's caseload (including issues involving risk) lays with the service supervisor. The service supervisor allocates appropriate training cases to the group supervision. High risk cases should not be allocated to group supervision. Service and University supervisors need to share any concerns they hold about trainee progress as some as possible with each other and also meet if training plans are required in the case of academic fails. It is the responsibility of the trainee to fully prepare for supervision, as per their specific supervision contracts.

Technical support
In order to learn the necessary CBT competencies, trainees are required to bring session tapes to service and University supervision each week. In order to support trainees in this, services should make access to suitable recording equipment the norm.

Clinical responsibility

Although the University group session clinical supervisor will provide some clinical guidance and advice, they will focus on the student's core CBT skills and not the trainee's client/patient caseload. The service clinical supervisor and group clinical supervisor are responsible for the clinical work undertaken by the trainee under their clinical supervision. It is the trainee's responsibility to keep the supervisor completely up to date with any ongoing clinical risk issues.

Caseload size and suitability

The University understands that are many pressures on services managing high volumes of referrals. For trainees to learn the CBT competences it is important that they have a caseload of suitable training patients. It is strongly recommended that trainees have a reduced caseload during their training year. 80% of a typical caseload, pro rata, is recommended whilst training. Teaching will be provided on assessing for suitability in CBT by the University and should be supported by the in service clinical supervisor when selecting appropriate cases. Services should 'cherry-pick' appropriate training places for trainees when appropriate. Trainees should not be expected to work with clients experiencing high and unstable risk or with complex and /or comorbid presentations. This is because the trainee can only learn the competencies when unfettered by clinical complexities. In addition, trainees should not be offering sessions in another therapeutic modality (e.g. PWP work or counselling), as this can compromise progress in developing competence in CBT, and produce poor outcomes for clients. Finally trainees should not be providing supervision to other colleagues during their training year.

Trainee Performance

Trainees' competence is robustly and regularly assessed throughout the course through a variety of methods and means. With this in mind the course requires that trainees are exempt from any performance management during their training year.

Shadowing

It is essential that trainees are provided the opportunity to observe the clinical practice of BABCP accredited CBT therapists, delivering evidence based treatments. This will enhance the learning and development of trainees, especially early in their training. The University will regularly provide clinical demonstrations as a routine part of teaching. The service should aim to provide the trainees with a minimum of three assessment sessions and three treatment sessions to shadow (this is a requirement for the practice portfolio submission).

Study leave/self-directed study

Trainees are expected to take personal responsibility for their learning outside of taught sessions. This will include (but is not limited to) reading, skills practice and self-practice/ self-reflection. In addition, reflecting on their current clinical practice is vital in the trainee's development. The University course has several timetabled reading weeks which should be kept free of other responsibilities in the

service as far as possible. Once formal teaching is completed, it is helpful for the trainees to continue to have at least on study day per week to facilitate completion of assignments and complete supervision hours if necessary.

Throughout the training teaching usually takes place on Tuesdays and Wednesdays. However, there may be assessments such as OSCEs that are timetabled on other days. It is important that trainees are allowed to attend these events, even if they do not fall on a Tuesday or Wednesday. The timetable indicates when this may occur and is available from the start of the course.

Until the course has finished the service should not arrange any events, training or commitments for the trainee on any of the dates where university study, teaching or assessment is timetabled.

Communication
Should any fitness to practice type issues arise during the training year, it is important that clear and prompt communication between the parties listed below is started. This is a joint responsibility and should be handled in a timely manner. This communication enables trainees to respond appropriately to documented concerns.

Manager Declaration

As the trainee's Manager, I have read the above and accept them as a basis for this student's full involvement with the Course requirements.

Manager signature: ……..

Manager name: ……..

Date:

Service Supervisor Declaration

As the trainee's on-site Supervisor, I have read the above and accept them as a basis for this student's full involvement with the Course requirements.

Supervisor signature: …….

Supervisor name: …….

Date:

Trainee Declaration

As the trainee, I have read the above and accept them as a basis for this student's full involvement with the Course requirements.

Trainee signature: ……..

Trainee name: ……..

Date:

Course Group Supervisor declaration

As the course representative, I have read the above and accept them as a basis for this trainee's full involvement with the Course requirements.

Supervisor signature: …….

Supervisor name: …….

Date:

Appendix 3: Supervisors' Signing Off Form for Case Work

This form must be submitted along with every paper submission.

Supervisor: To ensure that the HIPI trainee has completed the following work, we would be grateful if you could please sign to confirm that the Case-based Literature Review/Formulation Case Study/Anxiety Case Study/Depression Case Study was performed by the trainee.

Please note that no written assessment can be submitted without this confirmation and the form must be submitted to the IAPT administrator by the assessment deadline.

Part 1: To be completed by the trainee prior to submission:

Name:
Title of Assessment and Module:
Name of Supervisor:
Placement location:

Part 2 To be completed by the supervisor:

I confirm that the work described in this submission is a good reflection of the work completed by the trainee.

Signed: ..... Date:

If you feel unable to sign this form for any reason please contact the Programme Director.

Appendix 4: Trainee Progress Review Form: Interim evidence from service supervisor

To be completed on PebblePad.

Name of trainee:	Date:	
Name of supervisor:	Date:	
Clinical practice outcomes (minimum achievement)	**Achieved? Yes/No**	**Supervisor's signature**
100 hours clinical contact		
4 patients for at least 5 sessions each, evidences by 4 patient summaries		
4 assessment reports		
4 formulations		
4 treatment plans		
Two end of treatment reports (if available)		
Log of 40 hours clinical supervision		
Two CTS-R self-rated sessions and reflections		
One CTS-R supervisor-rated session and reflection		

Appendix 5: Interim Progress Review

To be completed on PebblePad

Please note

This review is based on the map of CBT competences for depression and anxiety disorders DH (2007). The review should be completed midway through training, and it is expected that the report will be written by the supervisor, although the HIPI trainee may be asked to provide relevant examples. It is anticipated that thorough comments would be provided which would encapsulate the supervisor's thoughts about the student's competence and professionalism.

The interim review should be completed based on the trainee's stage of training. Therefore, it is acceptable to insert NA (not applicable) where necessary, for the interim report.

	Service Supervisor comments	University Group Supervisor comments
1. Generic therapeutic competences		
Knowledge Awareness of mental health problems, BABCP and ethical guidelines and the CBT model of therapy being employed.		
Building and maintaining therapeutic alliances Engagement with client, building and maintaining a trusting therapeutic relationship and effectively disengaging with the client. Rupture-repair skills.		
Assessment skills Ability to make a generic assessment to include an overview of client history, needs, resources and motivation. Ability to produce distress ratings, problem statements and SMART goals. Appraising of risk to client or to others.		
Supervision		

Able to make use of supervision to maintain and demonstrate reflective practice and is able to accept and utilise constructive criticism. Able to perform effectively in supervision according to the contract agreed.		
2. Basic cognitive and behavioural therapy competences		
Knowledge Sound awareness of basic principles of CBT and BT; awareness of the cognitive biases relevant to common mental health problems, the role of safety behaviours and other aspects of behavioural avoidance for each common mental health problem		
Explaining the rationale for CBT Ability to explain and demonstrate rationale for CBT to client and ability to successfully socialise the patient to the model. Use of psychoeducation appropriately at step 3.		
Structuring sessions Sharing responsibility for session structure and content through: Adhering to an agreed agenda Planning and reviewing practice assignments (homework) Using summaries and feedback to structure the session		
Using measures and self-report records		

Ability to use IAPT MDS, disorder specific measures and self-monitoring to guide therapy and to monitor outcome		
Developing hypotheses about a maintenance cycle Ability to devise cross-sectional maintenance cycle and use this to set targets in the screening and assessment of the client.		
Problem solving Ability to help clients to develop, appraise and implement problem solving to a specific difficulty and/or learn a procedure to be applied to across difficulties		
Ending therapy Ability to plan for the end therapy in an effective and empathic manner and to plan for long-term maintenance of gains after treatment		
3. Specific cognitive and behavioural therapy techniques		
Behavioural techniques Ability to implement exposure to facilitate habituation, planning of behaviours, simple activity monitoring/scheduling and TRAP and TRAC in BA.		
Guided discovery and Socratic questioning Ability to use these skills to facilitate exploration of the client's thoughts, images, beliefs and feelings.		

Specific cognitive techniques Using thought records. Ability to detect, examine and help client reality test automatic thoughts/images. Ability to elicit key cognitions/images. Ability to identify and help client modify assumptions, attitudes and rules. Ability to identify and help client modify core beliefs. Ability to plan and conduct behavioural experiments to test out beliefs.		
Understanding the way the client sees the world, reaching a formulation and developing a treatment plan Ability to develop formulation based on the CBT competency framework and use this to develop treatment plan that matches the published treatment protocol. Ability to produce a formulation that maps and understands client's inner world and response to therapy.		
Understanding and conceptualising co-morbidity using CBT Ability to recognise and appropriately deal with co-morbidity in assessment and then phase treatment in order to treat co-morbidity.		
4. Problem specific competencies		

Specific phobias		
Health anxiety		
Social phobia		
Panic disorder (with or without agoraphobia)		
OCD		
GAD		
PTSD		
Depression – using a cognitive therapy approach		
Depression – using a behavioural activation approach		
Metacompetences: generic		
Capacity to: 1. Use clinical judgement when implementing treatment models		
2. Adapt interventions in response to client feedback		
3. Use and respond to humour displaying sensitivity and interpersonal effectiveness		
CBT specific metacompetences		
Capacity to: 1. Implement CBT in a manner consonant with the underlying philosophy of the model		
2. Formulate and to apply CBT models to the individual client		
3. Follow the CBT treatment protocol in a client centred manner		
4. Structure sessions and maintain appropriate pacing in CBT sessions		
5. Manage obstacles to CBT including aspects of client resistance.		
Trainee's own comments:		

3 targets identified by the supervisor for ongoing development: 1. 2. 3.

Service supervisor's signature:	
University group supervisor's signature:	
Supervisee's signature:	
Date:	

Appendix 6: Supervisor's Mid-Year Statement of Achievement

To be completed on PebblePad

CBT competency assessment

		Clinical supervisor's signature	**Date**
SUCCESSFUL	The HIPI trainee has demonstrated evidence of achievement of the clinical competencies detailed		
UNSUCCESSFUL	The HIPI trainee has NOT* demonstrated evidence of achievement of the clinical competences detailed.		
* Where this is the case the service clinical supervisor should, after consultation with the Programme Director, include a short report justifying this decision in the space provided below and propose actions that need to be taken by the trainee to remedy the situation.			

Please state the reasons why the trainee has been unsuccessful in achieving the clinical competencies expected of CBT practitioners. Clinical Supervisor's signature: Date:

Appendix 7: Trainee Progress Review Form:
Final evidence from service supervisor

To be completed on PebblePad

Name of trainee:		Date:
Name of supervisor:		Date:
Clinical practice outcomes (minimum achievement)	**Achieved? Yes/No**	**Supervisor's signature**
200 hours clinical contact		
8 patients for at least 5 sessions each		
8 assessment reports		
8 formulations		
8 treatment plans		
8 end of treatment reports		
Total 70 hours clinical supervision (5 hours minimum per case), clearly recorded and logged		
4 self-rated assessment sessions and reflections		
2 supervisor-rated assessment sessions and reflections		
2 case summaries		
8 patient summary sheets		

Appendix 8: Final Progress Review

To be completed on PebblePad

Please note

This review is based on the map of CBT competences for depression and anxiety disorders DH (2007). The review should be completed at the end of the training year, and it is expected that the report will be written by the supervisor, although the HIPI trainee may be asked to provide relevant examples. It is anticipated that thorough comments would be provided which would encapsulate the supervisor's thoughts about the student's competence and professionalism.

	Service Supervisor comments	University Group Supervisor comments
1. Generic therapeutic competences		
Knowledge Awareness of mental health problems, BABCP and ethical guidelines and the CBT model of therapy being employed.		
Building and maintaining therapeutic alliances Engagement with client, building and maintaining a trusting therapeutic relationship and effectively disengaging with the client. Rupture-repair skills.		
Assessment skills Ability to make a generic assessment to include an overview of client history, needs, resources and motivation. Ability to produce distress ratings, problem statements and SMART goals. Appraising of risk to client or to others.		
Supervision Able to make use of supervision to maintain and demonstrate reflective practice and is able to accept and utilise constructive criticism. Able to perform		

effectively in supervision according to the contract agreed.		
2. Basic cognitive and behavioural therapy competences		
Knowledge Sound awareness of basic principles of CBT and BT; awareness of the cognitive biases relevant to common mental health problems, the role of safety behaviours and other aspects of behavioural avoidance for each common mental health problem		
Explaining the rationale for CBT Ability to explain and demonstrate rationale for CBT to client and ability to successfully socialise the patient to the model. Use of psychoeducation appropriately at step 3.		
Structuring sessions Sharing responsibility for session structure and content through: Adhering to an agreed agenda Planning and reviewing practice assignments (homework) Using summaries and feedback to structure the session		
Using measures and self-report records Ability to use IAPT MDS, disorder specific measures and self-monitoring to guide		

therapy and to monitor outcome		
Developing hypotheses about a maintenance cycle Ability to devise cross-sectional maintenance cycle and use this to set targets in the screening and assessment of the client.		
Problem solving Ability to help clients to develop, appraise and implement problem solving to a specific difficulty and/or learn a procedure to be applied to across difficulties		
Ending therapy Ability to plan for the end therapy in an effective and empathic manner and to plan for long-term maintenance of gains after treatment		
3. Specific cognitive and behavioural therapy techniques		
Behavioural techniques Ability to implement exposure to facilitate habituation, planning of behaviours, simple activity monitoring/scheduling and TRAP and TRAC in BA.		
Guided discovery and Socratic questioning Ability to use these skills to facilitate exploration of the client's thoughts, images, beliefs and feelings.		
Specific cognitive techniques Using thought records. Ability to detect, examine and help client		

reality test automatic thoughts/images. Ability to elicit key cognitions/images. Ability to identify and help client modify assumptions, attitudes and rules. Ability to identify and help client modify core beliefs. Ability to plan and conduct behavioural experiments to test out beliefs.		
Understanding the way the client sees the world, reaching a formulation and developing a treatment plan Ability to develop formulation based on the CBT competency framework and use this to develop treatment plan that matches the published treatment protocol. Ability to produce a formulation that maps and understands client's inner world and response to therapy.		
Understanding and conceptualising co-morbidity using CBT Ability to recognise and appropriately deal with co-morbidity in assessment and then phase treatment in order to treat co-morbidity.		
4. Problem specific competencies		
Specific phobias		
Health anxiety		
Social phobia		
Panic disorder (with or without agoraphobia)		

OCD		
GAD		
PTSD		
Depression – using a cognitive therapy approach		
Depression – using a behavioural activation approach		
Metacompetences: generic		
Capacity to: 1. Use clinical judgement when implementing treatment models		
2. Adapt interventions in response to client feedback		
3. Use and respond to humour displaying sensitivity and interpersonal effectiveness		
CBT specific metacompetences		
Capacity to: 1. Implement CBT in a manner consonant with the underlying philosophy of the model		
2. Formulate and to apply CBT models to the individual client		
3. Follow the CBT treatment protocol in a client centred manner		
4. Structure sessions and maintain appropriate pacing in CBT sessions		
5. Manage obstacles to CBT including aspects of client resistance.		
Trainee's own comments:		

Service supervisor's signature:	
University group supervisor's signature:	
Supervisee's signature:	
Date:	

Appendix 9: Supervisor's Final Statement of Achievement

To be completed on PebblePad

CBT clinical competences

		Practice area clinical supervisor's signature	**Date**
SUCCESSFUL	The HIPI trainee has demonstrated evidence of achievement of the clinical competencies detailed in this review.		
UNSUCCESSFUL	The HIPI trainee has NOT* demonstrated evidence of achievement of the clinical competences detailed in this review.		
* Where this is the case the service clinical supervisor should, after consultation with the Programme Director, include a short report justifying this decision in the space provided below.			

Please state the reasons why the trainee has been unsuccessful in achieving the clinical competencies expected of CBT practitioners. Practice Area Clinical Supervisor's signature: Date:

Appendix 10: Cognitive Therapy Scale-Revised Feedback Form

To be completed on PebblePad

Name of trainee:……
Date:……..

CTS-R Items	Score	Comments
1. Agenda setting and adherence Did the therapist set a good agenda and adhere to it?		
2. Feedback Were there statements and/or actions concerned with providing and eliciting feedback?		
3. Collaboration Were there statements and/or actions encouraging the patient to participate appropriately, and preventing an unequal power relationship developing?		
4.Pacing and efficient use of time Were there statements and/or actions concerning the pacing of the session, helping to ensure the time was used effectively?		
5. Interpersonal Effectiveness Was a good therapeutic relationship evident (trust, warmth, etc.)?		
6. Eliciting appropriate emotional expression Were there questions and/or actions designed to elicit		

relevant emotions and promote a good emotional ambience?		
7. Eliciting key cognitions Were there questions and/or actions designed to elicit relevant cognitions (thoughts, beliefs, etc.)		
8. Eliciting and planning behaviours Were there questions and/or actions designed to elicit dysfunctional behaviours and engage the patient in planning for change?		
9. Guided discovery Were there questions and/or actions designed to promote self-reflection, helping the patient to make his/her own connections and discoveries?		
10. Conceptual integration Were there statements and/or actions designed to promote the patient's understanding of the models underpinning CT?		
11. Application of change methods Did the therapist facilitate in-session learning and change through a change method (cognitive and behavioural)?		
12. Homework setting Did the therapist set an appropriate homework effectively?		
Total Score		
Trainee Learning and Action Points		

Trainee signature:
Supervisor/Assessor signature:

Appendix 11: Cognitive Therapy Scale – Revised (OSCE)

This scale is a modified version of the Newcastle Cognitive Therapy Scale – Revised (Blackburn et al 2001) and is suitable for screening OSCEs and screening sessions conducted in clinical services.

Items

1. Session orientation and structure
2. Feedback
3. Collaborative language and behaviour
4. Pacing and efficient use of time
5. Interpersonal effectiveness
6. Use of CBT assessment model
7. Questioning skills
8. Risk assessment
9. Conceptual integration
10. Session closure

As a general rule, scoring should be used as follows, but please note the key features for each item:

Competence level	Score	Description
Incompetent	0	Absence of feature, or highly inappropriate performance
Incompetent / Novice	1	Inappropriate performance, with major problems evident
Novice / Advanced beginner	2	Evidence of competence, but numerous problems and lack of consistency
Advanced beginner / Competent	3	Competent, but some problems and/or inconsistencies
Competent / Proficient	4	Good features, but minor problems and/or inconsistencies
Proficient / Expert	5	Very good features, minimal problems and/or inconsistencies
Expert	6	Excellent performance, even in the face of patient difficulties

Item 1: Session orientation and structure

Key features:
This needs to include mention of the main aim of the session (assessing the suitability of CBT for the patient's problems), confidentiality (including its limits), and consent for any recording. The patient's preferred name should be established, and the therapist's name and role should be mentioned, as should the duration of the session. The format of the session should be outlined in brief (asking questions about the main problem, feeding back the therapist's understanding, and agreeing on what might be maintaining the problem) and this format should be adhered to.

Competence level	Score	Description
Incompetent	0	No introduction to the session, highly inappropriate introduction, or format not adhered to at all.
Incompetent / Novice	1	Inappropriate introduction to the session or inappropriate format set (e.g. lack of focus, unrealistic).
Novice / Advanced beginner	2	An attempt at an introduction to the session made, but major difficulties evident (e.g. suitability not mentioned). Poor adherence to format.
Advanced beginner / Competent	3	Appropriate introduction to the session, which was carried out well, but some omissions evident. Some adherence to the format.
Competent / Proficient	4	Appropriate introduction and format, minor difficulties evident (e.g. no mention of duration), but appropriate features covered (e.g. confidentiality). Moderate adherence.
Proficient / Expert	5	Appropriate introduction and format with all relevant aspects covered. Format adhered to. Minimal problems.
Expert	6	Excellent introduction and format, with everything covered very well, even in the face of difficulties.

Item 2: Feedback

Key features:
The patient's and therapist's understanding of key issues should be helped through the use of ***two-way*** feedback. The two major forms of feeding back information are through general summary and chunking of important units of information. The use of appropriate feedback helps the therapist to understand the patient's situation, and the patient to stay focused.

Features to be considered:
1. Frequency of feedback
2. Appropriateness of the contents of the feedback
3. Manner of its delivery and elicitation

Competence level	Score	Description
Incompetent	0	Absence of feedback or highly inappropriate feedback.
Incompetent / Novice	1	Minimal appropriate feedback.
Novice / Advanced beginner	2	Appropriate feedback, but not given frequently enough by therapist, with insufficient attempts to elicit and give feedback, e.g. feedback too vague to provide opportunities for understanding.
Advanced beginner / Competent	3	Appropriate feedback given and elicited frequently, although some difficulties evident in terms of content or method of delivery.
Competent / Proficient	4	Appropriate feedback given and elicited frequently. Minor problems evident (e.g. inconsistent).
Proficient / Expert	5	Highly appropriate feedback given and elicited regularly, facilitating shared understanding. Minimal problems.
Expert	6	Excellent use of feedback, or highly effective feedback given and elicited regularly, even in the face of difficulties.

Item 3: Collaborative language and behaviour

Key features:
The therapist's stance should be collaborative throughout the session, rather than being either, on the one hand, controlling or, on the other, non-directive. Language involving words and phrases such as 'we', 'us', and 'working together', and behaviour such as offering choice, and sitting alongside the patient to share a diagrammatic formulation, are all examples of taking a collaborative stance.

Features to be considered:
1. Verbal skills
2. Non-verbal skills
3. Shared written materials

Competence level	Score	Description
Incompetent	0	Patient is actively prevented or discouraged from being collaborative.
Incompetent / Novice	1	The therapist is too controlling, dominating, or passive.
Novice / Advanced beginner	2	Some occasional attempt at collaboration, but didactic style or passivity of therapist encourages passivity or other problems in the therapeutic relationship.
Advanced beginner / Competent	3	Collaborative stance evident, but some problems (e.g. therapist is verbally collaborative, but insufficient attention paid to patient's responses).
Competent / Proficient	4	Collaborative stance is evident, but not consistent. Minor problems evident.
Proficient / Expert	5	Very good use of collaborative language and behaviour throughout most of the session, both verbally and non-verbally. Minimal problems.
Expert	6	Excellent use of collaborative language and behaviour to encourage patient involvement, even in the face of patient difficulties.

Item 4: Pacing and efficient use of time

Key features:
The session should be well 'time managed' in relation to the agenda, with the session flowing smoothly through discrete start, middle, and concluding phases. The work must be paced well in relation to the patient's needs, and while important issues need to be followed, unproductive digressions should be dealt with smoothly. The session should not go over time, without good reason.

Features to be considered;

1. The degree to which the session flows smoothly through the discrete phases.
2. The appropriateness of the pacing *throughout* the session.
3. The degree of fit to the learning speed of the patient.

Competence level	Score	Description
Incompetent	0	Poor time management leads either to an aimless or overly rigid session.
Incompetent / Novice	1	The session is too slow or too fast for the current needs and capacity of the patient.
Novice / Advanced beginner	2	Reasonable pacing, but digression or repetitions from therapist and/or patient lead to inefficient use of time, session runs over time.
Advanced beginner / Competent	3	Good pacing evident some of the time, but diffuse at times. Some problems evident.
Competent / Proficient	4	Balanced allocation of time with discrete start, middle and concluding phases evident. Minor problems evident.
Proficient / Expert	5	Good time management skills evident, session running smoothly. Therapist working effectively in controlling the flow within the session. Minimal problems.
Expert	6	Excellent time management, or highly effective management evident even in the face of difficulties.

Item 5: Interpersonal effectiveness

Key features:
The patient is put at ease by the therapist's verbal and non-verbal (e.g. listening skills) behaviour. The patient should feel that the core conditions (i.e. warmth,

genuineness, empathy and understanding) are present. However, it is important to keep professional boundaries. In situations where the therapist is extremely interpersonally effective s/he is creative, insightful and inspirational.

Features to be considered:

1. Empathy – the therapist is able to understand and enter the patient's feelings imaginatively and uses this understanding to promote the alliance.
2. Genuineness – the therapist has established a trusting working relationship.
3. Warmth – the patient seems to feel liked and accepted by the therapist.

Competence level	Score	Description
Incompetent	0	Therapist's manner and interventions make the patient disengage and become distrustful and/or hostile (absence of empathy, genuineness, warmth).
Incompetent / Novice	1	Difficulty in showing empathy, genuineness and warmth.
Novice / Advanced beginner	2	Therapist's style (e.g. intellectualisation) at times impedes her/his empathic understanding of the patient's communications.
Advanced beginner / Competent	3	The therapist is able to understand explicit meanings of patient's communications, resulting in some trust developing. Some evidence of inconsistencies in sustaining relationship.
Competent / Proficient	4	The therapist is able to understand the implicit, as well as the explicit meanings of the patient's communications and demonstrates it in her/his manner. Minor problems evident (e.g. inconsistent).
Proficient / Expert	5	The therapist demonstrates very good interpersonal effectiveness. Patient appears confident that s/he is being understood, which facilitates self-disclosure. Minimal problems.
Expert	6	Highly interpersonally effective, even in the face of difficulties.

Item 6: Use of CBT assessment model

Key features:
The therapist should use a CBT model as the basis for the way in which s/he gathers information about the patient's problem(s). This includes a focus on key cognitions and key behaviours that may be maintaining the problem, as well as emotions and bodily symptoms. In addition, attention should be paid to triggers that tend to set off the problem, and both short- and long-term consequences of attempts to cope.

Features to be considered:

1. Attention paid to 'key' cognitions that seem particularly relevant in precipitating or perpetuating the problem.
2. Congruence between 'key' cognitions and the most problematic emotions.
3. Attention paid to 'key' behaviours that are making the problem worse in the longer term.

Competence level	Score	Description
Incompetent	0	Therapist fails to elicit relevant emotions, cognitions or behaviours.
Incompetent / Novice	1	Inappropriate emotions, cognitions and behaviours focused on, or key ones ignored.
Novice / Advanced beginner	2	Some emotions, cognitions and behaviours elicited, but links between them are not made clear to patient.
Advanced beginner / Competent	3	Some emotions, cognitions and behaviours elicited in a competent way, although some problems evident.
Competent / Proficient	4	A number of emotions, cognitions and behaviours elicited, leading to some understanding of their relationship to each other. Minor problems evident.
Proficient / Expert	5	Effective eliciting and selection of a number of emotions, cognitions and behaviours, including how they relate to one another. Minimal problems.
Expert	6	Excellent eliciting of key emotions, cognitions and behaviours, even in the face of difficulties.

Item 7: Questioning skills

Key features:
The therapist should ask predominantly open questions that follow on sequentially from one another. These should be phrased as simply as possible, so that they are easily understood. Multiple, closed and leading questions should be avoided. Questions asked should all be relevant to ascertaining the nature of the main problem or assessing level of risk. They should be sufficient to allow a basic understanding of the patient's difficulties. To avoid the questioning feeling like interrogation, summaries should be used regularly.

Features to be considered:

1. The extent to which most of the questions are open in nature and relevant to the assessment.
2. How much questions follow on logically from one another and from the patient's responses.
3. Use of summaries to provide breaks in continuous questioning.

Competence level	Score	Description
Incompetent	0	No questions asked, or only inappropriate questions asked.
Incompetent / Novice	1	Very few questions asked, most of which are irrelevant to an initial assessment.
Novice / Advanced beginner	2	Some relevant questions asked, but many are closed and leading. Patient's initial answers are not explored further.
Advanced beginner / Competent	3	Some good open questions asked, but too many closed questions. Insufficient summarising means the questioning sounds like an interrogation.
Competent / Proficient	4	Good use of questioning, with more open than closed questions, and occasional summaries. Minor problems evident (e.g. some multiple questions).
Proficient / Expert	5	Very good use of mostly open questions, with regular summaries. Minimal problems.
Expert	6	Excellent use of sequential relevant open questions and summaries, even in the face of patient difficulties

Item 8: Risk assessment

Key features:
The therapist should ascertain the level of risk posed by the patient's current difficulties. Central to this is an assessment of mental state, particularly in terms of depressed mood. Suicide risk should always be checked. It is often important to ask about possible risk to others, either through violence or neglect, especially where children or older people are involved. Further exploration of risk factors will depend on the patient's responses; this is one example of when a session may not finish on time, if there are important risk issues that need to be assessed in greater detail. Substance usage should also be assessed routinely, including use of alcohol, prescribed medication, and illegal drugs.

Features to be considered:
1. Assessment of the risk of self-harm.
2. Assessment of the extent to which the patient is a danger to others.
3. Substance usage risk factors.

Competence level	Score	Description
Incompetent	0	No assessment undertaken of any risk factors.
Incompetent / Novice	1	Some attempt made at risk assessment, but with major omissions, e.g. inadequate assessment of suicide risk.
Novice / Advanced beginner	2	Some areas of risk assessed well, but others neglected or inadequately assessed.
Advanced beginner / Competent	3	Competent risk assessment carried out, but more detail needed, e.g. quantity of alcohol drunk each week.
Competent / Proficient	4	Good assessment of all risks. Minor problems, such as omitting dosage of medication.
Proficient / Expert	5	Very good assessment of all risks, integrated well into the session. Minimal problems.
Expert	6	Excellent assessment of all possible risks, even in the face of patient difficulties

Item 9: Conceptual integration

Key features:
The patient should be helped to gain a rudimentary understanding of some of the maintaining factors of his/her problem. The therapist should do this through use of a diagrammatic initial formulation that includes at least one 'vicious cycle' and that is shared with the patient.

Features to be considered:
1. Whether a diagram is used to illustrate the conceptualisation
2. The extent to which maintaining cycles are consistent with CBT theory.

Competence level	Score	Description
Incompetent	0	No attempt made to summarise or conceptualise the patient's problem.
Incompetent / Novice	1	Some conceptualisation evident, but no attempt made to draw a diagram, or links between symptoms are inconsistent with CBT theory.
Novice / Advanced beginner	2	Conceptualisation evident, but no clear sense of a 'vicious cycle' (e.g. only the 'hot-cross bun' model is used).
Advanced beginner / Competent	3	One maintenance cycle clearly elicited and shared with the patient, although other maintaining factors are ignored.
Competent / Proficient	4	Good conceptualisation of maintaining factors. Minor problems evident, such as double-headed arrows.
Proficient / Expert	5	Very good conceptualisation of a number of maintenance cycles. Minimal problems.
Expert	6	Excellent conceptualisation of maintaining factors, even in the face of difficulties.

Item 10: Session closure

Key features:
The therapist should bring the session to a close by summarising the patient's main problem, making a clear statement regarding suitability of the CBT approach, inviting questions from the patient, and asking for feedback on how the patient has found the session.

Features to be considered:
1. Whether the main problem is succinctly summarised.
2. Whether a statement is made regarding suitability of CBT.
3. The extent to which patient feedback is sought and questions are invited.

Competence level	Score	Description
Incompetent	0	The session finishes without the therapist covering any of the key areas.
Incompetent / Novice	1	Inappropriate closure to the session, abrupt ending.
Novice / Advanced beginner	2	Some evidence of session closure, but many difficulties (e.g. no mention of suitability or no summary of the problem).
Advanced beginner / Competent	3	Competent session closure, but some problems evident (e.g. no questions invited).
Competent / Proficient	4	Good session closure, covering all the main points. Minor problems.
Proficient / Expert	5	Very good session closure. Minimal problems.
Expert	6	Excellent session closure, even in the face of difficulties.

Modified CTS-R: Screening for CBT OSCE Scoresheet

Name of trainee: **Name of marker:**

Item	Score	Comments
1. Session orientation and structure		
2. Feedback		
3. Collaborative language and behaviour		
4. Pacing and efficient use of time		
5. Interpersonal effectiveness		

6. Use of CBT assessment model		
7. Questioning skills		
8. Risk assessment		
9. Conceptual integration		
10. Session closure		
Overall comments:		
Overall mark: Pass Fail		

Appendix 12: Cognitive Therapy Scale – Revised (CTS-R)

Originators: I.-M. Blackburn, I.A. James, D.L. Milne & F.K. Reichelt
Collaborators: Garland, C. Baker, S.H. Standart & A. Claydon
Newcastle upon Tyne, UK 2001Dec

Name:	Scorer:	Date:	Session:
_____	_____	_____	_____

COGNITIVE THERAPY SCALE – REVISED (CTS-R)

The rating of the scale

The present seven point scale (i.e. a 0-6 Likert scale) extends from (0) where the therapist did not adhere to that aspect of therapy (non-adherence) to (6) where there is adherence and very high skill. Thus the scale assesses both adherence to therapy method and skill of the therapist. To aid with the rating of items of the scale, an outline of the key features of each item is provided at the top of each section. A description of the various rating criteria is given in the right hand margin – see example below in Figure 1. Further details are provided in the accompanying manual.

The examples are intended to be used as useful guidelines only. They are not meant to be used as prescriptive scoring criteria, rather providing both illustrative anchor points and guides.

Adjusting the scale in the presence of patient difficulties

The scale's dimensions were devised for patients assessed as being well/moderately suited for cognitive therapy (Safran & Segal, 1990). As such, adjustments may need to be made when patient difficulties are evident (e.g. excessive avoidance). Indeed, with problematic patients it is sometimes difficult to apply CT methods successfully; that is, with desirable change. In such circumstances the rater needs to assess the therapist's therapeutic skills in the application of the methods. Thus even though the therapist may be unsuccessful at promoting change, credit should be given for demonstrations of appropriate skilful therapy.

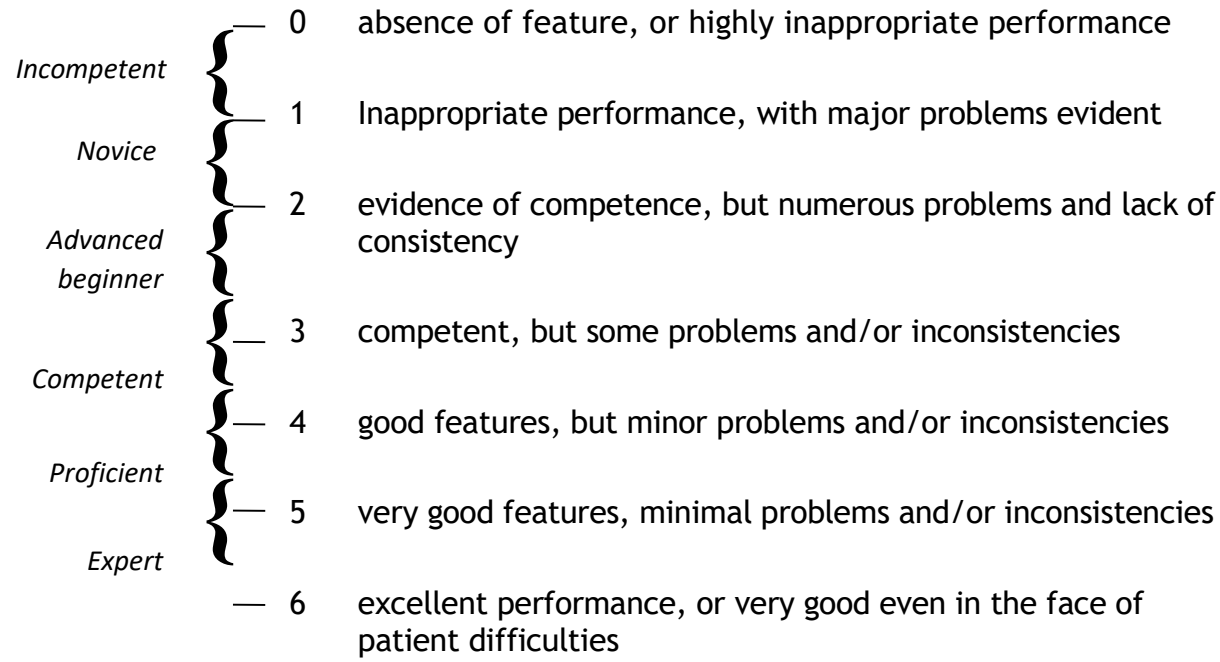
Safran, J.D. & Segal, Z.V. (1990) *Interpersonal processes in cognitive therapy*. New York, Basic Books.

Figure 1: Example of the scoring layout

Key features: this is an operationalised description of the item (see examples within the CTS-R).

Mark with an 'X' on the vertical line, using whole and half numbers, the level to which you think the therapist has fulfilled the core function. The descriptive features on the right are designed to guide your decision.

N.B. When rating, take into consideration the appropriateness of therapeutic interventions for stage of therapy and perceived patient difficulty.



* The present scale has incorporated the Dreyfus system (Dreyfus, 1989) for denoting competence, which is described fully in the manual. Please note that the top marks (i.e. near the 'expert' end of the continuum) are reserved for those therapists demonstrating highly effective skills, particularly in the face of difficulties (i.e. highly aggressive or avoidant patients; high levels of emotional discharge from the patients; and various situational factors).

The 'Key Features' describe the important features that need to be considered when scoring each item. When rating the item, you must first identify whether some of the features are present. You must then consider whether the therapist should be regarded as competent with the features. If the therapist includes most of the key features and uses them appropriately (i.e. misses few relevant opportunities to use them), the therapist should be rated very highly.

The 'Examples' are only guidelines and should not be regarded as absolute rating criteria.

Scoring Distribution

It is important to remember that the scoring profile for this scale should approximate to a normal distribution (i.e. mid-point 3), with relatively few therapists scoring at the extremes.

Dreyfus, H. L. (1989). The Dreyfus model of skill acquisition. *In* J. Burke (ed.) *Competency based education and training*. London: Falmer Press.

ITEM 1 - AGENDA SETTING & ADHERENCE

Key features: To address adequately topics that have been agreed and set in an appropriate way. This involves the setting of discrete and realistic targets collaboratively. The format for setting the agenda may vary according to the stage of therapy - see manual.

Three features need to be considered when scoring this item:

(i) presence/absence of an agenda which is explicit, agreed and prioritised, and feasible in the time available;
(ii) appropriateness of the contents of the agenda (to stage of therapy, current concerns etc.), a standing item being a review of the homework set previously;
(iii) appropriate adherence to the agenda.

Mark with an 'X' on the vertical line, the level to which you think the therapist has fulfilled the core function. The descriptive features on the right are designed to guide your decision.

NB: Agenda setting requires collaboration and credit for this should be given here, and here alone. Collaboration occurring at any other phase of the session should be scored under Item 3 (Collaboration).

Competence level	Examples NB: Score according to features, not examples!
0 ——	No agenda set, highly inappropriate agenda set, or agenda not adhered to.
1 ——	Inappropriate agenda set (e.g. lack of focus, unrealistic, no account of patient's presentation, homework not reviewed).
2 ——	An attempt at an agenda made, but major difficulties evident (e.g. unilaterally set). Poor adherence.
3 ——	Appropriate agenda, which was set well, but some difficulties evident (e.g. poor collaboration). Some adherence.
4 ——	Appropriate agenda, minor difficulties evident (e.g. no prioritisation), but appropriate features covered (e.g. review of homework). Moderate adherence.
5 ——	Appropriate agenda set with discrete and prioritised targets, reviewed at the end. Agenda adhered to. Minimal problems.
6 ——	Excellent agenda set, or highly effective agenda set in the face of difficulties.

ITEM 2 - FEEDBACK

Key features: The patient's and therapist's understanding of key issues should be helped through the use of two-way feedback. The two major forms of feeding back information are through general summary and chunking of important units of information. The use of appropriate feedback helps both the therapist to understand the patient's situation, and the patient to synthesise material enabling him/her to gain major insight and make therapeutic shifts. It also helps to keep the patient focused.

Three features need to be considered when scoring this item:

(i) presence and frequency, or absence, of feedback. Feedback should be given/elicited throughout the therapy - with major summaries both at the beginning (review of week) and end (session summary), while topic reviews (i.e. chunking) should occur throughout the session;
(ii) appropriateness of the contents of the feedback;
(iii) manner of its delivery and elicitation (NB: can be written).

Competence level	Examples NB: Score according to features, not examples!
0 —	Absence of feedback or highly inappropriate feedback.
1 —	Minimal appropriate feedback (verbal and/or written).
2 —	Appropriate feedback, but not given frequently enough by therapist, with insufficient attempts to elicit and give feedback (e.g. feedback too vague to provide opportunities for understanding and change).
3 —	Appropriate feedback given and elicited frequently, although some difficulties evident in terms of content or method of delivery.
4 —	Appropriate feedback given and elicited frequently, facilitating moderate therapeutic gains. Minor problems evident (eg. inconsistent).
5 —	Highly appropriate feedback given and elicited regularly, facilitating shared understanding and enabling significant therapeutic gains. Minimal problems.
6 —	Excellent use of feedback, or highly effective feedback given and elicited regularly in the face of difficulties.

ITEM 3 - COLLABORATION

Key features: The patient should be encouraged to be active in the session. There must be clear evidence of productive teamwork, with the therapist skilfully encouraging the patient to participate fully (e.g. through questioning techniques, shared problem solving and decision making) and take responsibility. However, the therapist must not allow the patient to ramble in an unstructured way.

Three features need to be considered: the therapist style should encourage effective teamwork through his/her use of:

(i) verbal skills (e.g. non-hectoring);
(ii) non-verbal skills (e.g. attention and use of joint activities);
(iii) sharing of written summaries.

NB: Questioning is a central feature with regard to this item, but questions designed to facilitate reflections and self discovery should be scored under Item 9 (Guided Discovery).

Competence level	Examples NB: Score according to features, not examples!
0 ——	Patient is actively prevented or discouraged from being collaborative.
1 ——	The therapist is too controlling, dominating, or passive.
2 ——	Some occasional attempt at collaboration, but didactic style or passivity of therapist encourages passivity or other problems in the therapeutic relationship.
3 ——	Teamwork evident, but some problems with collaborative set (e.g. not enough time allowed for the patient to reflect and participate actively).
4 ——	Effective teamwork is evident, but not consistent. Minor problems evident.
5 ——	Effective teamwork evident throughout most of the session, both in terms of verbal content and use of written summaries. Minimal problems.
6 ——	Excellent teamwork, or highly effective teamwork in the face of difficulties.

ITEM 4 - PACING AND EFFICIENT USE OF TIME

Key features: The session should be well 'time managed' in relation to the agenda, with the session flowing smoothly through discrete start, middle, and concluding phases. The work must be paced well in relation to the patient's needs, and while important issues need to be followed, unproductive digressions should be dealt with smoothly. The session should not go over time, without good reason.

Three features need to be considered:

(i) the degree to which the session flows smoothly through the discrete phases;
(ii) the appropriateness of the pacing throughout the session;
(iii) the degree of fit to the learning speed of the patient.

Competence level	Examples NB: Score according to features, not examples!
0 ——	Poor time management leads either to an aimless or overly rigid session.
1 ——	The session is too slow or too fast for the current needs and capacity of the patient.
2 ——	Reasonable pacing, but digression or repetitions from therapist and/or patient lead to inefficient use of time; unbalanced allocation of time, over time.
3 ——	Good pacing evident some of the time, but diffuse at times. Some problems evident.
4 ——	Balanced allocation of time with discrete start, middle and concluding phases evident. Minor problems evident.
5 ——	Good time management skills evident, session running smoothly. Therapist working effectively in controlling the flow within the session. Minimal problems.
6 ——	Excellent time management, or highly effective management evident in the face of difficulties.

ITEM 5 - INTERPERSONAL EFFECTIVENESS

Key features: The patient is put at ease by the therapist's verbal and non-verbal (e.g. listening skills) behaviour. The patient should feel that the core conditions (i.e. warmth, genuineness, empathy and understanding) are present. However, it is important to keep professional boundaries. In situations where the therapist is extremely interpersonally effective, he/she is creative, insightful and inspirational.

Three features need to be considered:

(i) empathy - the therapist is able to understand and enter the patient's feelings imaginatively and uses this understanding to promote change;
(ii) genuineness - the therapist has established a trusting working relationship;
(iii) warmth - the patient seems to feel liked and accepted by the therapist.

Competence level	Examples NB: Score according to features, not examples!
0 ——	Therapist's manner and interventions make the patient disengage and become distrustful and/or hostile (absence of/or excessive i, ii, iii).
1 ——	Difficulty in showing empathy, genuineness and warmth.
2 ——	Therapist's style (e.g. intellectualisation) at times impedes his/her empathic understanding of the patient's communications.
3 ——	The therapist is able to understand explicit meanings of patient's communications, resulting in some trust developing. Some evidence of inconsistencies in sustaining relationship.
4 ——	The therapist is able to understand the implicit, as well as the explicit meanings of the patient's communications and demonstrates it in his/her manner. Minor problems evident (e.g. inconsistent).
5 ——	The therapist demonstrates very good interpersonal effectiveness. Patient appears confident that he/she is being understood, which facilitates self-disclosure. Minimal problems.
6	Excellent interpersonal effectiveness, or highly interpersonally effective in the face of difficulties.

ITEM 6 – ELICITING OF APPROPRIATE EMOTIONAL EXPRESSION

Key features: The therapist facilitates the processing of appropriate levels of emotion by the patient. Emotional levels that are too high or too low are likely to interfere with therapy. The therapist must also be able to deal effectively with emotional issues which interfere with effective change (e.g. hostility, anxiety, excessive anger). Effective facilitation will enable the patient to access and express his/her emotions in a way that facilitates change.

Three features have to be considered:

(i) facilitation of access to a range of emotions;
(ii) appropriate use and containment of emotional expression;
(iii) facilitation of emotional expression, encouraging appropriate access and differentiation of emotions.

Competence level	Examples NB: Score according to features, not examples!
0 ——	Patient is under- or overstimulated (e.g. his/her feelings are ignored or dismissed or allowed to reach an unmanged pitch). Or the therapist's own mood or strategies (e.g. intellectualisation) adversely influences the session.
1 ——	Failure to facilitate access to, and expression of, appropriate emotional expression.
2 ——	Facilitation of appropriate emotional expression evident, but many relevant opportunities missed.
3 ——	Some effective facilitation of appropriate emotional expression, created and/or maintained. Patient enabled to become slightly more aware.
4 ——	Effective facilitation of appropriate emotional expression leading to the patient becoming more aware of relevant emotions. Minor problems evident.
5 ——	Very effective facilitation of emotional expression, optimally arousing the patient's motivation and awareness. Good expression of relevant emotions evident – done in an effective manner. Minimal problems.
6 ——	Excellent facilitation of appropriate emotional expression, or effective facilitation in the face of difficulties.

ITEM 7 – ELICITING KEY COGNITIONS

Key features: To help the patient gain access to his/her cognitions (thoughts, assumptions and beliefs) and to understand the relationship between these and their distressing emotions. This can be done through the use of questioning, diaries and monitoring procedures.

Three features need to be considered:

(i) eliciting cognitions that are associated with distressing emotions (i.e. selecting key cognitions or hot thoughts);
(ii) the skilfulness and breadth of the methods used (i.e. Socratic questioning; appropriate monitoring, downward arrowing, imagery, role-plays, etc.);
(iii) choosing the appropriate level of work for the stage of therapy (i.e. automatic thoughts, assumptions, or core beliefs).

NB: This item is concerned with the general work done with eliciting cognitions. If any specific cognitive or behavioural change methods are used, they should be scored under item 11 (change methods).

Competence level	Examples NB: Score according to features, not examples!
0 —	Therapist fails to elicit relevant cognitions.
1 —	Inappropriate cognitions and emotions selected, or key cognitions/emotions ignored.
2 —	Some cognitions/emotions (or one key cognition, e.g. core belief) elicited, but links between cognitions and emotions not made clear to patient.
3 —	Some cognitions/emotions (or one key cognition) elicited in a competent way, although some problems evident.
4 —	A number of cognitions and emotions (or one key cognition) elicited in verbal or written form, leading to a new understanding of their relationship. Minor problems evident.
5 —	Effective eliciting and selection of a number of cognitions/emotions (or one key cognition), which are generally dealt with appropriately. Minimal problems.
6 —	Excellent work done on key cognition(s) and emotion(s), or very good work done in the face of difficulties.

ITEM 8 – ELICITING BEHAVIOURS

Key features: To help the patient gain insight into the effect of his/her behaviours and planned behaviours with respect to the problems. This can be done through the use of questioning, diaries and monitoring procedures. This item helps ensure that the therapy is fully integrated with the patient's environment.

Two features need to be considered:

(i) eliciting behaviours that are associated with distressing emotions (including, use of safety seeking behaviours);
(ii) the skilfulness and breadth of the methods used (i.e. socratic questioning; appropriate monitoring, imagery, role-plays, etc.);

NB: This item is concerned with the general work done with eliciting behaviours. If any specific cognitive or behavioural change methods are used, they should be scored under item 11 (change methods).

Competence Level	Examples NB: Score according to features, not examples!
0 ——	Therapist fails to elicit relevant behaviours.
1 ——	Inappropriate behaviours focused on.
2 ——	Some behaviours elicited, but links between behaviours and emotions not made clear to patient.
3 ——	Some behaviours/emotions elicited in a competent way, although some problems evident.
4 ——	A number of behaviours/emotions elicited in verbal or written form, leading to a new understanding of their importance in maintaining problems. Minor difficulties evident.
5 ——	Effective eliciting and selection of a number of behaviours/emotions, which are generally dealt with appropriately. Minimal problems.
6 ——	Excellent work done on behaviours and emotions, or very good work done in the face of difficulties.

ITEM 9 - GUIDED DISCOVERY

Key features: The patient should be helped to develop hypotheses regarding his/her current situation and to generate potential solutions for him/herself. The patient is helped to develop a range of perspectives regarding his/her experience. Effective guided discovery will create doubt where previously there was certainty, thus providing the opportunity for re-evaluation and new learning to occur.

Two elements need to be considered:

(i) the style of the therapist - this should be open and inquisitive;
(ii) the effective use of questioning techniques (e.g. Socratic questions) should encourage the patient to discover useful information that can be used to help him/her to gain a better level of understanding.

Competence level	Examples NB: Score according to features, not examples!
0 —	No attempt at guided discovery (e.g. hectoring and lecturing).
1 —	Little opportunity for discovery by patient. Persuasion and debate used excessively.
2 —	Minimal opportunity for discovery. Some use of questioning, but unhelpful in assisting the patient to gain access to his/her thoughts or emotions or to make connections between themes.
3 —	Some reflection evident. Therapist uses primarily a questioning style which is following a productive line of discovery.
4 —	Moderate degree of discovery evident. Therapist uses a questioning style with skill, and this leads to some synthesis. Minor problems evident.
5 —	Effective reflection evident. Therapist uses skilful questioning style leading to reflection, discovery, and synthesis. Minimal problems.
6 —	Excellent guided discovery leading to a deep patient understanding. Highly effective discovery produced in the face of difficulties, with evidence of a deeper understanding having been developed.

ITEM 10 - CONCEPTUAL INTEGRATION

Key features: The patient should be helped to gain an appreciation of the history, triggers and maintaining features of his/her problem in order to bring about change in the present and future. The therapist should help the patient to gain an understanding of how his/her perceptions and interpretations, beliefs, attitudes and rules relate to his/her problem. A good conceptualisation will examine previous cognitions and coping strategies as well as current ones. This theory-based understanding should be well integrated and used to guide the therapy forward.

Two features need to be considered:

(i) the presence/absence of an appropriate conceptualisation which is in line with goals of therapy;

(ii) the manner in which the conceptualisation is used (e.g. used as the platform for interventions, homework etc.).

NB: This item is to do with therapeutic integration (using theory to link present, past and future). If the therapist deals specifically with cognitions and emotions, this should be scored under Items 6 (Facilitation of Emotional Expression) and 7 (Eliciting Key of Cognitions)

Competence level	Examples NB: Score according to features, not examples!
0 ——	The absence of an appropriate conceptualisation.
1 ——	The lack, or inappropriateness or misapplication of a conceptualisation leads to a neutral impact (e.g. interferes with progress or leads to aimless application of procedures).
2 ——	Some rudimentary conceptualisation arrived at, but not well integrated with goals of therapy. Does not lead to a clear rationale for interventions.
3 ——	Cognitive conceptualisation partially developed with some integration, but some difficulties evident (e.g. in synthesising and in sharing it with the patient). Leads to coherent interventions.
4 ——	Cognitive conceptualisation is moderately developed and integrated within the therapy. Minor problems evident.
5 ——	Cognitive conceptualisation is very well developed and integrated within the therapy – there is a credible cognitive understanding leading to major therapeutic shifts. Minimal problems.
6 ——	Excellent development and integration evident, or highly effective in the face of difficulties.

ITEM 11 - APPLICATION OF CHANGE METHODS

Key features: Therapist skilfully uses, and helps the patient to use, appropriate cognitive and behavioural techniques in line with the formulation. The therapist helps the patient devise appropriate cognitive methods to evaluate the key cognitions associated with distressing emotions, leading to major new perspectives and shifts in emotions. The therapist also helps the patient to both apply behavioural techniques in line with the formulation, and develop suitable plans to promote effective change. The therapist helps the patient to identify potential difficulties and think through the cognitive rationales for performing the tasks. The methods provide useful ways for the patient to test-out cognitions practically and gain experience in dealing with high levels of emotion. The methods also allow the therapist to obtain feedback regarding the patient's level of understanding of prospective practical assignments (i.e. by the patient performing the task in- session).

Three features need to be considered:

(i) the appropriateness and range of both cognitive methods (e.g. cognitive change diaries, continua, distancing, responsibility charts, evaluating alternatives, examining pros and cons, determining meanings, imagery restructuring, etc.) and behavioural methods (e.g. behavioural diaries, behavioural tests, role play, graded task assignments, response prevention, reinforcement of patient's work, modelling, applied relaxation, controlled breathing, etc.);
(ii) the skill in the application of the methods - however, skills such as feedback, interpersonal effectiveness, etc. should be rated separately under their appropriate items;
(iii) the suitability of the methods for the needs of the patient (i.e. neither too difficult nor complex).

NB: This item is not concerned with accessing or identifying thoughts, rather with their re-evaluation.

Competence Level	Examples NB: Score according to features, not examples!
0 ——	Therapist fails to use or misuses appropriate cognitive and behavioural methods.
1 ——	Therapist applies either insufficient or inappropriate methods, and/or with limited skill or flexibility.
2 ——	Therapist applies appropriate methods, but major difficulties evident.
3 ——	Therapist applies a number of methods in competent ways, although some problems evident (e.g. the interventions are incomplete).
4 ——	Therapist applies a range of methods with skill and flexibility, enabling the patient to develop new perspectives. Minor problems evident.
5 ——	Therapist systematically applies an appropriate range of methods in a creative, resourceful and effective manner. Minimal problems.

6 ___ Excellent range and application, or successful application in the face of difficulties.

ITEM 12 - HOMEWORK SETTING

Key features: This aspect concerns the setting of an appropriate homework task, one with clear and precise goals. The aims should be to negotiate an appropriate task for the stage of therapy in line with the conceptualisation; to ensure the patient understands the rationale for undertaking the task; to test out ideas, try new experiences, predict and deal with potential obstacles, and experiment with new ways of responding. This item ensures that the content of the therapy session is both relevant to, and integrated with, the patient's environment.

There are three aspects to this item:

(i) presence/absence of a homework task in which clear and precise goals have been set;
(ii) the task should be derived from material discussed in the session, such that there is a clear understanding of what will be learnt from performing the task;
(iii) the homework task should be set jointly, and sufficient time should be allowed for it to be explained clearly (i.e. explain, discuss relevance, predict obstacles, etc.).

NB: Review of homework from the previous session should be rated in Item 1 (Agenda Setting)

Competence Level	Examples NB: Score according to features, not examples!
0 ——	Therapist fails to set homework, or sets inappropriate homework.
1 ——	Therapist does not negotiate homework. Insufficient time allotted for adequate explanation, leading to ineffectual task being set.
2 ——	Therapist negotiates homework unilaterally and in a routine fashion, without explaining the rationale for new homework.
3 ——	Therapist has set an appropriate new homework task, but some problems evident (e.g. not explained sufficiently and/or not developed jointly).
4 ——	Appropriate new homework jointly negotiated with a clear goals and rationales. However, minor problems evident.
5 ——	Appropriate homework negotiated jointly and explained well, including an exploration of potential obstacles. Minimal problems.
6 ——	Excellent homework negotiated, or highly appropriate one set in the face of difficulties.

Appendix 12: Manual of the Revised Cognitive Therapy Scale (CTS-R)

Manual of the Revised Cognitive Therapy Scale (CTS-R)

Originators: I.A. James, I.-M. Blackburn
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Collaborators: A. Garland, P. Armstrong
Newcastle upon Tyne, UK 2001Dec

Introduction
This is a scale for measuring therapist competence in Cognitive Therapy and is based on the original Cognitive Therapy Scales (CTS, Young & Beck, 1980, 1988). The CTS-R was developed jointly by clinicians and researchers at the Newcastle Cognitive and Behavioural Therapies Centre and the University of Newcastle upon Tyne, UK.

The CTS-R contains 12 items, in contrast to earlier versions of the CTS which contained either 13 (Young & Beck, 1980) or 11 (Young & Beck, 1988). The development of the revised scale, together with the psychometric properties, is described in the appendices.

Table 1: The CTS-R Items

General items	Cognitive therapy specific items
Item 1: Agenda Setting & Adherence*	Item 1: Agenda Setting & Adherence*
Item 2: Feedback	Item 6: Eliciting Appropriate Emotional Expression **
Item 3: Collaboration	Item 7: Eliciting Key Cognitions
Item 4: Pacing and Efficient Use of Time	Item 8: Eliciting Behaviours**
Item 5: Interpersonal Effectiveness	Item 9: Guided Discovery
	Item 10: Conceptual Integration
	Item 11: Application of Change Methods
	Item 12: Homework Setting

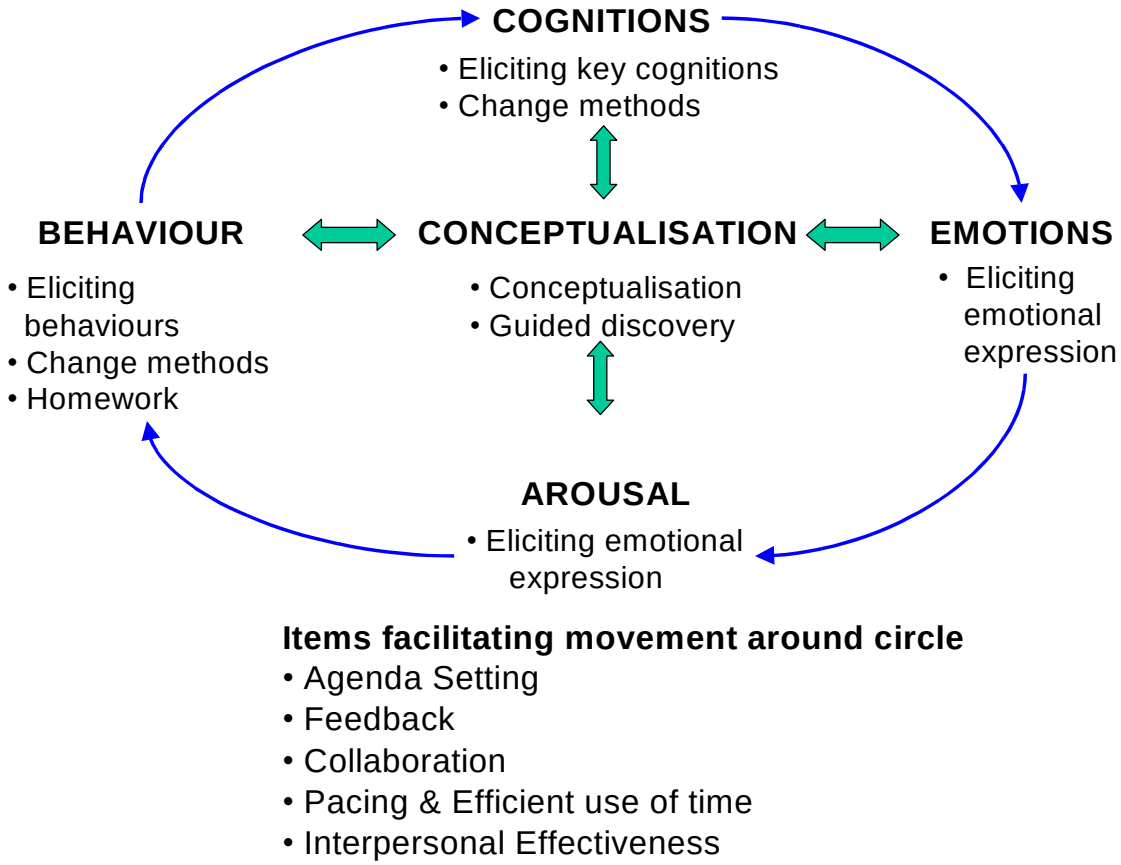
* Item 1 can be regarded as both a general and CT item.
** Items 6 and 8 are new items developed for the scale.

Theoretical Bases of the Scale
Two frameworks underpin the revised scale, the Cognitive Cycle and the Dreyfus Scale of Competence (Dreyfus, 1989).

The Cognitive Cycle: The cognitive cycle represented in Figure 1 demonstrates how the CTS-R items address specific cognitive features. At the heart of the scale, as in therapy, is the conceptualisation. In order to move the patient from a dysfunctional cycle, dominated by a dysfunctional conceptualisation, the therapist must address

the four features highlighted in the outer ring of the circle: thoughts, feelings, physiology and behaviour/planning. In terms of therapeutic competence, the therapist's must be skilled at encouraging the patient to move around the points of the cycle, using the Cognitive Specific items (Items 6-12) to address the features. To facilitate the smooth movement around the cycle, the therapist must also demonstrate competence in areas assessed by the remaining items 1-5 (agenda & adherence, feedback, collaboration, pacing, interpersonal effectiveness).

Figure 1: The relationship between the CTS-R items and the Cognitive Cycle*



* The cycle occurs within an **Environmental** context. Its relevance to the environment is explored mainly through Item 8 (Eliciting Behaviours) and Item 12 (Homework Setting).

Dreyfus Model of Competence: The Dreyfus Model has also been incorporated within the CTS-R. It is designed to assess the level of competence shown by the therapist (see Table 2). In the original Dreyfus scale there are five levels, to this we added a further level to denote 'incompetence', as outlined below.

Table 2: Adapted Dreyfus Level of Competence

Incompetent - The therapist commits errors and displays poor and unacceptable behaviour, leading to negative therapeutic consequences.

Novice - At this level the therapist displays a rigid adherence to taught rules and is unable to take account of situational factors. He/she is not yet showing any discretionary judgement.

Advanced Beginner - The therapist treats all aspects of the task separately and gives equal importance to them. There is evidence of situational perspective and discretionary judgement.

Competent - The therapist is able to see the tasks linked within a conceptual framework. He/she makes plans within this framework and uses standardised and routinised procedures.

Proficient - The therapist sees the patient's problems holistically, prioritises tasks and is able to make quick decisions. The therapist is clearly skilled and able.

Expert - The therapist no longer uses rules, guidelines or maxims. He/she has deep tacit understanding of the issues and is able to use novel problem-solving techniques. The skills are demonstrated even in the face of difficulties (e.g. excessive avoidance).

This model has been incorporated within the scoring system as demonstrated in the scoring layout below.

Scoring system

A detailed explanation of the scoring system is provided below. As you can see, each item is rated on a Likert scale, ranging from 0-6. Each level being defined in detail to conform to the levels of competence (see Table 2).

Example of the scoring layout:

Key features: this is an operationalised description of the item (see examples within the CTS-R).

Mark with an 'X' on the vertical line, using whole and half numbers, the level to which you think the therapist has fulfilled the key features. The descriptive features on the right are designed to guide your decision.

Competence level		**Examples**
Incompetent	0	Absence of feature, or highly inappropriate performance
Novice	1	Inappropriate performance, with major problems evident
Advanced beginner	2	Evidence of competence, but numerous problems and lack of consistency

	__ 3	Competent, but some problems and/or inconsistencies
Competent		
	— 4	Good features, but minor problems and/or inconsistencies
Proficient		
	— 5	very good features, minimal problems and/or inconsistencies
Expert		
	— 6	excellent performance, or very good even in the face of patient difficulties

Please note that the top marks (i.e. near the 'expert' end of the continuum) are reserved for those therapists demonstrating highly effective skills, particularly in the face of difficulties (i.e. highly aggressive or avoidant patients; high levels of emotional discharge from the patients; and various situational factors).

Maximum score on the scale is 72 (12 x 6). At the Newcastle Cognitive Therapy Centre we set a minimum competence standard of 36, which would be an average of 3 marks per item.

Item 1 - Agenda Setting and Adherence

Introduction

The agenda helps ensure that the most important issues are addressed in an efficient manner. Therapist and patient must establish these issues jointly. The agenda should review items from the previous session(s), in particular the homework assignment, and include one or two items for the session. Once set, it should be appropriately adhered to. However, if changes are necessary, because of an important new issue arising, the deviation from the agenda should be made explicit.

The key features of the 'agenda' is outlined in the CTS-R Rating Scale as follows:

Key features: To address adequately topics that have been agreed and set in an appropriate way. This involves the setting of discrete and realistic targets collaboratively. The format for setting the agenda may vary according to the stage of therapy - see manual.

Three features need to be considered when scoring this item:

(i) presence/absence of an agenda which is explicit, agreed and prioritised, and feasible in the time available;

(ii) appropriateness of the contents of the agenda (to stage of therapy, current concerns etc.), a standing item being a review of the homework set previously;

(iii) appropriate adherence to the agenda.

Mark with an 'X' on the vertical line, the level to which you think the therapist has fulfilled the key features. The descriptive features on the right are designed to guide your decision.

NB: Agenda setting requires collaboration and credit for this should be given here, and here alone. Collaboration occurring at any other phase of the session should be scored under Item 3 (Collaboration).

Short-term cognitive therapy requires that the important issues are discussed sensitively but managed in a business-like way. In order to cover a lot of material adequately in a relatively short space of time, specific and realistic targets need to be set in a collaborative manner, and adhered to appropriately. Indeed, it is of limited use to set a good agenda and then not be guided by it.

On setting the agenda the therapist must ensure the items are appropriate. They should be suitable for the stage of therapy, amenable to a CT rationale, consistent with the formulation, and conceived to take the therapy forward. In addition, the items should be clear and discrete. If the items are too vague, this may lead to confusion and also result in divergent and tangential material being discussed. It is important to note, however, that the therapist must be aware not to let the patient go into too much detail about any one item at this stage, as this will disrupt the

agenda setting process. The therapist must be careful not to include too many items, as this may lead to either important items being missed or the therapy being rushed.

The list of items should include material from both the patient and therapist. A discussion of the homework which was set previously should be a 'standing' item. Even when no homework was set in the previous session (for whatever reason), the value of such assignments should be discussed in order to restate the importance of this aspect of therapy. Unless this is done the patient may come to think that there is no need to complete the assignment carefully.

Part of socialising the patient to CT is to establish an expectation that he/she will need to come to each session having thought through the key topics for that day's therapeutic work.

Following the setting of the agenda, the patient should be asked to prioritise his/her list of items. The prioritisation permits the therapist to plan the session and allot appropriate time for the material. Efficient prioritising facilitates the pacing of the therapy.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Did the therapist set an agenda with clear, discrete, and realistic goals - and adhere to it?
2. Can you identify at least two specific agenda items?
3. Was the patient encouraged to participate in setting the agenda**?**
4. Do you think the patient clearly understood what the therapy was going to cover?
5. Did the agenda seem appropriate?
6. Were the items prioritised?
7. Was the session set sensitively?
8. Did you hear any of the following:
    - What would you like to get from today's session?
    - As usual at the beginning of the session, we need to set a plan.
    - What benefits do you think we get by setting the agenda?
    - Perhaps we need to put some time for X.
    - What is the most important thing to cover today? ... Are there any other things to include?
    - Is there anything that has been troubling you this week, which might help to illustrate your problems?
    - You have mentioned X, Y and Z. Which of these would you like to talk about first?
    - If we did discuss this item, how would it help take the therapy forward?
    - What would be most helpful to discuss today, keeping in mind the stage we're at in therapy?
    - By discussing X, how will this help us move forward?

Item 2 - Feedback

Introduction

The therapist should both provide and elicit feedback throughout each session. The therapist's feedback should occur at regular intervals and is particularly important at the end of the therapy session. This feedback helps to focus the patient on the main therapeutic issues, and assists in reducing vague or amorphous issues into manageable units. It also helps both the therapist and the patient to determine whether they have a shared understanding of the problems and concerns.

Eliciting feedback ensures that the patient understands the therapist's interventions, formulations and lines of reasoning. It also allows the individual to express positive and negative reactions regarding the therapy.

The key features of 'feedback' is outlined in the CTS-R Rating Scale as follows:

Key features: The patient's and therapist's understanding of key issues should be helped through the use of two-way feedback. The two major forms of feeding back information are through general summary and chunking of important units of information. The use of appropriate feedback helps both the therapist to understand the patient's situation, and the patient to synthesise material enabling him/her to gain major insight and make therapeutic shifts. It also helps to keep the patient focused.

Three features need to be considered when scoring this item:

(i) Presence and frequency, or absence, of feedback. Feedback should be given/elicited throughout the therapy – with major summaries both at the beginning (review of week) and end (session summary), while topic reviews (i.e. chunking) should occur throughout the session;
(ii) Appropriateness of the contents of the feedback;
(iii) Manner of its delivery and elicitation (NB: can be written).

This item stresses the importance of two-way feedback. By 'summarising' and 'chunking' information at regular intervals, the therapist can emphasise the major features, synthesise new material and highlight issues that require further clarification. By eliciting the patient's feedback (thoughts and feelings) regarding the therapy, the therapist can check the patient's attitude, knowledge base and understanding.

Chunking information and eliciting feedback should occur frequently. On occasions, when either particularly important or confusing material is being discussed, the feedback should occur after each major point; this can also help 'contain' distressing issues. During normal short-term CT, the two-way feedback should occur at least every 10 minutes.

Major summaries should occur at the beginning and end of each session, to help reinforce and consolidate therapeutic material.

It is important that the feedback be appropriate. For example, when providing feedback the therapist must choose the salient material presented to him her, and then summarise these features in a way that both clarifies and highlights key issues. This form of summarising and feeding back is the foundation for many forms of cognitive techniques (e.g. Socratic questioning). When eliciting feedback, the therapist should be aware that patients (especially people suffering from depression) often indicate understanding simply out of compliance. Hence, it is vital that the therapist explores the patient's understanding and attitude towards the therapy carefully.

The manner in which the feedback is elicited and delivered is also important. For example, the therapist should be sensitive to negative and covert reactions expressed both verbally and non-verbally by the patient, and should also ask for the patient's thoughts when such clues are noticed. Whenever appropriate the therapist should ask the patient either for suggestions about how to proceed, or to choose among alternative courses of action.

When giving feedback the therapist should deliver it in a manner that is constructive and helps to move the therapy forward. This will involve anticipation of how the information may be received (e.g. perceived as criticism).

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Do you think the feedback was appropriate? ... Sufficiently frequent?
2. Did the therapist chunk the salient pieces of information to provide a platform for new insight?
3. Was the patient encouraged to provide feedback throughout the session?
4. Do you think that the feedback was used effectively in helping the patient's understanding?
5. Did you hear any of the following:
    - Could you tell me the three most important issues we've discussed today?
    - Just to summarise, at the beginning of the session we spoke about X and the effect it had on your feelings. Then we discussed Y, etc. etc.
    - I think I have understood what you just said, let me see if I can repeat back the main points.
    - Could you tell me whether I've got that right?
    - Is there anything that I've said, that didn't make sense?
    - What was the most/lease helpful thing that we discussed today?

Item 3 - Collaboration

Introduction

Good therapeutic teamwork is a fundamental feature of cognitive therapy. Collaboration should be consistent throughout the session, although at times didactic approaches may be necessary (e.g. educating the patient about the physical effects of anxiety).

The key features of 'collaboration' is outlined in the CTS-R Rating Scale as follows:

Key features: The patient should be encouraged to be active in the session. There must be clear evidence of productive teamwork, with the therapist skilfully encouraging the patient to participate fully (e.g. through questioning techniques, shared problem solving and decision making) and take responsibility. However, the therapist must not allow the patient to ramble in an unstructured way. Three features need to be considered: the therapist style should encourage effective teamwork through his/her use of: (i) verbal skills (e.g. non-hectoring); (ii) non-verbal skills (e.g. attention and use of joint activities); (iii) sharing of written summaries. NB: Questioning is a central feature with regard to this item, but questions designed to facilitate reflections and self discovery should be scored under Item 9 (Guided Discovery).

As mentioned above, collaboration will be used during Agenda Setting (Item 1) and should be credited accordingly within this item. Hence, credit on this item should only be given for evidence of collaboration that occurs outwith Agenda Setting.

The therapist should adopt a style that promotes an egalitarian relationship, whereby he/she and the patient work actively towards shared goals. This is achieved by the development of a 'teamwork' approach. Hence the therapist should avoid being overly directive, too intellectual, controlling or passive.

The therapist needs to strike a balance between being structured on the one hand and on the other allowing the patient to make choices and take responsibility. In order to achieve a good therapeutic alliance, the therapist must assess the patient's needs, and particularly his/her preferred modes of learning. For example, Beck (1983) suggests that individuals who display sociotropic traits respond better to a warm supportive therapeutic relationships, while those with autonomous traits prefer to take a high level of responsibility within the therapy and respond better to a more task-oriented approach.

Good Collaboration will also involve striking a balance between the verbal and non-verbal features. For example, deciding when to talk and when to listen; when

to confront and when to back-off; when to offer suggestions and when to wait for the patient to devise his/her own.

Another important element of Collaboration is for the therapist to be open about the process and status of therapy. This will include the therapist explaining the rationale for interventions, admitting confusion; sharing summaries both verbally and in writing.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Was the patient encouraged to participate fully as a team member?
2. Was the therapist able to establish a collaborative relationship?
3. Did the therapist give the patient sufficient space and time to think?
4. Was the therapist overly directive or too controlling?
5. Did you hear any of the following:
    - How might we test that out?
    - Perhaps we could work out together an alternative way of looking at this issue.
    - Before setting this behavioural task, let's both examine the potential obstacles which might prevent us learning anything from it.
    - That's a difficult one, so let's put our heads together and try and think it through.
    - Could you help me make sense of this?
    - I'm sure that together we can work this one out.
    - Let's look at this together.
    - You're the expert with respect to your problem, so could you help me understand?
    - You've got your homework, so would you like me to do anything for next week?

Item 4 - Pacing and Efficient Use of Time

Introduction

The therapist should make optimal use of the time in accordance with items set in the agenda. He/she must maintain sufficient control, limit discussion of peripheral issues, interrupt unproductive discussion, and pace the session appropriately. Nevertheless, the therapist should avoid rushing crucial features of the session.

The key features of 'Pacing and efficient use of time' is outlined in the CTS-R Rating Scale as follows:

> Key features: The session should be well 'time managed' in relation to the agenda, with the session flowing smoothly through discrete start, middle, and concluding phases. The work must be paced well in relation to the patient's needs, and while important issues need to be followed, unproductive digressions should be dealt with smoothly. The session should not go over time, without good reason.
>
> Three features need to be considered:
>
> (i) The degree to which the session flows smoothly through the discrete phases;
> (ii) the appropriateness of the pacing throughout the session;
> (iii) the degree of fit to the learning speed of the patient.

The session should be well time managed, such that it is neither too slow nor too quick. For example, the therapist may unwittingly belabour a point after the patient has already grasped the message, or may gather much more data than is necessary before formulating a strategy for change. In these cases, the sessions can seem painfully slow and inefficient. On the other hand, the therapist may switch from topic to topic too rapidly, thus not allowing the patient to integrate the new material sufficiently. The therapist may also intervene before having gathered enough data to conceptualise the problem. In summary, if the therapy is conducted too slowly or too quickly, it may impede therapeutic change and could de-motivate the patient.

The pacing of the material should always be accommodated to the patient's needs and speed of learning. For example, when there is evidence of difficulties (e.g. emotional or cognitive difficulties), more time and attention may need to be given. In such circumstances the agenda items may be shuffled or adapted accordingly. In some extreme circumstances (e.g. disclosure of suicidal thoughts), the structure and pacing of the session will need to change drastically in accordance with the needs of the situation.

The therapy should move through discrete phases. At the start, there should be a structured agenda. Then the agreed plan of the session should be handled efficiently during the main phase.

It is important that the therapist maintains an overview of the session to allow correct pacing throughout. This may involve the therapist politely interrupting peripheral discussion and directing the patient back to the agenda.

A well paced session should not need to exceed the time allocated for the period and should cover the items set in the agreed agenda. It will also allow sufficient time for the homework task to be set appropriately, and not be unduly rushed.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Was the therapist able to recognise the patient's need and adapt the session accordingly?
2. Was there any time during the session when the session moved too slowly/quickly (e.g. agenda setting phase)?
3. Do you think the session flowed well overall?
4. Was the therapist able to avoid unproductive digressions?
5. Was there sufficient time left for the homework assignment?
6. Was the pacing of the session adapted well to the needs of the patient?
7. Did the patient appear rushed?
8. Did you hear any of the following:
    - How much time should we spend on that item?
    - Do you mind stopping a second, you've given me lots of information already. Just to make sure I have understood completely, let's look at the major points you've made.
    - We may have strayed off the topic a little, shall we get back and focus on the chief issues you raised.
    - Now we have 20 minutes left before the end of the session. Is there anything you think we must cover before the end - keeping in mind that we will also need to set the homework assignment?
    - Do you think we should move off this topic now?

Item 5 - Interpersonal Effectiveness

Introduction

The ability of the therapist to form a good relationship with the patient is deemed crucial to the therapy. Indeed, in order for the patient to be able to disclose difficult material, there must be both trust and confidence in the therapist. Rogers suggests that the non-specific factors of 'empathy, genuineness and warmth' are key features of effective therapy.

The key features of 'Interpersonal Effectiveness' is outlined in the CTS-R Rating Scale as follows:

Key features: The patient is put at ease by the therapist's verbal and non-verbal (e.g. listening skills) behaviour. The patient should feel that the core conditions (i.e. warmth, genuineness, empathy and understanding) are present. However, it is important to keep professional boundaries. In situations where the therapist is extremely interpersonally effective, he/she is creative, insightful and inspirational.

Three features need to be considered:

(iv) empathy - the therapist is able to understand and enter the patient's feelings imaginatively and uses this understanding to promote change;
(v) genuineness - the therapist has established a trusting working relationship;
(vi) warmth - the patient seems to feel liked and accepted by the therapist.

In order that the appropriate levels of the three features are conveyed, careful judgement is required from the therapist. Personal and contextual needs must be taken into account. For example, towards the end of therapy lower levels of warmth may be used, as compared to the beginning, in order to promote patient disengagement.

Empathy concerns the therapist's ability to make the patient aware that their difficulties are recognised and understood on both an emotional and cognitive level. The therapist needs to show that he/she shares the patient's feelings imaginatively. For example, the promotion of a shared-value system between therapist and patient will help to enhance this aspect of the relationship. The therapist should avoid appearing distant, aloof or critical.

A good therapist should adopt a genuine and straightforward therapeutic style. A sincere and open style will promote a trusting, collaborative working relationship. The therapist should avoid appearing condescending or patronising.

It is also important for the therapist to convey warmth and concern through both his/her verbal and non-verbal behaviour. The therapist should avoid being critical, disapproving, impatient or cold. He/she should convey an attitude of acceptance of the person, but not of course with respect to the style of thinking.

It is important to highlight that appropriate use of humour can often help to establish and maintain a good therapeutic relationship.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

I. Did you consider the relationship was positive?

2. Was the therapist displaying appropriate empathy, understanding, warmth and genuineness?

3. Did he/she appear appropriately genuine, helping to facilitate therapeutic trust?

4. Do you think he/she showed acceptance and liking of the individual, while remaining within professional boundaries?

5. Did the therapist appear confident?

6. Did the therapist empathise with the patient's distress?

7. Did the therapist acknowledge any difficulties?

8. Did you hear any of the following:
   - I understand that X was difficult for you to do
   - Shared laughter
   - This must have felt awful for you
   - You've made a great effort here. Thank you.
   - Despite the huge difficulties, you did really well.
   - Many people would feel that way, but you have decided to do something about it.

Item 6 - Eliciting Appropriate Emotional Expression

Introduction

The ability of the therapist to deal effectively with the emotional content of the therapy session is a crucial feature of therapy. The therapist should be able to increase or reduce the emotional ambience of a session through his her verbal and non-verbal behaviour. The therapist should then be able to use the patient's emotions to promote therapeutic change. The current item reflects the degree to which the therapist is able to create the circumstances through which emotional change and expression can be elicited and then used effectively.

Key features: The therapist facilitates the processing of appropriate levels of emotion by the patient. Emotional levels that are too high or too low are likely to interfere with therapy. The therapist must also be able to deal effectively with emotional issues which interfere with effective change (e.g. hostility, anxiety, excessive anger). Effective facilitation will enable the patient to access and express his/her emotions in a way that facilitates change.

Three features have to be considered:

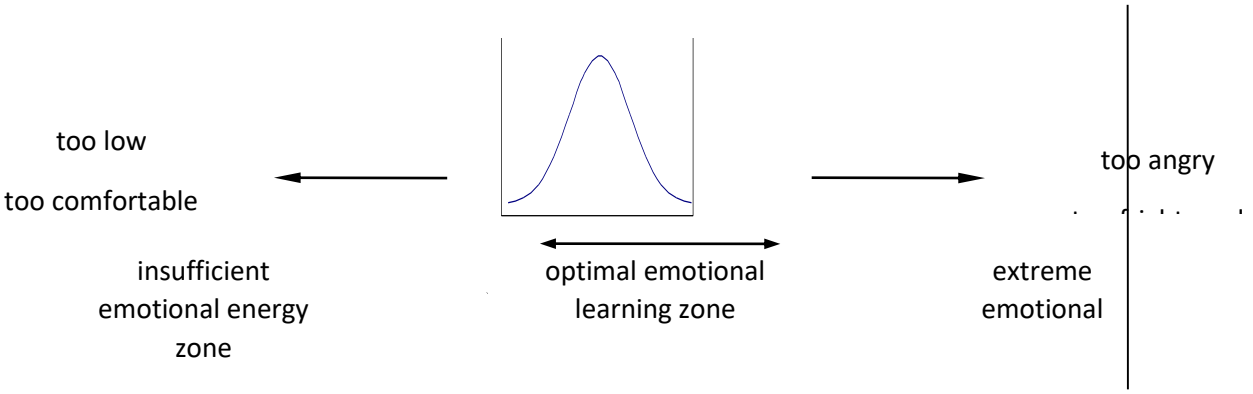
(i) facilitation of access to a range of emotions;
(ii) appropriate use and containment of emotional expression;
(iii) facilitation of emotional expression, encouraging appropriate access and differentiation of emotions.

Cognitive therapy requires both cognitive and emotional shift. In order to produce emotional change the therapist must first facilitate the patient to express himself/herself on an emotional level. The therapist should ensure that emotions associated with a particular situation or cognition are elicited and assessed for intensity. The therapist must also be able to assess the emotional shift within a session and work with it accordingly; increasing and decreasing the level of emotionality as appropriate (see Figure 6.1).

There is an optimal level of emotional affect required to motivate a person to change constructively. Too little emotional energy (i.e. apathy, lack of motivation, avoidance) will be insufficient to create change. In these cases the therapist must first be able to stimulate the patient (through verbal and non-verbal behaviour) to become an active participant in the therapeutic process.

On the other hand too much emotion (i.e. anger, despair, fear, etc.) will interfere with therapy. The therapist should be able to contain the energy, or use or dissipate it, in order that it no longer serves as an obstacle to effective change.

Figure 6.1: Curve of energy levels for optimal learning



A skilled ther st will also recognise inconsistency between the emotiona nd cognitive con t, and explore such discrepancies accordingly. For examp if a patient expresses no distressful emotion when talking about some unpleas t event, careful questioning will help the patient access his/her associated emotions.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Did the therapist pay sufficient attention to the person's emotions?
2. Did the therapist help the patient to differentiate between different emotions?
3. Did the therapist raise emotional topics in a sensitive manner?
4. Was there an optimal level of emotional arousal to promote change?
5. Did the therapist's activity serve to motivate the patient appropriately?
6. Did the therapist prepare the patient to work on his/her emotions?
7. Was the therapist able to contain any emotional outbursts?
8. Did you hear any of the following:
   - How did that make you feel?
   - On a scale of 1 to 100, how would rate your feelings?
   - You seem very distressed today? Am I right?
   - If you tried to do that, how would it make you feel?
   - How does it feel when your recalling that event?
   - You appear to be fearful of talking about that subject. I'm sorry, but I'd like to press you a little more.
   - Did you feel anything else than sadness?
   - You are relating very distressing events, and you are smiling. How do you understand this?

Item 7 - Eliciting Key Cognitions

Introduction

Cognitive therapy stresses the role of cognitions and the emotions associated with them in the genesis and maintenance of a range of psychiatric disorders. The current feature addresses the ability of the therapist to elicit important cognitions in an effective manner.

It is important to note that there are a number of techniques used frequently to elicit key cognitions, for example thought monitoring (e.g. thought eliciting diaries) and downward arrowing techniques. Such methods should be scored under this item rather than Item 11 (Application of Change Methods). The latter item is concerned with change techniques.

The key features of 'Eliciting Key Cognitions' is outlined in the CTS-R Rating Scale as follows:

Key features: To help the patient gain access to his/her cognitions (thoughts, assumptions and beliefs) and to understand the relationship between these and their distressing emotions. This can be done though the use of questioning, diaries and monitoring procedures.

Three features need to be considered:

(i) eliciting cognitions that are associated with distressing emotions (i.e. selecting key cognitions or hot thoughts);
(ii) the skilfulness and breadth of the methods used (i.e. Socratic questioning; appropriate monitoring, downward arrowing, imagery, role-plays, etc.);
(iii) choosing the appropriate level of work for the stage of therapy (i.e. automatic thoughts, assumptions, or core beliefs).

NB: This item is concerned with the general work done with eliciting cognitions and emotions. If any specific cognitive or behavioural change methods are used, they should be scored under item 11 (Application of Change Methods).

A therapist should be able to identify and elicit those thoughts, images and beliefs which are fundamental to the patient's distress (i.e. the key cognitions**).** Key cognitions often take the form of negative automatic self-statements or beliefs relating to the self and the world that either drive or maintain negative emotions.

In the case of depression, such negative automatic thoughts (NATs) might be:

- No one could ever love me, I'll always be reje
- My future is bleak, and it will always be this v } DEPRESSION

In panic with agoraphobia:

- I'm having a heart attack } FEAR & ANXIETY

- Unless I'm very careful, I'll collapse.

In PTSD:

- The world is a hostile place, I'm never quite sure when the next th } ANXIETY
wrong.
- I can't cope with things like I used to.

Other types of key cognitions are dysfunctional core beliefs (core schemata, Early Maladaptive Schemata). These are rigid, inflexible and dysfunctional self-beliefs which are not open to the 'normal' corrective processes of logical thinking. These can be expressed through basic assumptions and rules (If ... then; I should ...; people should...).

The negative automatic thoughts, basic assumptions, rules and core beliefs often exist in the face of overwhelming contradictory evidence (e.g. *The eminent professor who thinks she is worthless*). As part of the assessment, it is also important for the therapist to determine the different forms of cognitive biases being used to support the patient's thinking. For example, the patient may be engaging in 'minimising the positive'**:** reducing the frequency or impact of good events, perhaps even focusing on the negative side of such events *(e.g. "Now that I've got a new job, I'll have to get up early")* OR, 'catastrophising'**:** exaggerating the potential negative impact of an occurrence out of all reasonable proportions *(e.g. "Mark didn't call last night, I don't think he likes me any more").* Other cognitive biases include: overgeneralising, black and white (absolute) thinking, etc**.**

On certain occasions the patient may display a great deal of emotion (cry, shake, etc.) while discussing issues. At such times, the patient's thinking needs to be checked-out as he/she may be experiencing dysfunctional thoughts at that moment (such thoughts are termed 'hot cognitions'). During such an episode, the therapist must exercise a great deal of empathy and skill when eliciting these cognitions.

The therapist should also be able to elicit the key cognitions, when they are not immediately apparent. The therapist needs to use his her professional judgement in determining which are the 'key' cognitions, taking into account both the needs of the patient and the stage of therapy. For example, during the first few sessions it is not usually appropriate to elicit and tackle core beliefs, because the patient will not be sufficiently socialised to the therapy for effective work to be done.

<u>CHECKLIST: OUESTIONS FOR RATERS TO ASK THEMSELVES:</u>

1. Was the therapist able to identify and elicit the appropriate cognitions and biases?
2. Was the therapist able to access and work with key cognitions?
3. Was the therapist able to identify thinking biases and elicit hot cognitions?
4. Were the cognitions elicited well?
5. Does the therapist adequately demonstrate to the patient how to identify key cognitions

and biases?

6. Did you hear any of the following:
    - What was going through your mind at the time?
    - Did you make anything of that?
    - What did you say to yourself when ...?
    - There seems to be a rule there that you apply to yourself. Do you see what it is?
    - A word that comes up often in these records is "weak". Is this how you see yourself in general?
    - If you didn't finish your work on time, what would this say about you?

Item 8 - Eliciting Behaviours

Introduction

Behavioural problems are observed frequently in psychiatric disorders. They take numerous forms, including withdrawal, avoidance, compulsions and various types of safety seeking behaviours. As such, it is important that the therapist elicits the roles these behavioural features play in the maintenance of the patient's problems.

Key features: To help the patient gain insight into the effect of his/her behaviours with respect to the problems. This can be done through the use of questioning, diaries and monitoring procedures..

Two features need to be considered:

(iii) eliciting behaviours that are associated with distressing emotions (including, use of safety seeking behaviours);

(iv) the skilfulness and breadth of the methods used (i.e. socratic questioning; appropriate monitoring, imagery, role-plays, etc.).

NB: This item is concerned with the general work done with eliciting behaviours. If any specific cognitive or behavioural change methods are used, they should be scored under item 11 (Application of change methods).

It is important to examine the role that behaviours have in triggering and maintaining the patient's disorder. Behaviours often reinforce both negative thoughts and feelings. For example, the typical avoidance observed in social phobia prevents the person overcoming his/her fear, and obtaining the skills necessary to engage in social interactions.

Some activities can be termed "safety seeking behaviours" as patients employ them as a means of reducing their levels of distress (eg. self monitoring procedures, holding on tightly to objects). However, safety behaviours can often serve to unwittingly maintain a person's problems, ensuring that the dysfunctional cycles are preserved. On occasions the patient might react to difficulties by over-compensating in some manner (e.g. becoming aggressive when feeling vulnerable); such behavioural patterns clearly ought to be elicited and examined in relation to the relevant emotions associated with them.

The following table (Table 8.1) outlines some of the common forms of safety seeking behaviours associated with the different disorders. It is relevant to note that safety behaviours are often distinguished from avoidance and withdrawal strategies. The latter are escape strategies (eg. avoidance of situations/objects/people), while the former are active (ie. non-avoidant)

behaviours that either (i) reduce a perceived risk, or (ii) are used by the person to cope in situations where negative feelings are being experienced.

Table 8.1: Safety seeking behaviours associated with the different mental health disorders

Panic

Monitoring of pulse and other physiological sensations; deep breathing, holding onto objects, inactivity, muscle tension.

Generalised anxiety disorder

Worrying, scanning for danger, mental control, distraction, thought suppression, ruminations in an attempt to anticipate threat.

Social phobia

Gripping objects tightly to avoid tremor, self-monitoring, reassurance seeking, attempting not to attract attention, perceptual scanning, self absorption, excessive self-reflection, over-rehearsing and excessive planning, post-morteming, perceptual avoidance (eye-contact, tactile).

Obsessive compulsive disorder

Neutralisations (mental and physical), control seeking, employment of rituals, checking, excessive deliberation, excessive taking of responsibility.

Health anxiety

Self monitoring, reassurance seeking, medical consultations, hyper-vigilance, avoidance of physical exertion, selective attention to illness-related information (media, TV), bodily checking, selective attention on body.

Post traumatic stress disorder

Thought suppression, imagery, distraction.

This table provides some of the characteristic safety behaviours identified by people experiencing different mental health problems. It is important to remember that there is a large degree of co-morbidity with respect to people's affective states and one is likely to find someone exhibiting a range of safety behaviours from each of the different categories. Thus it is essential that a thorough individual formulation is developed.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Did the therapist examine adequately the role that behavioural features played in the triggering and maintenance of the patient's problems?
2. Did the therapist help the patient discover the impact of his/her behaviours in terms of relevant emtoinal features?
3. Did you hear any of the following:

- When you felt fearful, did you do anything that reduced your level of fear?
- If I had a camera and filmed you when you are feeling low, what would I see?
- Some people develop habits or rituals, have you noticed any patterns to your behaviour?
- When you check your heart rate, how do you feel?

Item 9 - Guided Discovery

Introduction

Guided discovery is a form of presentation and questioning which assists the patient to gain new perspectives for himself/herself without the use of debate or lecturing. It is used throughout the sessions in order to help promote the patient to gain understanding. It is based on the principles of socratic dialogue, whereby a questioning style is used to promote discovery, to explore concepts, synthesise ideas and develop hypotheses regarding the patient's problems and experiences.

The key features of 'Guided Discovery' is outlined in the CTS-R Rating Scale as follows:

> Key features: The patient should be helped to develop hypotheses regarding his/her current situation and to generate potential solutions for him/herself. The patient is helped to develop a range of perspectives regarding his/her experience. Effective guided discovery will create doubt where previously there was certainty, thus providing the opportunity for re-evaluation and new learning to occur.
>
> Two elements need to be considered:
>
> (i) the style of the therapist - this should be open and inquisitive;
> (ii) the effective use of questioning techniques (e.g. Socratic questions) should encourage the patient to discover useful information that can be used to help him/her to gain a better level of understanding.

It has been observed that patients are more likely to adopt new perspectives, if they perceive they have been able to come to such views and conclusions for themselves. Hence, rather than adopting a debating stance, the therapist should use a questioning style to engage the patient in a problem solving process.

Skilfully phrased questions, which are presented in a clear manner, can help to highlight either links or discrepancies in the patient's thinking. In order to accommodate the new information or learning, new insight is often achieved. Padesky (1993) emphasises that the aim of questioning is not to 'change minds' through logic, but to engage the patient in a socratic dialogue. Within this dialogue the patient can arrive at new perspectives and solutions for themselves.

The therapist's questioning technique should reveal a constant flow of inquiry from concrete and specific ("*Does your mood drop every time you argue with your mother?*") to abstract ("*Do you always feel this way when someone is shouting at you?*") and back again ("*What thoughts were going through your head when it was your mother shouting?*"). Good questions are those asked in the spirit of inquiry, while bad ones are those which lead the patient to a predetermined conclusion.

The techniques may also permit the patient to make both lateral and vertical linkages. The lateral links are those day to day features of the patient's life which produce and maintain his/her difficulties (i.e. the NATs, dysfunctional behaviours, moods and physical sensations). The vertical links are the historical patterns and

cycles, which manifestly relate to the patient's current problems (i.e. childhood issues, parenting, relationship difficulties, work issues, etc.).

The questions posed should not be way-beyond the patient's current level of understanding, as this is unlikely to promote effective change. Rather they should be phrased within, or just outside, the patient's current understanding in order that he/she can make realistic attempts to answer them. The product of attempting to deal with such intelligently phrased question is likely to be new discoveries.

The therapists should appear both inquisitive and sensitive without coming across as patronising.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Has the therapist used appropriate questions?
2. Does the manner in which the questions are asked facilitate the patient's understanding?
3. Did the questions lead to or promote change?
4. Did you hear any of the following:
    a) I wonder whether there are any other times in your life when you felt the same way?
    b) You have this dreadful image when you're with both John and Paul, but you never have it with Peter. Can you think of a reason for this?
    c) If you were not depressed, how might you think differently about this situation?
    d) How does this relate to what you told me earlier - that you never get anything right?
    e) What is the common link between X and Y?

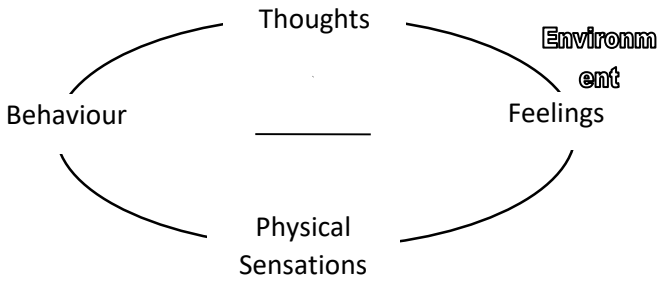
Item 10 - Conceptual Integration

Introduction

Conceptualisation concerns the provision of an appropriate knowledge base that promotes understanding and facilitates therapeutic change. It encompasses both the cognitive therapy rationale and the cognitive formulation. Through the conceptualisation the patient will gain an understanding of the cognitive rationale of his/her disorder, its underlying and maintaining features, and relevant triggers. Importantly, the patient should also gain an understanding of the relative efficacy of the coping strategies currently being used in order to deal with the problem.

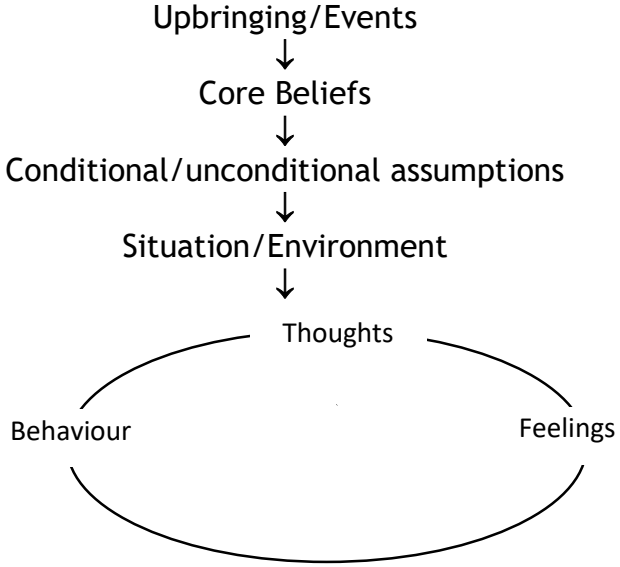
The conceptualisation process involves initially socialising the patient to the therapeutic rationale (i.e. establishing the links between "thoughts → feelings → behaviours"). This rationale (i.e. the generic CT model) is presented in Figure 10.1. Its specific format will vary with respect to the different disorders.

Figure 10.1: The generic CT model



After the initial assessment phase, the process involves the development of an appropriate understanding of the problem. This is termed formulation, and is a personalised account of the disorder in terms of both its genesis and maintaining features. The formulation involves establishing the lateral (i.e. situational and maintaining features) and vertical (i.e. historical) linkages underpinning the disorder. Figure 10.2 presents an integrated formulation, using both vertical and lateral linkages.

Figure 10.2: Integrated Formulation



Physical Sensations

Following the formulation, the patien e the knowledge of what needs to be changed and the most appropriate strategies for change (i.e. change mechanisms). When working effectively, both the therapist and patient will have a shared theoretical understanding of the aims, model and current status of the therapy with respect to the therapeutic goals.

The key features of 'conceptualisation' is outlined in the CTS-R Rating Scale as follows:

Key features: The patient should be helped to gain an appreciation of the history, triggers and maintaining features of his/her problem in order to bring about change in the present and future. The therapist should help the patient to gain an understanding of how his/her perceptions and interpretations, beliefs, attitudes and rules relate to his/her problem. A good conceptualisation will examine previous cognitions and coping strategies as well as current ones. This theory-based understanding should be well integrated and used to guide the therapy forward. Two features need to be considered: (i) the presence/absence of an appropriate conceptualisation which is in line with goals of therapy; (ii) the manner in which the conceptualisation is used (e.g. used as the platform for interventions, homework etc.). NB: This item is to do with therapeutic integration (using theory to link present, past and future). If the therapist deals specifically with cognitions and emotions, this should be scored under Items 6 (Facilitation of Emotional Expression) and 7 (Eliciting Key of Cognitions).

Conceptualising is one of the key processes of therapy through which change takes place. It provides the theoretical overview of the work. Its absence can lead to disjointed therapy, which might prevent major insight being gained by the patient. When it is not appropriately integrated within therapy, the work may lose its focus and only consist of a set of unrelated techniques.

In order for effective therapy to occur the conceptualisation must be appropriate. To arrive at an appropriate cognitive rationale a thorough assessment needs to take place, in which both therapist and patient collect information to increase their understanding of the problem. Through this data-gathering process the patient learns to monitor the important features of his/her disorder (NATs, feelings, behaviours, safety behaviours, cognitive biases, etc.), and thereby gain further insight. To instigate this process effectively, the therapist must have a good theoretical understanding of generic cognitive therapy and the specifics of the patient's disorder (i.e. the cognitive models of depression, panic, OCD, PTSD, etc.).

During this period, patients learn to break down situations using the rationale. In essence, they begin to become their own therapist. This process is often facilitated greatly through the use of suitable written material. Typically the therapist will illustrate relationships via diagrams or through the use of examples, stories and/or metaphors. If not performed adequately, the patient can feel misunderstood and alienated. He/she may become less active both in an out of sessions.

A good collaborative relationship is usually essential in developing a comprehensive formulation. The therapist must also be sensitive, particularly when working at the level of core beliefs. It is important to remember, however, that these features should be rated under the relevant items (e.g. Collaboration & Interpersonal Effectiveness respectively).

One of the main purposes of establishing the CT rationale is to socialise the patient to the model and generate evidence towards the formulation. The appropriately constructed formulation should be able to explain most of the features of the patient's disorders (historical and present, including: fears, vulnerabilities, avoidance, maintenance and compensation strategies, effective and dysfunctional coping strategies, etc.). The ultimate aim of the formulation is to arrive at an agreed set of key core beliefs which, based on empirical evidence, make a major contribution to the patient's understanding of his/her current difficulties. Thus the formulation provides the foundation for change. This shared 'frame of reference' then leads on to the choice of treatment techniques that help inform potential change mechanisms.

A good conceptualisation will provide an awareness of <u>effective</u> and dysfunctional cycles of thoughts ⇔ emotions ⇔ behaviour and thereby suggest potential mechanisms of change.

It is important to note that the patient's self-conceptualisation will not be entirely negative and dysfunctional. Therefore it is vital, when helping to define him/herself, that the therapist highlights the patient's strengths too. This more balanced conceptualisation, may also help clarify areas that could be used effectively in promoting change.

<u>CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:</u>

1. Has the therapist socialised the patient to the CT rationale?
2. Does the therapist demonstrate a good understanding of generic CT?
3. Does the therapist demonstrate a good understanding of the CT rationale for the specific disorder?
4. Does the patient have an adequate CT understanding of the problem?
5. If you asked the patient about his her problems, would he/she be able to produce a working conceptualisation that was broadly consistent with a CT perspective?
6. Has the conceptualisation been truly integrated (i.e. has it been used to guide the therapy)?

7. Did you hear any of the following:
    - Let's see how the various things we have talked about hold together.
    - What we have done so far is look at the way your thoughts affect the way you feel and what you do. It would be useful for us today to look at some general rules and attitudes that are contained in these thoughts. The reason for doing this is for us to try to understand where they come from. Is this OK with you?
    - Do you remember anybody saying this to you: "You are no good"?
    - Let's look at times in your life when you have been depressed before.
    - Are there times in your life when you have felt good about yourself?
    - Does this way of looking at your depression make sense to you?

Item 11 - Application of Change Methods

Introduction

Change methodologies are cognitive and behavioural strategies employed by the therapist which are consistent with the cognitive rationale and/or formulation and designed to promote therapeutic change. The potency of the techniques will depend upon whether they are applied at the appropriate stage in therapy, and the degree to which they are implemented skilfully. It is important to note that during some sessions it may not be appropriate to use a wide range of methods; a rater should take this into account when scoring this item.

The key features of 'Application of change methods' is outlined in the CTS-R Rating Scale as follows:

Key features: Therapist skilfully uses, and helps the patient to use, appropriate cognitive and behavioural techniques in line with the formulation. The therapist helps the patient devise appropriate cognitive methods to evaluate the key cognitions associated with distressing emotions, leading to major new perspectives and shifts in emotions. The therapist also helps the patient to apply behavioural techniques in line with the formulation. The therapist helps the patient to identify potential difficulties and think through the cognitive rationales for performing the tasks. The methods provide useful ways for the patient to test-out cognitions practically and gain experience in dealing with high levels of emotion. The methods also allow the therapist to obtain feedback regarding the patient's level of understanding of prospective practical assignments (i.e. by the patient performing the task in-session).

Two features need to be considered:

(iv) the appropriateness and range of both cognitive methods (e.g. cognitive change diaries, continua, distancing, responsibility charts, evaluating alternatives, examining pros and cons, determining meanings, imagery restructuring, etc.) and behavioural methods (e.g. behavioural diaries, behavioural tests, role play, graded task assignments, response prevention, reinforcement of patient's work, modelling, applied relaxation, controlled breathing, etc.);
(v) the skill in the application of the methods – however, skills such as feedback, interpersonal effectiveness, etc. should be rated separately under their appropriate items;
(vi) the suitability of the methods for the needs of the patient (i.e. neither too difficult nor complex).

NB: This item is not concerned with accessing or identifying thoughts, rather with their re-evaluation.

In deciding the appropriateness of a method it is important to determine whether the technique is a coherent strategy for change, following logically from the patient's formulation.

Clinical judgement is required in assessing the degree of skill with which a particular methodology is applied. This feature goes beyond mere adherence (i.e. the preciseness with which a technique is applied). Indeed, the rater should be concerned with the manner of application, i.e. the therapist must be articulate, comprehensible, sensitive and systematic when discussing and implementing the technique. The therapist should also be creative and resourceful in his/her selection of methods. He/she should be able to draw upon a wide range of suitable cognitive and behavioural methodologies.

It is important to remember that the same technique can have a different function depending on the stage of therapy. For example, a diary can act as an assessment tool early on in therapy, but later may serve as an effective way of promoting the re-evaluation of thought processes. The timing of the intervention is vital and must be suited to the needs of the patient. For example, if a therapist challenges basic assumptions or core beliefs too early in therapy, before he/she has a clear understanding of the patient's view of the world, the patient could feel misunderstood and alienated. Only after sufficient socialisation, should the therapist get the patient to start to reassess that level of cognition. The evaluation of automatic thoughts starts earlier, first as part of the socialisation into the cognitive model and then as a change method to improve mood and to improve on coping behaviour.

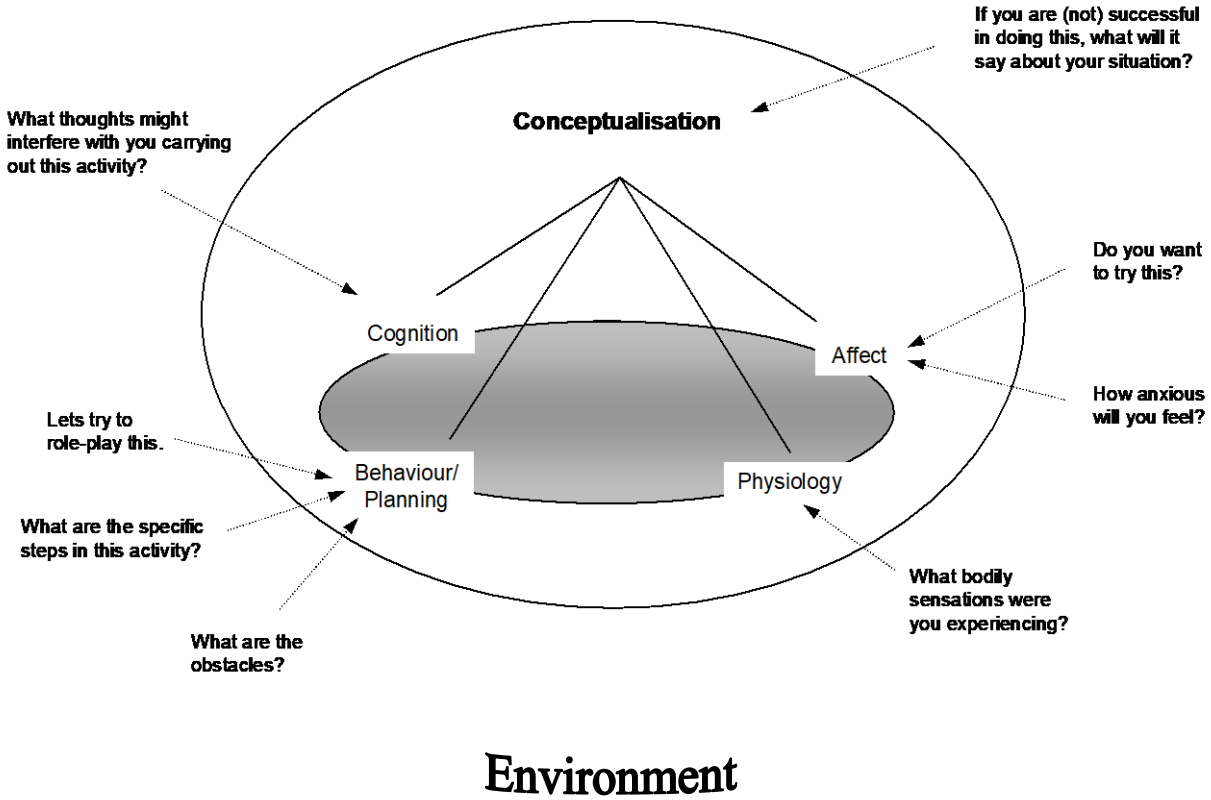
As with the application of cognitive techniques, the therapist must display skill in applying behavioural methodologies. The rationale for employing the tasks should be carefully explored, and clear learning goals established. It is important to remember that behavioural tasks play a key role with respect to the reinforcement of new learning. For example, by engaging a patient in a role-play, one can assess whether the theoretical information has been truly learned and integrated into his/her behavioural repertoire. The role-play will also allow the person to practice new skills. Behavioural tasks are also useful methodologies to employ prior to asking the patient to use the activity in a homework task. For example, it is useful to get the patient to complete monitoring sheets within the session in order to ensure the task is understood correctly. In this way the behavioural methodologies are important feedback and reinforcement activities.

In addition, the therapist needs to elicit and develop practical plans with the patient in order that effective change takes place (e.g. the where, what, when, and how of a desensitisation programme). Indeed, part of the process of producing effective behavioural change is the development of plans that help to test out hypotheses and break unhelpful patterns of behaviour. For example, when setting a behavioural task, the therapist should get the patient to:

- think through the relevance of the assignment
- be confident in his/her ability to perform it, and be sufficiently motivated
- check through anticipated level of arousal
- plan what needs to be done carefully, and be cognisant of potential obstacles
- practice the behaviour
- be able to relate either success or failure to a change in perspective.

In planning the task, relevant questions should be asked of the person's concepts, cognitions, affective and physiological states, and behavioural repertoire. See Figure 11.1 below.

Figure 11.1: Examples of questions used when planning a behavioural intervention



It is important to note that sometimes it is inappropriate to use many methodologies within a particular session. The therapist should not be penalised in such cases, when done for appropriate reasons.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Has the therapist ensured that the patient understands the rationale underpinning the method?
2. Was the method conducted skilfully?
3. Were the learning goals achieved?
4. Were too many/few techniques used in the session?
5. Were the techniques suitable and appropriate for the patient (i.e. neither too complicated nor too demanding)?
6. Was the technique consistent with the formulation?
7. Were the techniques administered with skill?
8. Prior to using the techniques were the learning goals clearly established?

9. Where necessary, was a competent explanation of the rationale of the technique given?
10. Were there valuable opportunities missed when appropriate techniques could have been administered?
11. Did you hear any of the following:
    - What are the benefits of thinking in this way . . . and are there any problems?
    - How else could you have seen this situation? Are there alternative views?
    - What would you say to your best friend?
    - Have you ever had the same experience in the past and reacted differently?
    - Would other people have the same opinion of you?
    - What are the disadvantages of thinking that way? What are the advantages?
    - Let's see whether there are events/situations/experiences that disconfirm this belief about yourself?
    - Can we test this assumption in the next week? What might you try and do differently to see whether your predictions are right
    - See questions outlined in Figure 11.1

Item 12 - Homework Setting

Introduction

Progress is more likely to occur when patients are able to apply the concepts learned in the therapy sessions to their lives outside; homework assignments are the bridges between therapy and the real world. The current item rates the therapist's competence in setting relevant homework tasks. The tasks should be 'custom-tailored' to the needs of the patient. They should ideally test hypotheses, incorporate new perspectives, and may encourage the patient to experiment with new behaviours outside of the session. The therapist should always explain the rationale for the prospective assignments, and elicit reactions to the homework. The homework rationale should follow on logically from the contents of the session and be consistent with the formulation.

Key features: This aspect concerns the setting of an appropriate homework task, one with clear and precise goals. The aims should be to negotiate an appropriate task for the stage of therapy in line with the conceptualisation; to ensure the patient understands the rationale for undertaking the task; to test out ideas, try new experiences, predict and deal with potential obstacles, and experiment with new ways of responding. This item ensures that the content of the therapy session is both relevant to, and integrated with, the patient's environment.

There are three aspects to this item:

(i) presence/absence of a homework task in which clear and precise goals have been set;
(ii) the task should be derived from material discussed in the session, such that there is a clear understanding of what will be learnt from performing the task;
(iii) the homework task should be set jointly, and sufficient time should be allowed for it to be explained clearly (i.e. explain, discuss relevance, predict obstacles, etc.).

NB: Review of homework from the previous session should be rated in Item 1 (Agenda Setting).

Homework helps to transfer within-session learning to real-life settings. In other words, this item bridges the gap between in-session work and the patient's activity out of the therapy session. To facilitate the transfer, the homework material is usually based upon material discussed in the session.

Homework also provides a structure for helping patients gather data and test hypotheses. It also encourages autonomy rather than reliance on the therapist, and therefore plays an important role in relapse prevention. To help empower the patient, and encourage compliance, the assignments should be negotiated. It also is important to explore possible difficulties, and how these might be overcome. To mitigate against potential problems. It is often useful for the therapist to suggest that the patient visualise carrying out the assignment to identify future problems.

In addition, it is desirable to get patient's feedback regarding a specific assignment ("*Does it sound useful?*" "*Does it seem manageable?*" "*Is the assignment clear?*" "*What will be learned from the accomplishment/non-accomplishment of the task?*"). These questions will help to determine whether the patient is both clear about the task, and understands the cognitive rationale underpinning it. It is vital that the patient is aware of the cognitive aspects of the assignment and how the results will impact on his/her interpretations. Indeed, one of the important features of homework tasks is that they bring about cognitive shift, and so they must be seen as more than just isolated behavioural assignments.

Because the setting of homework tends to occur towards the end of the session, there is sometimes a tendency to rush the process. This tendency should be avoided, as it can lead to ill-prepared and unclear tasks being set. Hence it is good practice to leave sufficient time to set the homework appropriately.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Did the therapist adequately explain the rationale underpinning the assignment?
2. Did the therapist check that the patient was confident about conducting the task correctly?
3. Did the patient see the relevance of the assignment?
4. Was the assignment adequately planned within the session?
5. Were the obstacles to conducting the plan discussed?
6. Were the learning goals established sufficiently?
7. Did the therapist set the most appropriate homework task?
8. Was the homework material consistent with the themes from the session?
9. Was the task explained sufficiently?
10. Will the patient learn something useful from engaging in this task?
11. Did you hear any of the questions highlighted in Figure 12.1.

Figure 12.1: Examples of questions used when setting homework assignments