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

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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

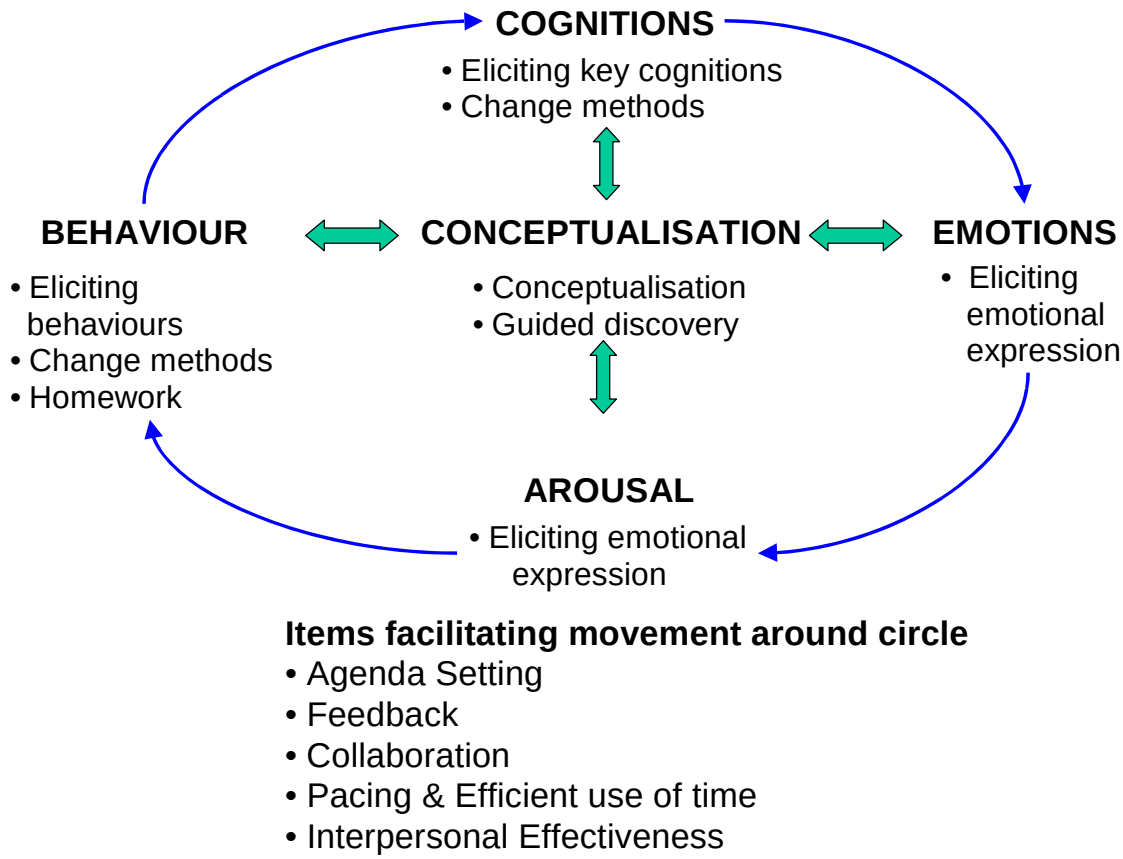
* Item 1 can be regarded as both a general and CT item.
** Items 6 and 8 are new items developed for the scale.

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 c ıly 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
	1	Inappropriate performance, with major problems evident
Novice	2	Evidence of competence, but numerous problems and lack of consistency
Advanced beginner	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:

(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.

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:

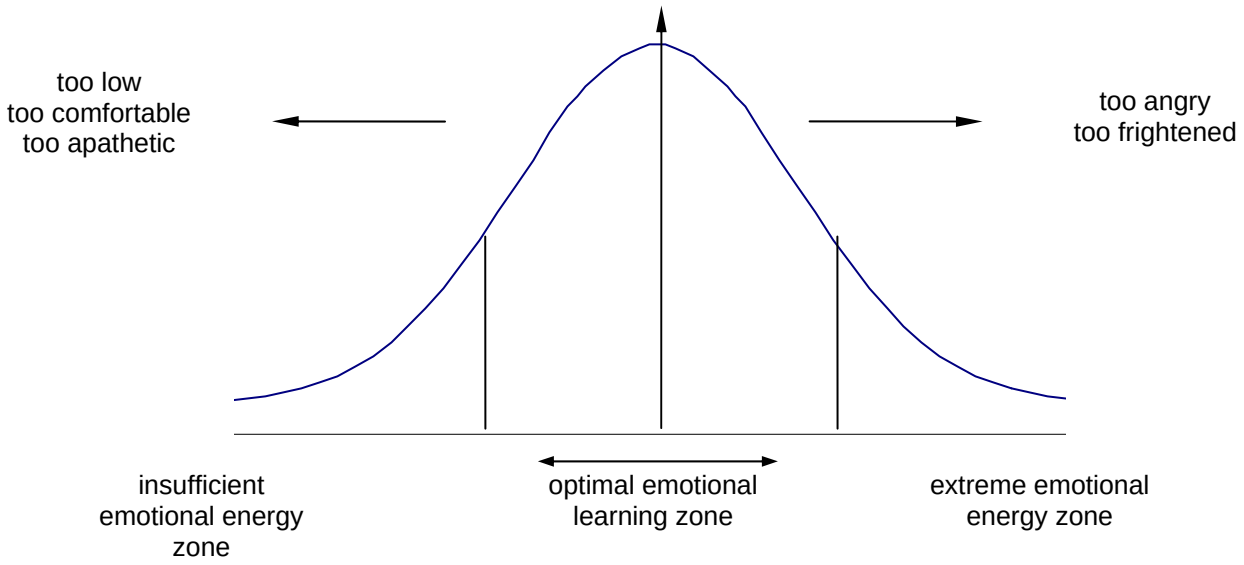
(i) facilitation of access to a range of emotions;
(ii) appropriate use and containment of emotional expression;
(iii) facilitation of emotional expression, encouraging appropriate access and differentiation of emotions.

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 therapist will also recognise inconsistency between the emotional and cognitive content, and explore such discrepancies accordingly. For example, if a patient expresses no distressful emotion when talking about some unpleasant 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 rejected.*
- *My future is bleak, and it will always be this way.* } DEPRESSION

In panic with agoraphobia:

- *I'm having a heart attack*
- *Unless I'm very careful, I'll collapse.* } FEAR & ANXIETY

In PTSD:

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

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.

CHECKLIST: OUESTIONS FOR RATERS TO ASK THEMSELVES:

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:

(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 (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:
    - I wonder whether there are any other times in your life when you felt the same way?
    - 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?
    - If you were not depressed, how might you think differently about this situation?
    - How does this relate to what you told me earlier - that you never get anything right?
    - What is the common link between X and Y?

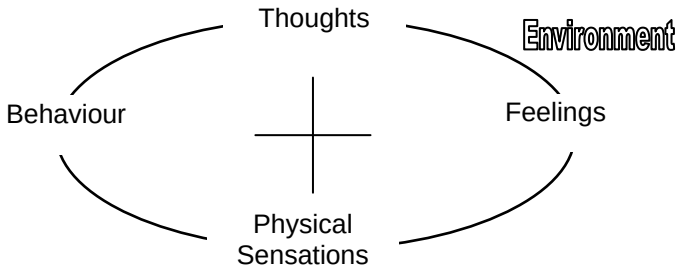
Item 10 - Conceptual Integration

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.

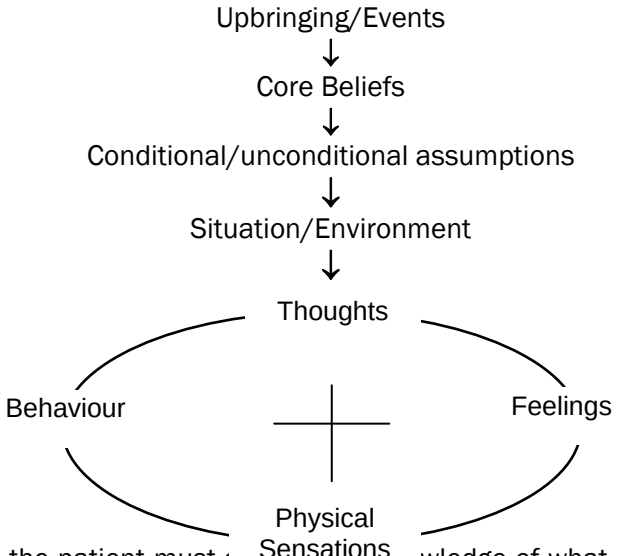
The conceptualisation process involves initially socialising the patient to the therapeutic rationale (i.e. establishing the links between "thoughts → feelings → behaviours"). This rationale (i.e. the generic CT model) is presented in Figure 10.1. Its specific format will vary with respect to the different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



Following the formulation, the patient must a wledge 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 effective 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.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

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:

(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.

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.

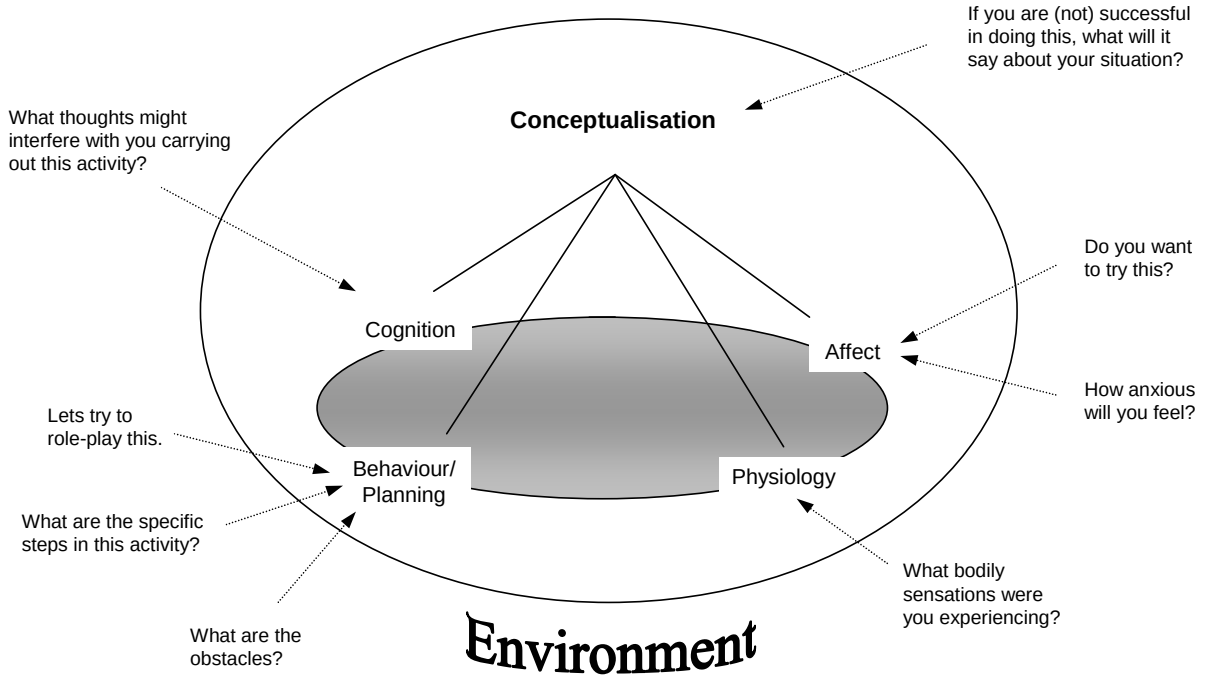
As with the application of cognitive techniques, the therapist must display skill in applying behavioural methodologies. The rationale for employing the tasks should be carefully explored, and clear learning goals established. It is important to remember that behavioural tasks play a key role with respect 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