

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

**THE DEVELOPMENT OF THE HOMEWORK ADHERENCE AND
COMPETENCE SCALE (HAACS): A MEASURE FOR ASSESSING
THERAPIST ADHERENCE AND COMPETENCE IN
ADMINISTERING HOMEWORK ASSIGNMENTS
WITHIN COGNITIVE BEHAVIOUR THERAPY**

**A thesis presented in partial fulfilment of the requirements
for the degree of Master of Arts in Psychology
at Massey University, Albany**

PAUL WEDGE

2005

ABSTRACT

Homework assignments are considered an integral feature of Cognitive Behaviour Therapy (CBT) and are believed important in producing and maintaining treatment gains. Accordingly, increasing attention has been focused on measuring therapist adherence and competence in administering homework assignments in CBT. Existing measurement instruments have been criticised for, among other things, having a limited homework focus. The present study describes the development of the Homework Adherence And Competence Scale (HAACS); a new measure for specifically assessing therapist adherence and competence in administering homework assignments within CBT. An empirically and theoretically based guiding model for practice is described, which underpinned the development process. The detailed pilot testing and measure revision process is also described. The final version of the HAACS has evidence for face and content validity, and had excellent interrater reliability for both the adherence and competence constructs.

ACKNOWLEDGEMENTS

Firstly, I acknowledge Massey University for their funding contributions that made this project possible. The Post Graduate Research Fund payment that enabled the rater training and first pilot study to proceed. My supervisor's research grant which funded the second pilot study, and the Masterate Scholarship award which enabled me to pay the bills throughout the year.

My sincerest and warmest appreciation is extended to my supervisor, Dr. Nikolaos Kazantzis for his support, encouragement, enthusiasm, commitment, and expertise. I particularly appreciated his patience and ability to stay calm when I was not! My thanks are also extended to Professor Keith Dobson, international collaborator for this project, for gaining access to the archived data from the National Institute of Mental Health (NIMH) study, and for his valuable expert feedback during the development of the measure. I also thank Kevin Ronan for a useful conceptual discussion which culminated in the decision to run a second pilot study, and Bev Harhoff for her valuable feedback on an early version of the measure.

A huge thank you to Amber, Gillian, Greg, Kay, and Mette, the five raters who gave up their weekends to participate in the project. Their commitment to the project and specific feedback was invaluable in producing a highly reliable measure. Thank you to the members of the research lab group for useful discussions about homework, the thesis process in general, and my study specifically. I took away many ideas which were implemented in this thesis. In particular, I thank Margo for giving up her free time

to assist with the second pilot study, and becoming my sounding board, and providing invaluable statistical support!

I also acknowledge and thank Linda and Michelle Kemp for their administrative support and organising the technical aspects of using rooms, and equipment outside of normal hours.

I thank Neil for his enduring and supportive friendship, his wise counsel at various times through the year, and for undertaking the unenviable task of proof-reading the final document!

Finally and very importantly, I acknowledge my family for their patience and understanding throughout this project. To Delwyn who described herself as a “thesis widow” during various points of the process: thank you for your love, encouragement, support, sense of humour and infectious laughter. To Phoebe, Bella and Olivia: thank you for encouraging me to write my “book”, for being the wonderful children that you all are, and for reminding me on a daily basis what life is all about! I love you all.

TABLE OF CONTENTS

Abstract.....	ii
Acknowledgements	iv
List of Tables	x
List of Figures	xii

CHAPTER 1

INTRODUCTION	1
1.1 Overview of Chapters.....	1
1.2 Cognitive-Behavioural Therapy and Homework.....	4
1.3 Therapist Adherence and Competence.....	6
1.4 Research Aims	7
1.5 Cognitive Behavior Therapy Homework Project.....	8

CHAPTER 2

EMPIRICAL BASIS OF HOMEWORK	11
2.1 Treatment Outcome.....	11
2.2 Practitioner Surveys	13
2.3 Future Directions: Process Research.....	14

CHAPTER 3

THEORETICAL BASIS OF HOMEWORK.....	17
3.1 Respondent (Classical) Conditioning.....	18
3.2 Operant Conditioning	19
3.3 Social Learning Theories.....	21
3.4 Social Cognition Theories	22
3.5 Summary.....	25

CHAPTER 4**GUIDING MODEL FOR PRACTICE.....27**

4.1 Existing Models and Recommendations for Practice27

4.2 A New Guiding Model30

CHAPTER 5**MEASURES OF THERAPIST ADHERENCE AND COMPETENCE.....33**

5.1 Cognitive Therapy Scale33

5.2 Collaborative Study Psychotherapy Rating Scale.....34

5.3 Cognitive Therapy Adherence and Competence Scale35

5.4 Therapist Homework Assignment Competency Scale.....36

CHAPTER 6**THE PRESENT STUDY.....37**

6.1 Summary.....37

6.2 Research Objectives38

CHAPTER 7**MEASURE DEVELOPMENT39**

7.1 Introduction.....39

7.2 Item Selection and Wording40

7.3 Adherence Items and Scaling41

7.4 Competence Items and Scaling.....43

CHAPTER 8**METHOD47**

8.1 Overview47

8.2 Client and Therapist Data.....49

8.3	Raters.....	51
8.4	Measure	52
8.5	Data Analysis	54

CHAPTER 9

PILOT STUDY ONE.....	57
9.1 Introduction.....	57
9.2 Results - Rater Feedback	57
9.3 Results – Rating Scores.....	60
9.4 Results - Expert Feedback	67
9.5 Discussion.....	68

CHAPTER 10

PILOT STUDY 2.....	75
10.1 Introduction.....	75
10.2 Results - Rater Feedback	75
10.3 Results – Ratings Data	79
10.4 Discussion.....	83

CHAPTER 11

DISCUSSION	87
11.1 Limitations.....	87
11.2 Clinical Implications	88
11.3 Empirical Implications	89
11.4 Conclusion	90

References.....	91
Appendix A Haacs - Training Version	105
Appendix B Training Material	117
Appendix C Haacs - Pilot One Version.....	141
Appendix D Rater Feedback Questionnaire	155
Appendix E Haacs - Pilot Two Version	161
Appendix F Haacs - Final Version	175
Appendix G Rating Distribution Charts	189

LIST OF TABLES

Table 1 <i>Rater Feedback For Pilot One General Questions</i>	58
Table 2 <i>Rater Feedback For Pilot One Item and Anchor Descriptions</i>	59
Table 3 <i>Rater by Rater Cross-Tabulation for Pilot One Adherence Items</i>	60
Table 4 <i>Percent Agreement Statistics for Pilot One Adherence Items by Individual Session</i>	61
Table 5 <i>Percent Agreement Statistics for Pilot One Adherence Items by Individual Item</i>	63
Table 6 <i>Problematic Adherence Items for Pilot One</i>	64
Table 7 <i>Intraclass Correlation Coefficients for Pilot One Competence Items by Individual Session</i>	65
Table 8 <i>Problematic Competence Items for Pilot One</i>	66
Table 9 <i>Summary of Content Changes Incorporated into the Second Revision of the HAACS</i>	71
Table 10 <i>Rater Feedback for Pilot Two General Questions, Compared With Pilot One</i>	76
Table 11 <i>Rater Feedback for Pilot Two Item Description Ratings, Compared With Pilot One</i>	77
Table 12 <i>Rater Feedback for Pilot Two Anchor Description Ratings, Compared With Pilot One</i>	78
Table 13 <i>Rater by Rater Cross-Tabulation for Pilot Two Adherence Items</i>	79
Table 14 <i>Percent Agreement Statistics for Pilot Two Adherence Items by Individual Session, Compared With Pilot One</i>	80

Table 15 *Percent Agreement Statistics for Pilot Two Adherence Items by**Individual Item, Compared With Pilot One*.....81Table 16 *Intraclass Correlation Coefficients for Pilot Two Competence Items by**Individual Session, Compared with Pilot One*.....83Table 17 *Summary of Content Changes Incorporated into the Final Revision of the**HAACS*86

LIST OF FIGURES

<i>Figure 1.</i> Cyclical process for recommending homework.	31
<i>Figure 2.</i> Therapist Quick Reference (TQR).	32
<i>Figure 3.</i> Overview of the development of the initial version of the HAACS.	39
<i>Figure 4.</i> Example translation of a TQR item into a HAACS adherence and competence item.	41
<i>Figure 5.</i> Comparison of CTACS and HAACS homework review items.	42
<i>Figure 6.</i> Comparison of CTACS and HAACS homework design and assign items.	43
<i>Figure 7.</i> Example item from the first version of the HAACS.	45
<i>Figure 8.</i> Overview of the evaluation and revision methodological process.	48
<i>Figure 9.</i> Therapist Quick Reference - Adapted for rating the HAACS (version one).	53
<i>Figure 10.</i> Comparison of anchors 4 and 5 from Item 10 in the HAACS second revision.	72
<i>Figure 11.</i> Therapist Quick Reference - Adapted for rating the HAACS (version two).	73
<i>Figure 12.</i> Competence responses (q1-q10) for pilot one, session one.	191
<i>Figure 13.</i> Competence responses (q11-q19) for pilot one, session one.	191
<i>Figure 14.</i> Competence responses (q1-q10) for pilot one, session two.	192
<i>Figure 15.</i> Competence responses (q11-q19) for pilot one, session two.	192
<i>Figure 16.</i> Competence responses (q1-q10) for pilot one, session three.	193
<i>Figure 17.</i> Competence responses (q11-q19) for pilot one, session three.	193
<i>Figure 18.</i> Competence responses (q1-q10) for pilot one, session four.	194
<i>Figure 19.</i> Competence responses (q11-q19) for pilot one, session four.	194

<i>Figure 20.</i> Competence responses (q1-q10) for pilot two, session one.	195
<i>Figure 21.</i> Competence responses (q11-q22) for pilot two, session one.	195
<i>Figure 22.</i> Competence responses (q1-q10) for pilot two, session two.	196
<i>Figure 23.</i> Competence responses (q11-q22) for pilot two, session two.	196
<i>Figure 24.</i> Competence responses (q1-q10) for pilot two, session three.	197
<i>Figure 25.</i> Competence responses (q10-q22) for pilot two, session three.	197
<i>Figure 26.</i> Competence responses (q1-q10) for pilot two, session four.....	198
<i>Figure 27.</i> Competence responses (q11-q22) for pilot two, session four.....	198

CHAPTER 1

Introduction

1.1 Overview of Chapters

This introductory chapter sets the scene for the present study by providing an overview of the use of homework assignments within CBT, together with the impetus for, and problems associated with, measuring therapist adherence and competence in using homework assignments. The research aims are then stated to provide an overall picture of the goals of the present study, which are then placed within the context of the broader Cognitive Behavior Therapy Homework Project. The remaining chapters then follow a logical progression towards achieving the stated research aims.

Chapter two outlines the empirical support for the use of homework assignments in CBT. It is noted that sufficient evidence exists to suggest that the use of homework assignments may contribute to the production and maintenance of treatment gains from CBT. Practitioner surveys are cited that support the importance of the use of homework assignments in clinical practice, especially among practitioners with a CBT orientation. Finally, some limited process research is identified that provides preliminary support for the theoretical foundations for using homework assignments in therapy.

Next, chapter three provides a summary of the behavioural and cognitive theoretical foundations underpinning the use of homework. In addition to traditional

respondent and operant conditioning principles, social learning and social cognition models are also described.

Chapter four begins by describing and critiquing existing models and recommendations for administering homework assignments. Next, a new guiding model for practice is described which overcomes the limitations of previous models, and incorporates the empirical and theoretical foundations outlined in chapters two and three.

Chapter five describes and critiques four key existing measures of therapist adherence and competence in delivering CBT. Strengths and limitations of the existing measures are summarised, as an important consideration in the development of a new measure.

Chapter six provides a brief summary of the implications from chapters two through five, as they relate to the rationale for the development of a new measure for therapist adherence and competence in using homework assignments in CBT. The research aims are then restated prior to the remaining chapters which cover the measure development and evaluation process.

In chapter seven the development of the first version of the Homework Adherence And Competence Scale (HAACS) is described. While this would ordinarily form part of a methods chapter, the HAACS development was separated out in this chapter, as it represented *the* fundamental undertaking in the present study, in terms of time commitment and conceptual effort. The basis for item and anchor selection and

wording is described, as is the rationale for the scaling methods for the adherence and competence constructs.

Chapter eight then describes the remainder of the method used in this study. The pilot testing process is described, together with other key considerations, including client and therapist data, rater training and demographics, and the analytical procedures that were used in the present study. It was noted that feedback received from raters during their training resulted in the first revision of the HAACS. Content remained unchanged, however a significant formatting change improved the usability of the measure prior to pilot study one.

Chapter nine describes pilot study one. Results are separated into the three key areas that were used to evaluate the HAACS. Firstly, rater feedback was examined as a critical input into whether the HAACS was clear and easy to use. In particular, raters were asked to rate each item and anchor for degree of clarity. Secondly, the actual rating results were examined to determine problematic items. Thirdly, substantive expert feedback was also sought. A discussion section then describes the integration of the three results areas, and subsequent changes that were made to the HAACS.

Chapter ten describes pilot study two, which was designed to evaluate changes that resulted from the revision to the HAACS made after pilot study one. Rater feedback results and actual rating results were examined. In this pilot study substantive expert feedback was not sought, as it had been very positive after pilot study one, and specific recommendations for change had been incorporated into the revised HAACS.

A discussion section describes the integration of the two result areas, and describes some final changes that were made to the HAACS.

Finally, Chapter eleven provides an overall discussion, including the limitations of the present study, and its significance and contribution in terms of future clinical and empirical applications.

1.2 Cognitive-Behavioural Therapy and Homework

Internationally, Cognitive-Behavioural Therapy (CBT) is one of the most highly-researched psychotherapies (Hollon & Beck, 2004; Lambert & Ogles, 2004). It is recognised as a well-established empirically supported treatment for depression, panic disorder, generalised anxiety disorder, and several health problems (Chambless et al., 1996; Kendall & Chambless, 1998). Furthermore, surveys have indicated that CBT is widely practiced among psychologists in New Zealand and overseas (Fehm & Kazantzis, in press; Kazantzis & Deane, 1998; Kazantzis, Lampropoulos, & Deane, 2004; Patchett-Anderson, 1997).

In simple terms, homework is the generic name given to various activities that are undertaken by clients in between therapy sessions. However, the following quotation provides a more comprehensive definition of homework that is useful at the beginning of the present study:

Homework assignments are planned therapeutic activities undertaken by clients between therapy sessions. Their content are derived primarily from the empirically supported cognitive behavioral therapy model for the

particular presenting problem, but are tailored for the client based on an individualized conceptualization. Designed collaboratively, homework assignments are focused on the client's goals for therapy. Homework assignments represent the main process by which clients experience behavior and cognitive therapeutic change, practice and maintain new skills and techniques, and experiment with new behaviors. Homework assignments also provide an opportunity for clients to collect information regarding their thoughts, moods, physiology, and behaviors in different situations, and to read information related to therapy and their presenting problems. (Kazantzis, in press).

Homework assignments are considered important in therapy as they allow therapists the opportunity to utilise the period of time between specific therapy sessions to engage clients in activities that are focussed towards therapy goals (Kazantzis & Lampropoulos, 2002). Surveys of therapist attitudes and opinions indicate that homework assignments are considered important in the treatment of various problems across a range of therapies (Kazantzis & Deane, 1998; Kazantzis, Lampropoulos, & Deane, 2003), including inter alia: behavioural therapy (Shelton & Levy, 1981), CBT (A. T. Beck, Rush, Shaw, & Emery, 1979), dynamic therapies (Badgio, Halperin, & Barber, 1999), experiential therapies (Greenberg, Watson, & Goldman, 1988), and marital and family therapies (Carr, 1997). Within CBT specifically, homework assignments are considered an integral feature (A. T. Beck et al., 1979; J. S. Beck, 1995; Persons, Davidson, & Tompkins, 2001), with some writers suggesting that a therapy without homework could not be considered cognitive behavioural (Thase & Callan, in press).

1.3 *Therapist Adherence and Competence*

The creation of empirically supported treatments (see Chambless et al., 1996; Kendall & Chambless, 1998), together with standardised treatment manuals (Addis & Krasnow, 2000; Luborsky & DeRubeis, 1984; Waltz, Addis, Koerner, & Jacobson, 1993) has provided impetus for increased measurement and evaluation of therapist adherence and competence, particularly in the realm of CBT (CBT: Barber, Liese, & Abrams, 2003; Dobson & Kazantzis, 2003; Kazantzis, 2003; Waltz et al., 1993). It is noted that there is considerable controversy surrounding the use of treatment manuals in clinical practice (Addis & Krasnow, 2000). For instance, manuals have been criticized for ignoring the importance of individual therapist factors, (Garfield, 1998) for overemphasising technique instead of theory (Silverman, 1996), and that adhering to a manual does not necessarily equate with competent delivery (e.g., Castonguay, Goldfried, Wiser, & Raue, 1996). Despite these criticisms, a number of benefits have been noted that relate to therapy, research, training and practice. Particularly relevant to the present study is that treatment manuals can facilitate the development of rating scales for adherence and competence, and can facilitate the discovery of the active ingredients of a treatment (Lambert & Ogles, 2004).

Within CBT, homework may be an active ingredient, and the role of homework and the process of recommending homework assignments has certainly been receiving increasing attention (Detweiler & Whisman, 1999; Kazantzis & Ronan, in press; Scheel, Hanson, & Razzhavaikina, 2004). Various measures have been designed to measure therapist adherence and competence in the delivery of CBT, for example, the Cognitive Therapy Scale (CTS: Young & Beck, 1980), the Collaborative Study Psychotherapy Rating Scale (CSPRS: Hollon et al., 1984) and the Cognitive Therapy

Adherence and Competence Scale (CTACS: Barber et al., 2003). However, there are concerns about the utility of these existing measures (Kazantzis, 2003; McGlinchey & Dobson, 2003; Shaw & Dobson, 1988). Furthermore, these measures are very limited in that only 1-2 items specifically evaluate therapist competence in the use of homework assignments.

The Therapist Homework Assignment Competency Scale (THACS: Bryant, Simons, & Thase, 1999) is the only measure that focuses solely on rating homework. However, is limited to just four items which were based on the single homework item in the CTS, rather than a guiding theoretical model of homework administration.

1.4 Research Aims

Given the limitations of the existing measures of therapist adherence and competence in administering homework assignments within CBT, the present study has five research aims which will be addressed:

1. To describe empirical support, theoretical models and a guiding model for practice for the use of homework in CBT.
2. To describe the existing measures of therapist adherence and competence in the use of homework in CBT.
3. To develop a new measure to assess therapist adherence and competence in the use of homework in CBT.
4. To undertake a preliminary evaluation of the new measure with a sample diagnosed with major depressive disorder.
5. To discuss the findings and the implications for further research.

1.5 Cognitive Behavior Therapy Homework Project

The present study contributes to the team “Cognitive Behavior Therapy Homework Project”, which was initiated by a core research team at Massey University, New Zealand, and now has a host of notable international collaborators. The team research project has an overall aim of developing an understanding of the mechanism by which homework produces its effect in CBT. More specifically, the team research project has five broad objectives:

1. To undertake conventional and statistical reviews of the empirical literature to clarify current knowledge.
2. To survey psychologists’ use of homework assignments in clinical practice to determine the necessity and utility of future research.
3. To design a theoretical model and treatment manual for the use of homework assignments in therapy.
4. To design conceptually-driven methods of assessing homework completion and therapist competence in using homework assignments, and evaluate their psychometric properties.
5. To conduct prospective process and treatment-outcome research to evaluate the utility of the theoretical model and treatment manual.

Within this context, the research aims of the present study *partially contribute* to the fourth objective of the team research project, namely the *development* (and preliminary evaluation) of a method (measure) of assessing therapist competence in using homework assignments. A full-scale evaluation of the measure’s psychometric properties is beyond the scope and means of the present study. However, a full

psychometric study has been planned as a separate project following the development of the measure in the present study. Cognisant of this fact, the discussion includes specific recommendations for consideration in the psychometric evaluation of the measure and also for future research using the measure.

CHAPTER 2

Empirical Basis of Homework

Chapter 1 noted that CBT is one of the most highly-researched psychotherapies (Hollon & Beck, 2004; Lambert & Ogles, 2004). As homework assignments are considered an integral feature of CBT (A. T. Beck et al., 1979; J. S. Beck, 1995; Persons et al., 2001; Thase & Callan, in press), it is not surprising that homework has received more empirical research attention than any other single feature of the CBT process (Persons et al., 2001). This chapter provides a review of the empirical research into the use of homework assignments, to lay the groundwork for a guiding model for practice (Chapter 4) and the development of the new HAACS measure (Chapter 7).

2.1 *Treatment Outcome*

There have been in excess of 30 individual treatment-outcome studies investigating the use of homework assignments (Beutler et al., 2004; Kazantzis, Deane, & Ronan, 2000; Scheel et al., 2004). Studies that have examined the correlation between client homework compliance and treatment outcome have consistently shown that increased homework completion is correlated with reduced symptomology at treatment termination (e.g., Addis & Jacobson, 2000; Bryant et al., 1999; Burns & Nolen-Hoeksema, 1991, 1992; Burns & Spangler, 2000; Edelman & Chambless, 1995; Persons, Burns, & Perloff, 1988). However, inconsistent results have appeared from those studies that have contrasted therapy with homework to therapy without homework. Some studies have produced statistically significant results (Harmon, Nelson, & Hayes, 1980; Kazadin & Mascitelli, 1982; Marks et al., 1988), whereas other studies failed to reach statistical significance (Blanchard, Nicholson, Radnitz et al.,

1991; Blanchard, Nicholson, Taylor et al., 1991; Kornblith, Rehm, O'Hara, & Lamparski, 1983). While the evidence appeared inconsistent, a statistical power analysis of 27 studies provided evidence to suggest that the studies may not have been designed with sufficient statistical power sensitivity to detect homework effects (Kazantzis, 2000). The results found that on average, the studies had a 42% chance of *not detecting large* effect sizes, a 68% chance of *not detecting medium* effect sizes, and a 91% chance of *not detecting small* effect sizes, assuming that an effect did in fact exist.

A subsequent meta-analysis (27 studies, $N=1702$) was conducted, which also overcame the statistical power issue identified above (Kazantzis et al., 2000). The meta-analysis found a strong relationship between the use of homework assignments and improved treatment outcomes, with a mean effect size of .36 (95% CI=.23-.48; $N=375$). This result provided a clearer quantitative picture of the apparent inconsistent results, and indicates that where therapy includes homework, 68% of clients would be likely to improve. Similarly, the meta-analysis also confirmed that homework compliance was indeed a significant correlate of therapy outcome ($r=.22$; 95% CI=.22-.22; $N=1327$).

In summary, studies indicate that CBT with homework is more effective than CBT without homework (Bryant et al., 1999; Neimeyer & Feixas, 1990). Studies also show that a linear relationship exists; clients who do more homework have better outcome than those who do little homework (Burns & Spangler, 2000; Kazantzis, Ronan, & Deane, 2001; Neimeyer & Feixas, 1990; Persons et al., 1988). Moreover, clients who comply with homework recommendations have been shown to have better outcomes than those who do not comply (Bryant et al., 1999; Kazantzis et al., 2000).

Other research has also established the role of homework assignments in predicting longer term treatment effects (Edelman & Chambless, 1995; Neimeyer & Feixas, 1990; Park et al., 2001). Thus, a strong empirical rationale exists, that supports the importance and use of homework assignments in CBT.

2.2 *Practitioner Surveys*

Practitioner surveys in New Zealand and overseas indicate that the use of homework assignments is widespread, particularly among CBT therapists (Fehm & Kazantzis, in press; Kazantzis, Busch, Ronan, & Merrick, 2004; Kazantzis & Deane, 1999; Kazantzis, Lampropoulos et al., 2004).

In New Zealand, Kazantzis and Deane (1999) surveyed practicing psychologists and found that 98% reported the use of homework assignments ($N=221$). A second New Zealand survey ($N=330$) was conducted with a wider range of health professionals (Kazantzis, Busch et al., 2004). The respondents identified themselves as psychiatrists or physicians (7%), nurses (5%), social workers (19%), psychologists (29%), and counsellors (52%). In this survey, 83% of the respondents reported using homework assignments in therapy. In both studies, practitioners identifying as having a CBT orientation reported a higher use of homework assignments than other orientations. The CBT oriented practitioners also reported being more specific in their homework administration. It should be noted that both of these studies were limited by modest sample sizes and a single geographic location.

Two international surveys support the New Zealand findings. A survey of German practitioners ($N=140$) by Fehm and Kazantzis (in press) found that the majority

of respondents reported using homework assignments with at least half of their clients. Specifically, 37% reported using homework assignments with all their clients, 26% reported using homework with two thirds of clients, and 13% reported using homework with half their clients. Similar to the New Zealand surveys, CBT oriented practitioners reported a higher use of homework assignments than other practitioners. The survey was limited by a small sample size.

A larger sample ($N=827$) was obtained from a survey of American Psychological Association (APA) members (Kazantzis, Lampropoulos et al., 2004). The results of this survey were consistent with the New Zealand and German surveys. Most psychologists reported using homework assignments in their practice. Specifically, 68% of respondents reported 'often' or 'almost always' using homework assignments, and 77% of respondents indicated they assigned one homework assignment per therapy session. Again, CBT oriented psychologists reported a higher use of homework assignments than other orientations.

In summary, practitioner surveys conducted in several countries, and with different health professionals, have confirmed that homework assignments are used consistently in practice. Not surprisingly, therapists identifying as having a CBT orientation reported using homework assignments more frequently, and being more specific in their homework administration.

2.3 Future Directions: Process Research

Sections 2.1 and 2.2 presented strong empirical and practical grounds for using homework assignments in therapy. In particular, a strong link was suggested between

the use of homework and treatment outcome, and homework assignments were reported as being used frequently by practitioners, especially those with a CBT orientation.

More recently, there has been a call for research to focus on psychotherapy process issues, rather than whether homework compliance is associated with outcomes (Kazantzis & Ronan, in press; Kazantzis et al., 2001). For example, there has been limited investigation into the association between therapist factors and client adherence (Detweiler & Whisman, 1999). However, the limited research that has been conducted supports a relationship between therapist competence in the review and assignment of homework assignments and client homework compliance (Kazantzis, Deane, Ronan, & Lampropoulos, in press).

A career counselling study ($N=61$) by Worthington (1986) found the only predictors of compliance were the client having some prior history of compliance, involving the clients in homework assignments early in therapy, and the therapist checking the client's attitude towards the homework.

A study ($N=30$) of written versus verbally administered homework assignments found significantly improved rates of compliance among the clients receiving written homework assignments (Cox, Tisdelle, & Culbert, 1988).

Startup and Edmonds (1994) designed a study ($N=25$) which examined 235 sessions of CBT for depression. The intention was to identify a number of therapist factors that may have predicted client compliance. An association between compliance and outcome was found, however the therapist factors of collaboration, clarity of

explanation, and providing a rationale for the homework were not found to be predictors of homework compliance.

A more recent study ($N=26$) by Bryant, Simons, and Thase (1999) used archived data from the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Project (TDCRP) archived data (Elkin, Parloff, Hadley, & Autry, 1985). A newly designed measure, the Therapist Homework Assignment Competency Scale (THACS: Bryant et al., 1999), was used to show that the therapist review of homework assignments was related to client homework compliance.

Kazantzis, Deane et al. (in press) also identify a series of studies from counselling literature that provide preliminary support for the theoretical foundations for using homework assignments in therapy (Conoley, Padula, Payton, & Daniels, 1994; Mahrer, Gagnon, Fairweather, Boulet, & Herring, 1994; cited in Kazantzis, Deane et al, in press). Specifically, the therapists ability to review homework has emerged as a predictor of client compliance. In terms of designing and assigning homework, the therapist discussing the client's beliefs about undertaking the homework have also been supported. Finally, Kazantzis, Deane et al. (in press) note from the cited studies that other therapist factors that have shown promise in enhancing client compliance include: practising homework in-session, negotiating a contractual agreement, recommending assignments that build on clients existing skills and strengths, and providing specific, concrete, and written summaries of the homework. Clearly, further research is required into the interplay of process factors (therapist and client) and treatment outcome.

CHAPTER 3

Theoretical Basis of Homework

Since its original inception, CBT has undergone a number of adaptations and modifications to work with, for example, the elderly, children, groups, couples, and with families. Despite various modifications, J. S. Beck (1995) highlights ten principles that underlie all cognitive behavioural therapies:

1. Cognitive therapy is based on an ever-evolving formulation of the patient and her problems in cognitive terms.
2. Cognitive therapy requires a sound therapeutic alliance.
3. Cognitive therapy emphasizes collaboration and active participation.
4. Cognitive therapy is goal oriented and problem focussed.
5. Cognitive therapy initially emphasizes the present.
6. Cognitive therapy is educative, aims to teach the patient to be her own therapist, and emphasizes relapse prevention.
7. Cognitive therapy aims to be time limited.
8. Cognitive therapy sessions are structured.
9. Cognitive therapy teaches patients to identify, evaluate, and respond to their dysfunctional thoughts and beliefs.
10. Cognitive therapy uses a variety of techniques to change thinking, mood, and behaviour. (pp 5-8)

The principles above were listed to provide a broader context for the use of homework assignments within CBT. In summary, the principles can be viewed as having an “outward focus” (Blackburn & Twaddle, 1996). This outward focus is

enhanced by the setting of homework, and several studies suggest that compliance with homework is related to better outcomes (Chapter 2). Homework assignments within CBT are designed to facilitate the generalisation and maintenance of in-session skill acquisition to the client's everyday situations that they encounter. This process of generalisation and maintenance is attributed to the long term benefits of CBT (A. T. Beck, 1976). However, the theoretical basis for using homework assignments in CBT is much broader than the principles of generalisation and maintenance alone. This chapter reviews the behavioural theories of respondent (classical) conditioning, operant conditioning, generalisation and maintenance, and then reviews cognitive theories, including social learning theories and social cognition theories. Finally, the implications of these theories for using homework assignments in CBT are summarised. The aim of this chapter is to outline the theoretical basis of why homework assignments are central to CBT, to understand how homework is thought to produce its effects, and to identify implications for the guiding model for practice in Chapter 4.

3.1 Respondent (Classical) Conditioning

Respondent (or classical) conditioning involves a situation where the pairing of two different stimuli changes the response to one of them (Martin & Pear, 2003). In the first instance, the existence of an unconditioned stimuli (UCS) produces an automatic or reflexive unconditioned response (UCR). The UCS is then paired with an unrelated conditioned stimulus (CS) that would ordinarily not elicit any response of note. Following a number of such pairings, the UCR which was initially elicited by the UCS becomes associated with the CS and becomes a conditioned response (CR) to the CS. For example, food in the mouth (an US) produces salivation (an UR). The repeated

pairing of ringing a bell (a CS) with the food in the mouth (UCS) will eventually lead to the ringing of the bell alone (CS) producing salivation (now a CR).

The corollary of the conditioning process described above, is that a CR may be extinguished by maintaining exposure to the CS whilst concurrently reducing or eliminating the CR. For instance, systematic desensitization (Wolpe, 1985) uses a combination of exposure and counter-conditioning to reduce anxiety responses to feared stimuli (e.g., specific phobias). Firstly, exposure to the feared CS commences at such a low level that the original anxiety CR does not occur. The exposure to the CS is gradually increased by a series of minimal increments, such that the original anxiety response is reduced. At the same time, a counter-conditioning process introduces a new CR (relaxation) that is incompatible with the original CR (anxiety). Respondent conditioning processes such as these are often operating in homework assignments for anxiety problems (Kazantzis & L'Abate, in press).

3.2 Operant Conditioning

Unlike respondent conditioning which focuses on pairing stimuli to condition their responses, operant conditioning focuses on the consequences that follow responses. Specifically, a consequence that causes a behaviour to increase is defined as a reinforcer, a consequence that causes a behaviour to decrease is a punisher, and consequences that are neutral tend to extinguish behaviours (Martin & Pear, 2003). These principles have a number of implications. For instance, if a client completes homework that was previously assigned and then the therapist does not review it in the next session, this could be a neutral consequence which might contribute to the homework behaviour being extinguished in future. It is also possible that the same

consequence may have different operant effects for different individuals. It is important therefore for a therapist to determine specific reinforcers for each client. For instance, different levels of verbal praise may have different reinforcing effects (i.e., some clients may need more praise than others for it to be reinforcing). Operant principles also have clear implications for psychopathology in that they may underpin various behaviours that perpetuate a client's presenting problems. From a homework perspective, assignments can be collaboratively designed to test out hypotheses about possible perpetuating behaviours, e.g., social isolation in depression, or avoidance in phobias (Kazantzis & L'Abate, *in press*). Furthermore, non-completion of assignments can yield as much useful information as completion, in that investigation of homework non-completion may uncover operant conditioning factors at work in the client's natural environment.

Two central tenets of homework assignments in CBT are the principles of generalisation and maintenance. Generalisation refers to transferring learned behaviour to new settings, and maintenance refers to making the new behaviours endure (Catania, 1992; Herzberg, 1941; Kanfer & Phillips, 1970; Martin & Pear, 2003). Therefore, without either of these principles operating, a skill learned within therapy would not be able to be used in different settings outside of therapy (no generalisation), and over time the learned skill would be lost and need to be relearned (no maintenance).

Behavioural theory suggests various techniques to improve stimulus generalisation, including varying the training condition, programming common stimuli and training sufficient stimulus exemplars, and also techniques to improve response generalisation, including training sufficient response exemplars and varying acceptable

responses during training (Martin & Pear, 2003). The clear implication for homework is that assignments that are designed and practised in session, need to be assigned and practiced outside of therapy in such a way as to provide for appropriate generalisation to the client's natural environment.

Similarly, behavioural theory also suggests various techniques to improve maintenance, including using natural contingencies of reinforcement and using intermittent schedules of reinforcement (Martin & Pear, 2003; Skinner, 1974). Thus, while therapist praise may be an important external reinforcer, it is important to consider other reinforcers in the natural environment that will provide intrinsic reward. Additionally, to increase the likelihood of maintenance, it is important that varying amounts of the target behaviour are practised over varying time periods. One method of achieving this aim would be to break a larger homework task down into smaller segments which are '*chained*' together to progressively '*shape*' the new behaviour (Kazantzis & L'Abate, in press; Martin & Pear, 2003). The successful completion of a number of smaller and different tasks would likely provide an increased sense of mastery and reduced distress (both natural reinforcers) and increased variation (intermittent reinforcement).

3.3 *Social Learning Theories*

Social learning theory is also relevant to the use of homework in CBT. The "Theory of Reasoned Action" (TRA: Ajzen & Fishbein, 1977) was subsequently revised and extended as the "Theory of Planned Behavior" (TPB: Ajzen, 1985; Ajzen, 1988). Both of these theories emphasise three aspects of behavioural intention: attitude

toward undertaking the activity, a subjective norm, and perceived behavioural control. Applied to homework in CBT, this theory implies that a client's motivation to undertake homework is influenced by a cost/benefit trade-off, the cost being the perceived difficulty of the homework assignment, and the benefit being the perceived gain from undertaking the homework assignment (Kazantzis & L'Abate, in press).

3.4 Social Cognition Theories

Social cognition theories further enhance our understanding of how homework may exert its influence in CBT. Bandura's (1977) social learning theory focused more on cognitive concepts and was subsequently renamed as "Social Cognitive Theory" (Bandura, 1986). Similar to the generic cognitive model for situational conceptualization (A. T. Beck et al., 1979; J. S. Beck, 1995; Greenberger & Padesky, 1995; Persons et al., 2001), Bandura emphasised the reciprocal relationships between the cognitive, emotional, behavioural and physiological facets of a person's experience together with the environment (Bandura, 1977, 1986). Central to Bandura's theory, and important in the context of homework compliance, is the concept of self-efficacy beliefs, which are a person's expectations about the degree of confidence that they can perform or endure the actions necessary to obtain a desired goal (Bandura, 1989). Furthermore, four processes are specified by which self-efficacy beliefs can be developed by individuals: (a) the interpreted results of previous performance or mastery experience, (b) learning through observation or modelling, (c) social persuasions received from others, and (d) somatic and emotional states. Each of these four processes have distinct implications for integrating homework assignments into therapy. Firstly, a client's willingness to participate in homework will be based on beliefs created from previous perceived successes and failures, and specific homework

assignments should be set which can build success beliefs. Secondly, modelling of homework assignments will be important where a client has little previous experience. Thirdly, therapists should encourage clients to develop confidence in their ability to complete homework. Finally, a client's emotional state will impact the degree of confidence they feel as they consider homework assignments (Kazantzis & L'Abate, in press).

A number of other specific models emerged from social cognition theory (see Armitage & Conner, 2000; Conner & Norman, 1996; Horne & Weinman, 1998), which also have implications for homework. The "Health Belief Model" (Janiz & Becker, 1984; Rosenstock, 1974) and the "Protection Motivation Theory" (Rogers, 1983; Rogers & Prentice-Dunn, 1997) are fairly similar motivational models of health behaviour. Like the social learning theories and social cognition theories already mentioned, these models effectively condense to the belief that an individual's behaviour and decisions are based on a subjective cost/benefit analysis of the likely outcomes of alternative courses of action (Armitage & Conner, 2000; Conner & Norman, 1996; Horne & Weinman, 1998). Thus, in addition to the implications for homework already mentioned, it is also important to address any barriers to the completion of homework assignments and highlight the benefits.

Due to the limitations of the motivational social cognition models as explanatory models for health behaviours, theorists have recently been proposing multi-stage models of health behaviour (Armitage & Conner, 2000; Horne & Weinman, 1998). Two models that have a number of appealing features are the five-stage "Transtheoretical Model" (DiClemente et al., 1991; Prochaska & DiClemente, 1983,

1984, 1986), and the seven-stage “Precaution Adoption Process” (Weinstein, 1988; Weinstein, Lyon, Sandman, & Cuite, 1998; Weinstein, Rothman, & Sutton, 1998). Other congruent models with varying stages include the “Health Action Process Approach” (Schwarzer, 1992) and the “Rubicon Model” (Heckhausen, 1991). These models generally differentiate between planning and action stages. However in the context of homework assignments it is not the stages of behaviour that are important per se, but the variables hypothesised to be important in a client progressing from one stage to the next (Kazantzis & L'Abate, in press). Stage models have been criticised for lacking in precise operational definitions of what actually happens in terms of social cognitive variables (Armitage & Conner, 2000).

One social cognition model that explicitly deals with the role of emotion as a predictor of health behaviour is the “Self-Regulation Model” (Cameron, 1997; Leventhal, 1970; Leventhal, Meyer, & Nerenz, 1980). The model proposes that a threat prompts motives to cope with emotional arousal caused by the threat as well as the actual threat itself. Thus, homework assignments that deal with the presenting problems (the threat) and alleviate the emotional distress are more likely to result in client adherence (Leventhal, Nerenz, & Steele, 1984).

Finally, the “Elaboration Likelihood Model” (Petty & Cacioppo, 1981, 1986) is a persuasion based model that proposes that an individual’s cognitive response to message content becomes important when they are motivated to process thoughtfully. In the homework context the implication is that persuasive messages from the therapist may be all that is required for the client to adopt a favourable attitude towards the homework assignment.

3.5 Summary

In summary, this section has described various theories and models that provide a theoretical basis for the use of homework and implications for how homework assignments could be implemented in therapy sessions. The broadest implication is that the techniques used by a therapist to implement homework assignments will impact on client compliance and therefore, according to empirical findings, treatment outcome.

CHAPTER 4

Guiding Model for Practice

From its early period through to modern day, CBT formulations continue to view homework assignments as an integral part of the therapy (e.g., A. T. Beck et al., 1979; J. S. Beck, 1995; Detweiler & Whisman, 1999; Persons et al., 2001; Scheel et al., 2004). Despite this, the empirical research noted in chapter two has been undertaken in the absence of a clear theoretical model, and as yet the means by which homework specifically generates its effects remains relatively unclear (Kazantzis, 2003; Scheel et al., 2004). It is only very recently that the theoretical and empirical underpinnings of CBT are being refined into preliminary models for practice (Kazantzis, MacEwan, & Datillio, in press; Scheel et al., 2004). This chapter reviews the strengths and limitations of the existing models and recommendations for practice. Next, a new guiding model for practice (Kazantzis, MacEwan et al., in press) is discussed, which meets the third objective of the team Cognitive Behavior Therapy Homework Project outlined in chapter one. This new guiding model will form the foundation for the measure development that is central to the present study (Chapter 7).

4.1 Existing Models and Recommendations for Practice

The use of homework assignments have been recommended for over half a century (Dunlap, 1932; Herzberg, 1941; Kanfer & Phillips, 1966; Masters & Johnson, 1970). This section focuses on the major models and recommendations for homework from the time of Beck's cognitive theory (A. T. Beck, 1976; A. T. Beck et al., 1979) onwards. This work was considered seminal and prior models were more behaviourally rather than cognitively based.

Shelton and Levy (1981) proposed a specific model for practice for integrating homework assignments in behaviour therapy. Their model for practice was consistent with the recommendations made by A. T. Beck et al. (1979) which highlighted that all therapy sessions should begin and end with a discussion about homework, and that the therapist should assign homework with a high degree of behavioural specificity. However, a number of criticisms of the model have also been raised.

Shelton and Levy's model (1981) was derived from empirical work intended to improve medication compliance. Given the medication background, and that fact that there have been significant advancements in the understanding and practice of cognitive therapy since 1981, a major criticism of the model is that it is not sufficiently flexible to accommodate the range of homework in CBT (Kazantzis, MacEwan et al., in press). A second criticism raised by Kazantzis, MacEwan, et al. (in press) is that the Shelton and Levy model (1981) does not sufficiently address the role of the therapeutic relationship in determining homework completion. For example, there is no consideration of what specific relationship or therapist qualities may improve or deter homework completion. Also, therapist beliefs are considered important in influencing behaviours in discussing homework (Padesky, 1999). Finally, a third criticism is that the Shelton and Levy model (1981) does not adequately deal with clients cognitions and beliefs in determining their level of homework completion (Kazantzis, MacEwan et al., in press). The role of the client's cognitive conceptualization has been identified by a number of authors as being central to understanding homework non completion (J. S. Beck, 1995; Persons, 1989; Persons et al., 2001). Some of the more common psychological barriers to completion of homework in depression include perfectionism / unrelenting standards,

desire for social acceptance, procrastination / fear of failure, and forgetting.

Furthermore, Chapter 3 outlined the theoretical bases for undertaking homework within CBT. In particular, the cognitive theories suggested that clients have existing beliefs that will determine whether a certain assignment will be attempted. Furthermore, a client will form beliefs based on the experience of having attempted a certain homework task, which will then influence their future completion or non-completion.

As discussed in chapter three, the behavioural principle of generalisation together with various social learning and social cognition models provide a theoretical understanding and basis for the use of homework assignments in CBT. In addition to specific implications that were noted in that section, it would also make sense that an overarching model for practice would incorporate client, therapist and task features, and the interrelationships between them. Detweiler and Whisman (1999) partially accomplish this with their heuristic model for understanding client homework compliance. Their model does incorporate client, therapist and task characteristics, representing an improvement over previous explanatory attempts which focused more on therapist behaviours (Shelton & Levy, 1981). However, while Detweiler and Whisman (1999) base their heuristic model on the research literature, it is limited by its focus on client adherence, does not draw on any theoretical bases for homework assignments and is not a guiding model for practice.

In contrast, the most recent model to appear in the literature (Scheel et al., 2004) proposes a theoretically and empirically based model of the homework recommendation process. The conceptual model has six stages: client-therapist formulation, therapist delivery, client receipt, implementation, therapist asking about

homework compliance, and client report of homework experience. Scheel et al (2004) propose brief practice strategies under each stage, with each strategy based on specific empirical support. While this appears a *prima facie* strength, a serious limitation is that the implications from the theoretical foundations of homework do not appear to have been incorporated in their strategies. In fact, it appears that significant aspects of both the theoretical bases and empirical literature have not been reviewed. As a consequence of the lack of breadth and depth in the theoretical and empirical review, their “model for practice” as presented has a limited scope.

4.2 *A New Guiding Model*

A new “guiding model for practice” has been proposed (Kazantzis, MacEwan et al., in press). This new guiding model (a) overcomes the limitations of the existing models and recommendations noted in Section 4.1, (b) consolidates, refines and makes explicit the voluminous recommendations that exist in the literature, and (c) ensures that the recommendations are empirically and theoretically grounded. The model synthesises the common process features and clinical recommendations from all the contributors to the book, which include inter alia, Jan Scott and Anne Garland (depression), Robert Leahy (panic, agoraphobia, and generalized anxiety), Jennifer Hudson and Philip Kendall (children), Frank Dattilio (couples and families), and David Coon, Larry Thompson and Dolores Gallagher-Thompson (older adults). In addition, the model also synthesised the recommendations that have appeared in numerous other publications (a limited selection includes: Detweiler & Whisman, 1999; Padesky & Greenberger, 1995; Persons et al., 2001; Scheel et al., 2004; Shelton & Levy, 1981; Tompkins, 2002). Finally, the model also drew extensively on the implications from

empirical and theoretical foundations of using homework, such as those outlined in chapters two and three.

A major advantage of this new model is that it makes explicit information that was either spread over several sources, or was difficult to glean as the information was buried within the text of existing literature. Furthermore, Kazantzis, MacEwan et al., (in press) suggest four improvements over previous models: (i) a focus on facilitative qualities of the therapeutic relationship, (ii) a focus on facilitative qualities of the therapist and therapist beliefs, (iii) specific grounding in the foundations of behavioural and cognitive theory, and (iv) emphasises the use of individual conceptualization for tailoring the content and process of homework administration.

The model conceptualises the process of recommending homework in CBT as a three stage cyclical process of reviewing previous homework, designing new homework, and assigning the homework as outlined in *Figure 1* below (Kazantzis, MacEwan et al., in press).

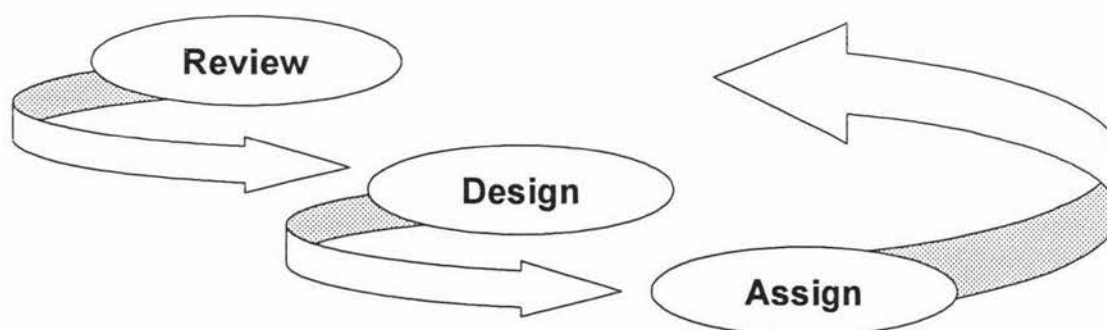


Figure 1. Cyclical process for recommending homework (Kazantzis, MacEwan et al., in press).

The key guiding model's recommendations are summarised in a Therapist Quick Reference (TQR) which outlines the key therapist behaviours in recommending homework assignments, under the headings of review, design and assign (Figure 2).

Therapist's Quick Reference *

1. REVIEW	2. DESIGN	3. ASSIGN
<ul style="list-style-type: none"> ♦ Discuss Non-Completion and <u>Quantity and Quality</u> of Completion ♦ Provide Verbal Reinforcement for <u>any</u> Portion Carried-Out ♦ Situational Conceptualization to Identify Beliefs about the Consequences, and their Synthesis of Learning ♦ Use Individualized Conceptualization to Make Sense of Persistent Non-Completion ♦ Problem-Solve Obstacles ♦ Record Homework Completion in session notes 	<ul style="list-style-type: none"> ♦ Guided Discovery to Identify Coping Strategies and Beliefs ♦ Use Disorder Specific Cognitive Model and Individualized Conceptualization ♦ Collaboratively Select Task ♦ Present a Rationale that Aligns with the Clients' Treatment Goals ♦ Ask about Client's Ability and Perceived Task Difficulty ♦ In- Session Practice of Task ♦ Guided Imagery to Begin Experiential Learning ♦ Situational Conceptualization to Identify Beliefs and Situational Triggers 	<ul style="list-style-type: none"> ♦ Ask Client to Summarize Rationale in Relation to Therapy Goals ♦ Collaborate to Specify How the Task Will be Practically Possible (i.e., when, where, how often, and how long it will take) ♦ Consider Potential Difficulties ♦ Emphasize Learning 'Experiment' Focus ♦ Ask Client to Summarize Task and Obtain Rating of Readiness, Importance, and Confidence (renegotiate if < 70%) ♦ Make a Written Note of the Homework for the Client (or Use Homework Form)

Therapists' Quick Reference © Copyright 2005 by Nikolaos Kazantzis, Frank Deane, and Kevin Ronan. From the book *Using Homework Assignments in Cognitive Behavior Therapy* edited by Kazantzis, Deane, Ronan, & L'Abate (2005) published by Brunner-Routledge.

Figure 2. Therapist Quick Reference (TQR).

CHAPTER 5

Measures of Therapist Adherence and Competence

The previous chapters have outlined the increasing attention that the role of homework and the process of recommending homework assignments has been receiving from empirical, theoretical and guiding model for practice perspectives. Furthermore, the creation of empirically supported treatments (see Chambless et al., 1996; Kendall & Chambless, 1998), together with standardised treatment manuals (Addis & Krasnow, 2000; Luborsky & DeRubeis, 1984; Waltz et al., 1993) has provided impetus for the increased measurement and evaluation of therapist adherence and competence. This measurement focus has been particularly notable in CBT (Barber et al., 2003; Dobson & Kazantzis, 2003; Kazantzis, 2003; Waltz et al., 1993) and with homework assignments specifically (Addis & Krasnow, 2000; Fehm & Fehm-Wolfsdorf, 2001; Padesky, 1999).

Moreover, the importance of measuring therapist adherence and competence is underscored by surveys which highlighted that while a large percentage of practitioners reported using homework assignments, they did not routinely adhere to practice recommendations for integrating that homework into practice (Kazantzis, Busch et al., 2004; Kazantzis & Deane, 1999). This chapter outlines the key existing measures have been designed to measure therapist adherence and/or competence in CBT.

5.1 *Cognitive Therapy Scale*

The Cognitive Therapy Scale (CTS: Young & Beck, 1980) is an 11 item scale that was designed to measure therapist competence in delivering CBT. However, only

one item expressly relates to the use of homework. A factor analysis of the scale identified two factors, skill and structure, with the homework item falling under the structure factor (Vallis, Shaw, & Dobson, 1986). A number of studies have undertaken psychometric evaluations of the CTS with very mixed results, and there has been difficulty establishing interrater reliability even among experts (for a review, see Kazantzis, 2003). A recent revision of the CTS (Milne, Claydon, Blackburn, James, & Sheikh, 2001) improved the reliability and validity of the original CTS by modifying several of the original items and adding three new items. However, the revised CTS is still limited by containing only one homework item.

The items in the CTS are rated using a seven point Likert scale, which is an appropriate number of points from a test development perspective (Streiner & Norman, 1995). However, a significant limitation is that only every second point is anchored with a description. The tendency in this case is that the labelled points tend to be endorsed more than the unlabelled points (Streiner & Norman, 1995). This that may be a factor contributing to the mixed psychometric results.

5.2 Collaborative Study Psychotherapy Rating Scale

The Collaborative Study Psychotherapy Rating Scale (CSPRS: Hollon et al., 1984) was designed as part of the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program (TDCRP: Elkin et al., 1985). The measure was designed to evaluate adherence to three different therapeutic approaches: CBT, interpersonal therapy and pharmacotherapy. The 96 item total scale includes 28 items that specifically assess CBT. The CBT total scale is then separated into six subscales, of which one subscale is homework. A psychometric evaluation

highlighted two discrete factors labelled CT-Abstract and CT-Concrete. The CT-Concrete scale, which included administration of homework, was found to be predictive of subsequent treatment outcome (DeRubeis & Feeley, 1990).

However there are concerns about the utility of both the CTS and CSPRS measures (Kazantzis, 2003; McGlinchey & Dobson, 2003; Shaw & Dobson, 1988). Neither instrument has been widely validated and the constructs of adherence and competence are overlapping, with neither instrument measuring both constructs (Barber et al., 2003). Additionally, these measures are limited in the number of items that evaluate both therapist adherence and competence in the use of homework assignments.

5.3 Cognitive Therapy Adherence and Competence Scale

The Cognitive Therapy Adherence and Competence Scale (CTACS: Barber et al., 2003; Liese, Barber, & Beck, 1995) is a recent revision of the CTS. With 21 items, the CTACS provides a much wider coverage of cognitive therapist's activities than the original 11 item CTS. Despite this, is still limited in its coverage of homework, with only two specific items. In comparison to the CTS and the CSPRS, a strength of the CTACS is that it separates the adherence and competence constructs, and measures both constructs using the same items and raters. The CTACS also exhibits strong psychometric properties, although the data has only been validated within the context of CBT for substance abuse (i.e., Barber et al., 2003; Kazantzis, 2003).

Similar to the CTS, it uses a seven point Likert scale. An improvement over the CTS is that all seven points on the Likert scale are anchored with descriptions, which may contribute to its improved reliability over the CTS. In the psychometric evaluation

of the CTACS (Barber et al., 2003) it was noted that the adherence construct was highly correlated with the competence construct. An explanation offered for this result was that raters confuse the two constructs, and thus rate them similarly. Another explanation could be that the CTACS measures adherence using the frequency of therapist behaviour as a proxy for adherence. The use of frequency as a proxy for adherence is questioned by this writer. It is possible raters could equate the frequency of an intervention as being the same as competence, and that could explain why the two constructs were highly correlated.

The question of how to measure adherence, and to distinguish it from competence remains an issue to be addressed in the development of the HAACS (Chapter 7).

5.4 Therapist Homework Assignment Competency Scale

Of particular relevance to the present study is the Therapist Homework Assignment Competency Scale (THACS: Bryant et al., 1999) which is the only measure designed to focus solely on therapist behaviours in administering homework. The THACS is a four item measure resulting from a revision of the single CTS homework item. Although developed nearly two decades after the original CTS, there was no attempt to incorporate more recent theoretical or empirical findings in the model (i.e., the content of Chapters 2, 3, and 4). Despite this limitation, the Bryant et al study (1999) as outlined in Chapter 2, provided preliminary data that therapist competence in reviewing homework as assessed by the THACS was a predictor of subsequent treatment outcome.

CHAPTER 6

The Present Study

6.1 *Summary*

To summarise, treatment-outcome research indicates that independent evaluation of therapist adherence and competence in delivering CBT are important factors. Theoretically and practically, homework assignments are a key aspect of helping client's acquire and generalise skills to their real life situations. Given this central role of homework within CBT, and data showing that therapist competence in delivering CBT structure (including homework) predicts treatment outcome, it is possible that therapist competence in facilitating homework alone may be a significant factor in the variance in CBT outcome.

Existing measures of therapist adherence and competence each have their own relative strengths, but have also been criticized for various aspects, including not being based on guiding theoretical models, having limited psychometric properties, confusing adherence and competency constructs, and having a limited number of homework specific items (i.e., between 1-4 items).

In conclusion, the aim of the present study is to develop a new measure of therapist adherence and competence in administering homework assignments in CBT, which is based on a theoretically grounded guiding model for practice, and retains the strengths while addressing the shortfalls in existing measures. The specific research objectives are outlined in Section 6.2.

6.2 *Research Objectives*

Chapter 1 outlined five specific research objectives that were set for the present study:

1. Describe empirical support, theoretical models and a guiding model for practice for the use of homework in CBT.
2. Describe the existing measures of therapist adherence and competence in the use of homework in CBT.
3. Develop a new measure to assess therapist adherence and competence in the use of homework in CBT.
4. Undertake a preliminary evaluation of the new measure with a sample diagnosed with major depressive disorder.
5. Discuss the findings and the implications for further research.

The first objective was covered in Chapters 2, 3, and 4, and the second objective was covered in Chapter 5. The remaining three objectives will be covered in Chapters 7-11) that follow.

CHAPTER 7

Measure Development

7.1 Introduction

The development of a new measure to assess therapist adherence and competence in the use of homework in CBT was THE fundamental undertaking in the present study. The development process consumed the largest proportion of total effort, both in time commitment and conceptual effort. For that reason, the development process and considerations that led to the production of the initial draft of the HAACS measure have been separated from the method (Chapter 8) and is described separately in this chapter.

Figure 3 highlights the importance of the information that was reviewed in chapters two through five as it related to the development of the HAACS.

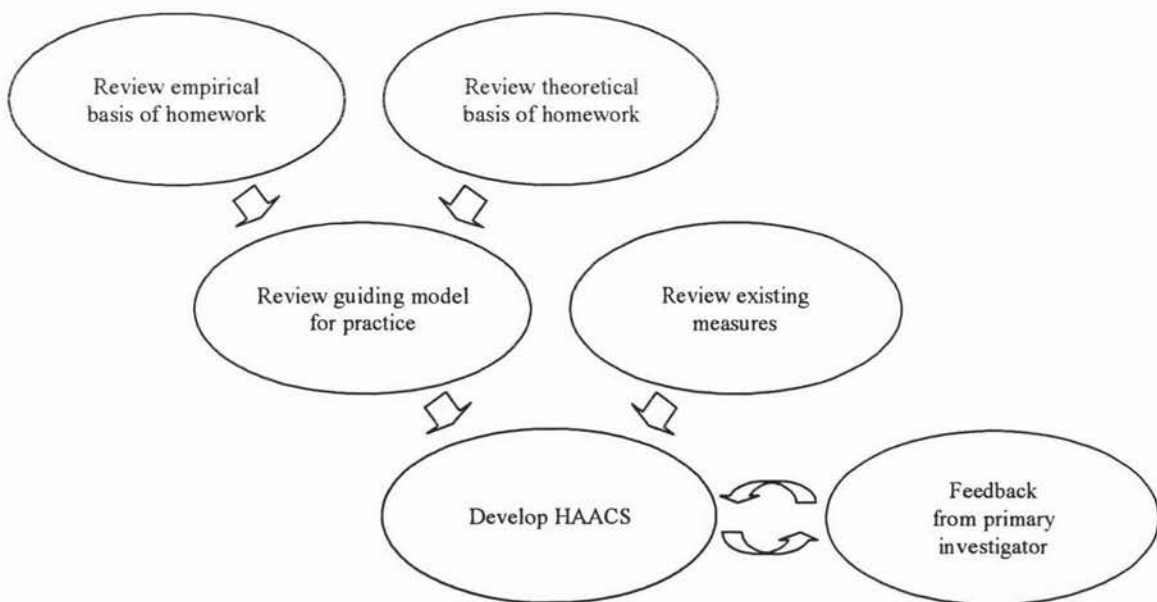


Figure 3. Overview of the development of the initial version of the HAACS.

The empirical and theoretical reviews (Chapters 2 and 3) provided key information for the development of the guiding model for practice (Chapter 4). The key recommendations from the guiding model for practice were summarised in the TQR (Figure 2) which formed the starting point for item selection in the HAACS (Section 7.2 below). Reviews of existing measures of therapist adherence and competence (Chapter 5) provided a starting point for decision making regarding adherence and competence item scaling (Sections 7.3 and 7.4 respectively).

7.2 *Item Selection and Wording*

Following the extensive conceptual review process described above (*Figure 3*), the original 20-item TQR became the starting point for item selection. The first decision was to evaluate the TQR items to determine whether they were suitable for inclusion in an observational rating measure. It was decided that it was not feasible to include one review item (recording homework completion in session notes), and one assign item (making a written note of the homework). From an adherence perspective it may have been possible to observe if these tasks were completed, but it would not have been possible to rate the items for competence based on observation alone. This reduced the total item pool to 18 items. During the iterative discussion process with the primary investigator, it was determined that the measure would benefit from an additional design item (discussing new homework at an appropriate time). This resulted in 19 items being identified for the initial HAACS measure.

As noted in Chapter 5, a significant strength of the CTACS measure was its separation of adherence and competence constructs, and measuring both constructs using the same items and raters. Accordingly, the same approach was adopted in the

development of the HAACS. The next step then, was to take each of the brief item descriptions from the TQR, and reword them into two different questions: an adherence question and a competence question. The adherence questions began with “Did the therapist ...” and the competence questions began with “How well did the therapist ...”. For example, *Figure 4* illustrates how the TQR item for problem solving obstacles was translated into adherence and competence items in the HAACS.

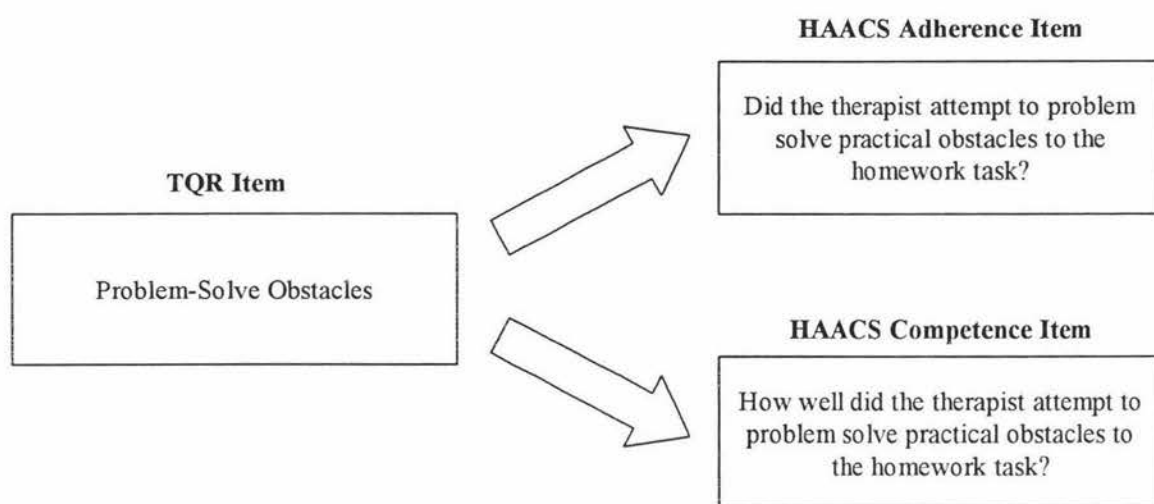


Figure 4. Example translation of a TQR item into a HAACS adherence and competence item.

7.3 Adherence Items and Scaling

The next consideration was how to scale the adherence items. Again, the CTACS was used as an initial consideration, based on its strengths as noted in Chapter 5, and the decision (see Section 7.2) to follow a similar approach for measuring adherence and competence constructs. It was noted that the authors of the CTACS (Barber et al., 2003) followed the approach taken by Barber, Krakauer, Calvo, Badgio, and Faude (1997) and measured adherence with a 7-point Likert scale, using frequency as a proxy for adherence. A weakness of the CTACS noted in Chapter 5, was that it only contained two items for homework administration: one item for reviewing homework, and one

item for assigning homework (and ignored homework design). In contrast, there are a number of specific therapist activities that comprise reviewing, designing and assigning homework, which were detailed in separate items in the HAACS. *Figure 5* compares the single CTACS item for reviewing homework with the five items in the HAACS. Similarly, *Figure 6* compares the single CTACS item for assigning homework with the fourteen design and assign items in the HAACS.

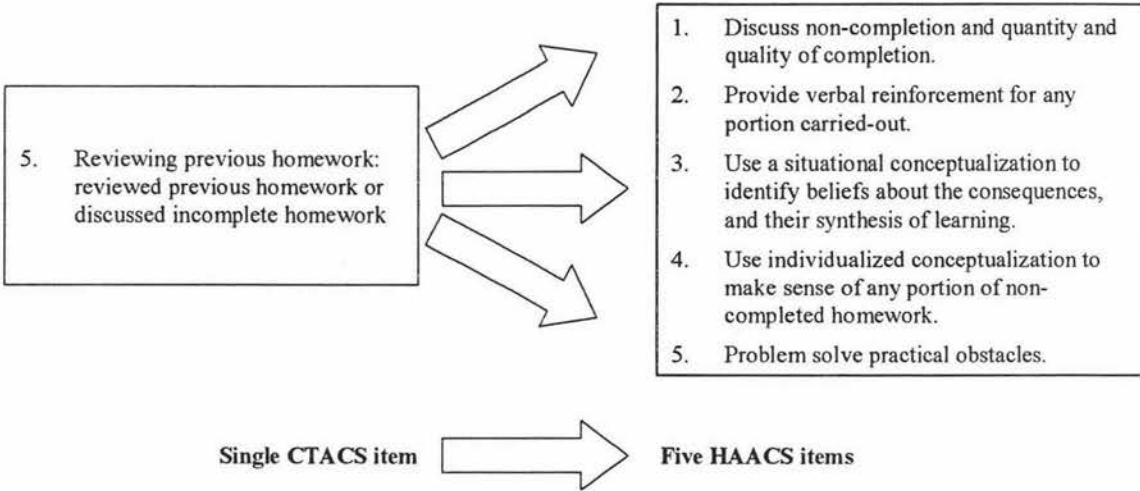


Figure 5. Comparison of CTACS and HAACS homework review items.

When an item is kept at a broad level (e.g., reviewing homework in the CTACS) then measuring frequency with a Likert scale may be appropriate, given that a number of activities can be performed which signify frequency and therefore adherence. However, when that same broad item is broken into several specific activities (i.e., the items in the HAACS), then the use of frequency no longer applies, as the specific activity is either performed or not performed. Based on that analysis, a major decision was reached to depart from the CTACS methodology, and to measure the adherence items in the HAACS using a dichotomous “yes-no” rating system.

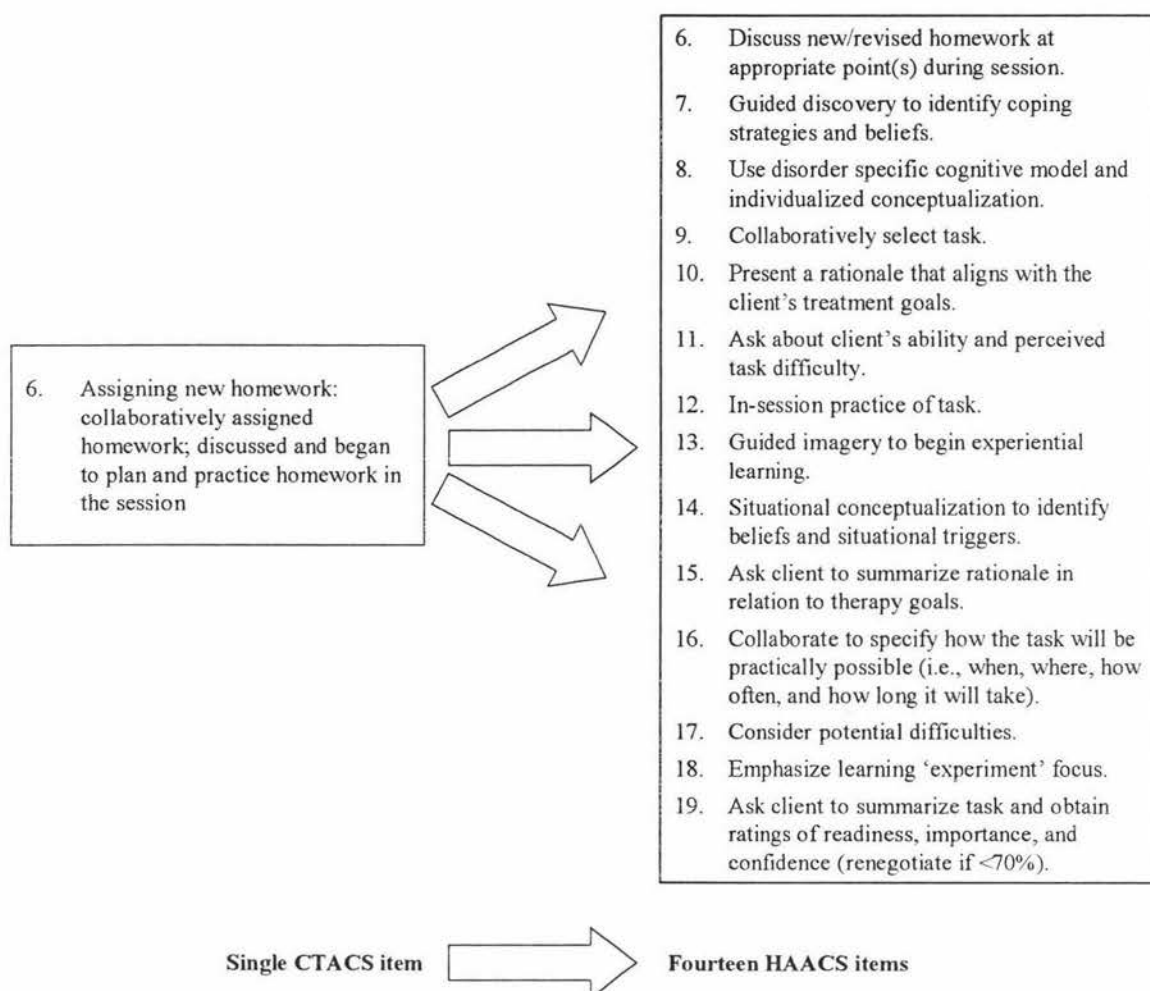


Figure 6. Comparison of CTACS and HAACS homework design and assign items.

7.4 Competence Items and Scaling

Unlike the adherence construct, the decision to use a Likert scaling system for the competence construct was straightforward and consistent with all the measures reviewed in Chapter 5. Consistent with the CTACS (and CTS), it was decided that a seven point Likert scale be used. Furthermore, a number of studies suggest that using less than five points significantly reduces reliability, whereas exceeding seven points provides little incremental reliability (Streiner & Norman, 1995). The final decision required prior to constructing the competence item scales was how many of the seven points should be anchored with descriptions. A weakness noted with the CTS (Chapter

5) was that only every second point was anchored. Moreover, Streiner and Norman (1995) note that the anchored points tend to be endorsed more often than the non-anchored points. They also note that the decision to only label every other point is often made because the scale constructor cannot think of enough adjectives for every single point. Taking these considerations into account, the decision was made to anchor every single point with detailed descriptions to facilitate interrater reliability. This labelling approach was consistent with the CTACS which reported good reliability (Barber et al., 2003).

An underlying Likert scale was created where 0 = non-adherence/extremely poor, 1 = poor, 2 = mediocre, 3 = fair, 4 = good, 5 = very good, and 6 = excellent. Then for each of the 19 competence items, anchors were created that described what therapist behaviour would look like for each of points on the underlying scale. The downside of the approach taken was that it significantly increased the development time for the HAACS. It required 133 descriptive anchors to be written (i.e., 19 items x 7 anchors). In contrast, anchoring every second point would have required 76 descriptive anchors to be written (i.e., 19 items x 4 anchors). Creating the 133 descriptive anchors proved to be a lengthy and iterative process, with feedback sought at regular intervals from the primary investigator. Care was taken to ensure that the descriptive anchors reflected therapist behaviours that would be displayed for each specific item. Furthermore, each of the anchor descriptions had to build in complexity from 0 to 6, with each incremental step reflecting an appropriate increase from the previous step, and remaining consistent with the underlying Likert scale.

Finally, based on feedback from the primary investigator, the HAACS was reformatted to produce a look that was consistent with other measures developed and being used in the Cognitive Behavior Therapy Homework Project. The first version of the HAACS that was used for training purposes is attached in Appendix A, and a illustrative competence item is provided in *Figure 7*.

CD6	<u>How well did the therapist ask about the client's ability and perceived difficulty of the homework task?</u>	Rating	<div></div>
0	The therapist did not ask about the client's ability and perceived difficulty of the task.		
1	The therapist made a cursory enquiry about the client's ability and perceived difficulty of the task, but did not discuss it any further.		
2	The therapist enquired about the client's ability and perceived difficulty of the task, and made an ineffective attempt to elicit feedback from the client (e.g., the therapist did not listen to the client's responses, asked closed questions, questions did not follow the client's responses).		
3	The therapist enquired about the client's ability and perceived difficulty of the task, and elicited a general statement from the client, for example, the client was vague and said "Sure, I can do it" and this response was taken at face value and not probed any further.		
4	The therapist enquired about the client's ability and perceived difficulty of the task, and through Socratic questioning identified a broad issue (e.g., "That thought record looks too hard. There is so much to complete"). However, the therapist then provided their own solutions to resolve the issues raised (e.g., "Okay, just complete the first three columns of the thought record")		
5	The therapist enquired about the client's ability and perceived difficulty of the task, and through Socratic questioning identified specific issues (e.g., in addition to feeling overwhelmed by the entire thought record, it transpired that the client had difficulty distinguishing emotions and thoughts on thought record). Through further exploration the therapist and client collaboratively resolved the issue (e.g., the therapist and client worked on automatic thoughts in-session, and/or the homework was redesigned to focus on practicing the identification emotions as distinct from automatic thoughts).		
6	The therapist enquired about the client's ability and perceived difficulty of the task, and through Socratic questioning identified specific issues. Through further exploration the therapist and client collaboratively resolved the issue. The therapist also elicited additional client learning from the discussion, for example, the client learnt that breaking items into smaller chunks was less overwhelming, and also identified an underlying rule (e.g., "I've failed if I can't work things out for myself").		

Figure 7. Example item from the first version of the HAACS.

CHAPTER 8

Method

8.1 Overview

The development of the initial version of the HAACS measure was a major undertaking in the present study. Accordingly, the method for that particular process was ring-fenced and described separately in Chapter 7. This chapter completes the method by describing the pilot testing process undertaken to evaluate and revise the HAACS (see *Figure 8* for an overview of the process).

Following the initial development of the HAACS, a group of five independent raters were employed and trained in the use of the HAACS (Section 8.3 and Appendix B). Based on informal feedback received from the raters during the training, the HAACS underwent its first revision (Section 8.4 and Appendix C). One week later the raters participated in the first pilot study where they used the revised HAACS to rate four DVD recorded CBT sessions (Section 8.2). This took place over the course of a single day, with all raters gathered together, rating the same sessions concurrently, without discussion between rating sessions. In addition to the raw data collected from the first pilot, the raters also completed a formal feedback questionnaire at the conclusion of the pilot (Appendix D). The questionnaire allowed the raters to rate and comment on the training, the measure in general (i.e., instructions, format, and ease of use), and also any difficulties and ambiguities experienced with individual items and descriptive anchors. Furthermore, the HAACS was then forwarded for substantive comment to Professor Keith Dobson, international collaborator on the

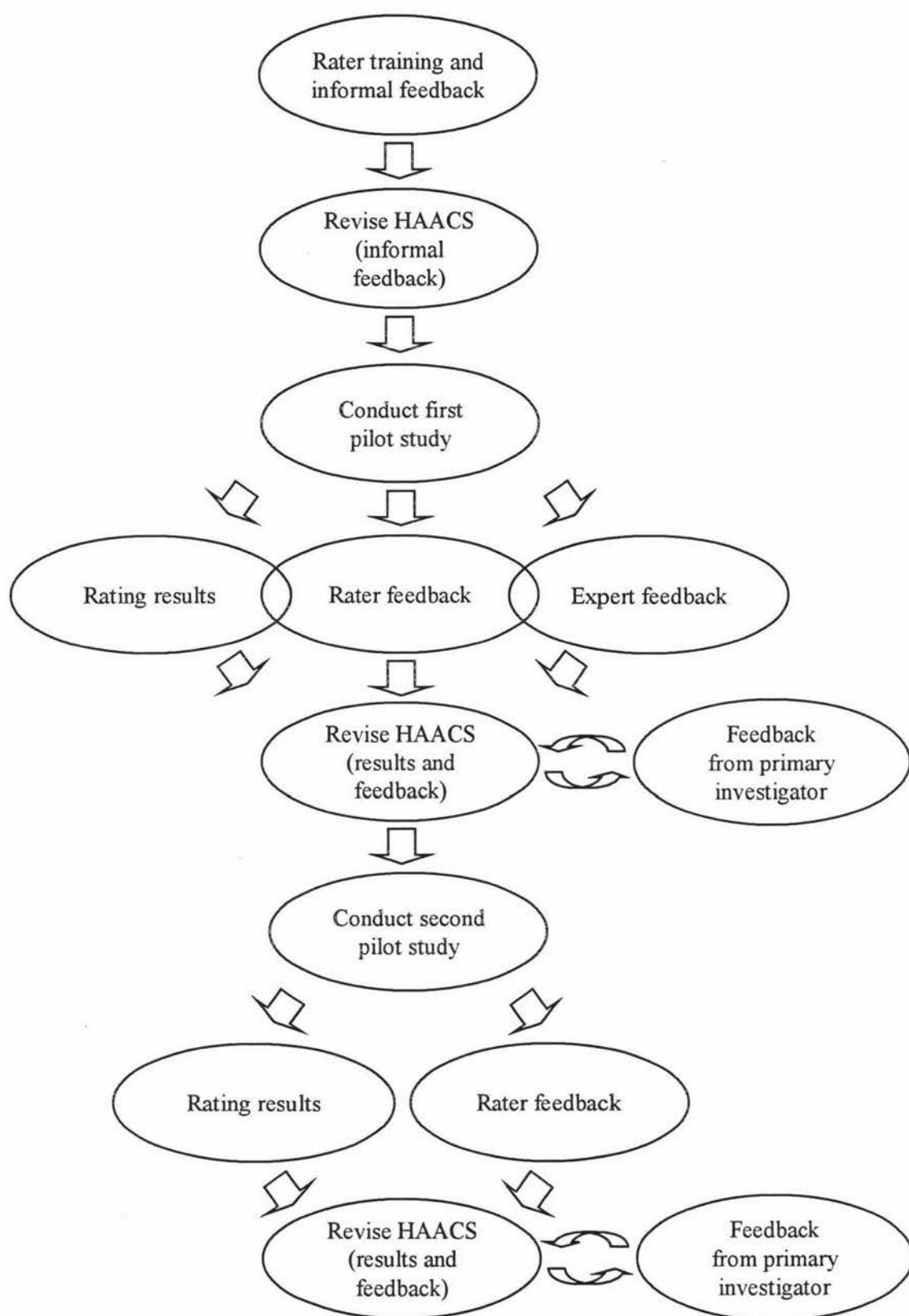


Figure 8. Overview of the evaluation and revision methodological process.

Cognitive and Behavior Therapy Homework Project, and also to associated members of the research team at Massey University. On the basis of the analysis of the data collected from the first pilot, the rater feedback, and the expert feedback, the HAACS was further amended and a second revision produced (Appendix E).

Initially, a second pilot study to evaluate the second revision of the HAACS was scheduled to take place a few weeks after the first pilot study. However, there were a number of unforeseen circumstances and delays during the feedback and revision process, which was compounded by the summer Christmas holiday period. Consequently, the second pilot study was not able to be conducted until sixteen weeks after the first pilot study. Due to the lengthy period between the two pilot studies, it was decided to use the same DVD sessions from pilot one. The rationale was to maintain consistency between the pilot studies, with the major change being the different version of the HAACS. Consistent with the first pilot, a whole day was arranged for the raters to complete pilot study two. Unfortunately, one rater was unable to attend the scheduled day, so that rater completed the ratings a few days later, over two consecutive evenings. The data from the second pilot study was analysed and feedback again obtained from the raters. This resulted in the third and final revision of the HAACS (Appendix F).

8.2 *Client and Therapist Data*

This study used archived data recorded on digital Video Disk (DVD) format, obtained from a recently completed National Institute of Mental Health (NIMH) component analysis of depression study (Dimidjian et al., 2003; Dobson et al., 2003; Jacobson & Gortner, 2000). The clients in the NIMH study were all diagnosed with major depressive disorder, met standard inclusion criteria, and had been randomly

assigned to the CBT group in the study. Three trained therapists conducted the CBT sessions, including two therapists that had participated in a prior component analysis of CBT for depression study (Jacobson et al., 1996) also funded by the NIMH.

Approval to use the archived data (including prior ethical approval and client consent in the U.S.A.) was obtained through Keith Dobson, the international collaborator for the present study, and researcher in the original NIMH study (Dobson et al., 2003). Ethical approval in New Zealand was covered by a Massey University Low Risk Notification which was received by the Assistant to the Vice-Chancellor (Ethics & Equity) on 14 July 2004.

The four sessions rated in the present study were taken from the same therapist and client dyad, and covered four consecutive sessions (sessions four to seven). The aim of the pilot testing process at this stage of development was to evaluate the clarity of the HAACS content. The decision not to vary the therapist-client dyad and use four consecutive sessions was made to keep as many aspects of the study as stable as possible, and keep the focus on the use of the measure. The decision to focus on consistency and context, rather than evaluating different stages of therapy is also supported by Waltz et al. (1993). This method of using trained independent observers to evaluate recorded therapy sessions was recommended for general use in clinical research (Waltz et al., 1993), and was the method used for the CSPRS and also in the evaluation of the CTACS.

8.3 *Raters*

Five raters (four female, one male) rated four CBT sessions recorded on DVD. The raters average age was 34.8 years (range 24 to 44 years). Four were graduate clinical psychology students and the fifth was a first year registered clinical psychologist. As a minimum requirement, raters had to have completed three specific Massey University clinical psychology papers. The first required paper "Psychotherapy I: Theory, Research and Practice" contained an introduction to CBT principles and structure, including CBT for depression. The second required paper "Psychotherapy II: Theory, Research and Practice" included information on the empirical findings regarding the use of homework across different therapy approaches (including CBT). The third required paper "Theory and Practice of Cognitive Behaviour Therapy" focussed on CBT principles, structure, and the use of CBT techniques. The paper also provided an opportunity for participants to rate three CBT video sessions using the CTS. This was considered a valuable prelude to undertaking a similar task in the present study.

Training was conducted for approximately seven hours over the course of a single day. The training material used is attached in Appendix B. The training provided the context for the present study, namely the Cognitive Behavior Therapy Homework Project, summaries of Chapters 2-5, and the aims and method of the present study. An opportunity was provided to brainstorm existing knowledge of the use of homework in CBT, and then the guiding model for practice, the TQR and HAACS were introduced. Next, specific CBT terminology used in the HAACS was discussed, as was the distinction between the adherence and competence constructs. Common rating

considerations were noted (e.g., rater bias, halo effects, leniency effects), and then finally the raters participated in a trial rating session.

8.4 Measure

The HAACS was the measure used in the present study, and the development of the first version of the HAACS was outlined in Chapter 7. Based on preliminary feedback from the rater training session (Section 8.3), significant changes were made to the formatting of the HAACS and the instructions, with the intention of making it easier to use. The item and anchor content remained unchanged. The first revision of the HAACS is attached in Appendix C.

Additional feedback from the training resulted in the TQR (Figure 2) from the guiding model for practice being adapted for use while rating the HAACS. Specifically, the content of the TQR was amended to match the specific items contained in the HAACS (see Chapter 7: two items were removed from the original TQR and one new item was added). Furthermore, each item in the TQR-Amended was numbered to match the item number in the HAACS. Each item in the TQR-Amended also had the page number of the HAACS item noted in brackets (see Figure 9).

Figure 9. Therapist Quick Reference - Adapted for rating the HAACS (version one).

Therapist's Quick Reference* - Adapted for Rating the HAACS

REVIEW	DESIGN	ASSIGN
<ol style="list-style-type: none"> 1. Discuss non-completion and quantity and quality of completion (p.3). 2. Provide verbal reinforcement for any portion carried-out (p.4). 3. Situational conceptualization to identify beliefs about the consequences, and their synthesis of learning (p.5). 4. Use individualized conceptualization to make sense of any portion of non-completed homework. (p.6) 5. Problem solve practical obstacles (p.7). 	<ol style="list-style-type: none"> 6. Discuss new/revised homework at appropriate point(s) during session (p.8). 7. Guided discovery to identify coping strategies and beliefs (p.9). 8. Use disorder specific cognitive model and individualized conceptualization (p.10). 9. Collaboratively select task (p.11). 10. Present a rationale that aligns with the client's treatment goals (p. 12). 11. Ask about client's ability and perceived task difficulty (p.13). 12. In-session practice of task (p.14). 13. Guided imagery to begin experiential learning (p.15). 14. Situational conceptualization to identify beliefs and situational triggers (p.16). 	<ol style="list-style-type: none"> 15. Ask client to summarize rationale in relation to therapy goals (p.17). 16. Collaborate to specify how the task will be practically possible (i.e., when, where, how often, and how long it will take) (p.18). 17. Consider potential difficulties (p.19). 18. Emphasize learning 'experiment' focus (p.20). 19. Ask client to summarize task and obtain ratings of readiness, importance, and confidence (renegotiate if <70%) (p.21).

*Therapist Quick Reference © Copyright 2005 by Nikolaos Kazantzis, Frank Deane, and Kevin Ronan. From the book "Using Homework Assignments in Cognitive Behavior Therapy" edited by Kazantzis, Deane, Ronan, & L'Abate (2005) published by Brunner-Routledge.

8.5 *Data Analysis*

The use of observational measures such as the HAACS requires a great deal of judgement to be made by the raters. Thus, the rater can be a major factor in the reliability of the measure, and the calculation and reporting of interobserver or interrater reliability is required (Gregory, 2000). There are numerous options for analysing agreement type data, however, there is little consensus in the literature about which measure is best (Uebersax, 2003; Vincent, 2002). The key to deciding which methods are appropriate in a particular study hinges on establishing the purpose of the analysis and the questions that need answering (Uebersax, 2003). Given that the key aim of this study was to evaluate the HAACS measure during its early development phase, the primary analytical goals were (a) to identify whether the measure should be altered to improve its clarity, and (b) to provide a preliminary indication of interrater reliability.

To meet the first analytical goal, formal rater feedback was sought. ~~regarding~~. The rater feedback questionnaire asked them to rate the training, measure instructions, measure format, measure ease of use, and the clarity of individual items and anchors, using a six point Likert scale ranging from 1=do not agree, to 6=totally agree (a copy is attached in Appendix D). To further assist with the identification of which items required scrutiny to improve agreement, the distributions of rater scores across individual items were also analysed to identify problematic items and potential causes of disagreement.

To meet the second goal, two different measures were required. Firstly, the Intraclass Correlation Coefficient (ICC: Shrout & Fleiss, 1979) was used as the

preliminary estimate of interrater reliability for the ordinal competence ratings. This was consistent with recent literature for evaluating interrater agreement or reliability within CBT (Barber et al., 2003; Persons & Bertagnolli, 1999). In contrast, a percentage of agreement statistic was used for the dichotomous adherence ratings (Uebersax, 2003). This involved creating a cross-tabulation table for every pair of raters (i.e., a total of ten cross-tabulation pairings) comparing their agreement for every item in four possible categories (i.e., no-no, no-yes, yes-no, and yes-yes).

CHAPTER 9

Pilot Study One

9.1 *Introduction*

The major purpose of pilot study one was to generate preliminary data to enable the newly developed HAACS measure to be evaluated and improved. As outlined in chapter eight, five raters used the HAACS measure to rate four CBT sessions recorded on DVD. The raters completed a feedback questionnaire form with the results summarised in Section 9.2. The adherence rating scores were used to calculate percentage agreement statistics, and the competence rating scores were used to calculate inter-rater reliability and to identify the distribution of scores. Section 9.3 summarises the adherence and competence rating score results. The HAACS was also forwarded for expert feedback, and the comments received are noted in Section 9.4. Finally, Section 9.5 discusses the analysis of the results, and the resulting changes that were made to the HAACS and the TQR prior to the second pilot study.

9.2 *Results - Rater Feedback*

At the conclusion of session four, the raters completed a formal feedback questionnaire (Appendix D) which asked them to rate a series of questions using a six point Likert scale ranging from 1=do not agree, to 6=totally agree. This section summarises the results of the feedback by providing the rater's mean rating. With only five raters it was not useful to calculate standard deviations, so instead high and low scores are reported. Table 1 provides the rater responses to the first four general questions. It was decided that a mean rating of less than five (i.e., less than "mostly

agree”) could indicate a problematic item. Two questions (regarding clarity of instructions and clarity of formatting) had a mean rating greater than or equal to five (mostly agree). However, the other two items (regarding effectiveness of training and measure ease of use) were rated lower than five, indicating that the raters did not feel adequately prepared for using the measure, and that the measure could be easier to use.

Table 1

Rater Feedback For Pilot One General Questions

Question	Lowest rating	Highest rating	Mean rating
The training fully prepared me for using the measure	3	6	4.60
The instructions were clear	4	6	5.00
The measure was clearly formatted	5	6	5.40
The measure was easy to use	2	5	4.00

Note. Items rated as follows: 1 (*do not agree*), 2 (*barely agree*), 3 (*mildly agree*), 4 (*tend to agree*), 5 (*mostly agree*), 6 (*totally agree*).

Following the first four general questions, each of the 19 HAACS items then had two questions. The first question asked if the description for the item was clear (applies to adherence and competence), and the second question asked if the anchors for the item were clear (applies to competence only). Again, raters used the same six point Likert scale. The results from these questions is presented in Table 2. Looking firstly at the item description questions, items 3, 4, 6, 8, 14, 16, and 19 (37% of the total items) had a mean rating of less than 5. Turning secondly to the item anchor questions, items 3, 4, 6, 9, 14, 18, and 19 (37% of the total items) had a mean rating of less than 5.

Table 2

Rater Feedback For Pilot One Item and Anchor Descriptions

Item	Item description			Anchor description		
	Lowest rating	Highest rating	Mean rating	Lowest rating	Highest rating	Mean rating
1	6	6	6.00	4	6	5.00
2	6	6	6.00	4	6	5.00
3	2	5	4.00	2	6	4.00
4	1	6	4.00	4	6	4.40
5	5	6	5.80	5	6	5.80
6	1	6	4.60	3	6	4.80
7	4	6	5.20	4	6	5.20
8	4	6	4.80	4	6	5.00
9	4	6	5.60	3	6	4.60
10	5	6	5.80	4	6	5.00
11	5	6	5.80	5	6	5.20
12	4	6	5.40	5	6	5.60
13	5	6	5.40	5	6	5.40
14	3	6	4.00	3	6	4.40
15	6	6	6.00	3	6	5.40
16	1	6	4.80	4	6	5.00
17	5	6	5.80	4	6	5.40
18	4	6	5.40	3	6	4.80
19	2	6	4.60	1	5	4.00

Note. Items rated as follows: 1 (*do not agree*), 2 (*barely agree*), 3 (*mildly agree*), 4 (*tend to agree*), 5 (*mostly agree*), 6 (*totally agree*).

These problematic items were compared with the actual rating results to identify further investigation (Section 9.3).

9.3 Results – Rating Scores

Adherence Data

For each session in pilot study one, the data for each rater was cross-tabulated against every other rater, producing a total of ten cross-tabulation pairings. Each cross-tabulation compared the 19 individual adherence items into the four possible combinations (i.e., no-no, no-yes, yes-no, and yes-yes). As an example, Table 3 shows the cross-tabulation data calculated for pilot one, producing a total of 760 parings (i.e., 10 rater-pairings x 19 items x 4 sessions).

Table 3

Rater by Rater Cross-Tabulation for Pilot One Adherence Items

		Rater-I		Total
		No	Yes	
Rater-II	No	122	82	204
	Yes	118	438	556
	Total	240	520	760

Similar to Table 3, cross-tabulation data were also constructed for each of the four individual sessions, however the number of pairings dropped to 190 (i.e., 10 rater-pairings x 19 items). The resulting data was then used to calculate the percentage agreement figures for each individual session, and for pilot one in total. As Table 4 highlights, the percentage agreement figures for the individual sessions were reasonably

consistent. All sessions achieved greater than 70% agreement, within a range of 72% to 78%, with the overall result for pilot one being 74%. Established guidelines for evaluating levels of agreement with dichotomous data (such as kappa) state that when the reliability coefficient is between .60 and .74 then the level of clinical significance is good, and when the reliability coefficient is between .75 and 1.00 then the level of clinical significance is excellent (Cicchetti, 1994; Cicchetti & Sparrow, 1981; Fleiss, 1981).

Table 4

Percent Agreement Statistics for Pilot One Adherence Items by Individual Session

Session	% overall agreement
1	78%
2	72%
3	74%
4	72%
OVERALL	74%

Furthermore, the cross-tabulation data was calculated on an item-by-item basis for all of pilot one. However, only 40 pairings were available at the individual item level (i.e., 10 rater-pairings x 4 sessions). It was decided that less than 70% agreement could indicate problematic agreement. As shown in Table 5, the percentage agreement statistics for individual items ranged from 40% to 100%. Within this range, nearly half of the individual items (47%) achieved less than 70% overall agreement (items 8, 9, 12,

13, 14, 15, 16, 18, and 19). These item-by-item results were far more variable than the reasonably consistent results found in the session by session and overall pilot one statistics (Table 4). This result was not completely unexpected though, as variation would become more apparent with the smaller individual item dataset.

Next, the items identified as problematic from the rater feedback questionnaire (mean rating <5.00) were compared with those items identified as problematic from the percentage agreement statistics ($<70\%$ agreement). Table 6 shows that of the 12 items identified as problematic, four items (i.e., 8, 14, 16, and 19) were problematic both from a clarity perspective (raters feedback) and from the actual ratings. A further three items (i.e., 3, 4, and 6) were identified by the raters feedback as unclear, although they actually achieved 90%-100% agreement when rating the items. The remaining five items (i.e., 9, 12, 13, 15, and 18) were problematic from the actual ratings, although the rater's feedback indicated the items were clear. The implications and corrective steps taken are outlined in the discussion Section (9.5) that follows.

Competence Data

The competence ratings were entered into SPSS to calculate the ICC(2,5) for each of the four individual sessions and also for pilot one overall. Table 7 presents the ICC results together with 95% confidence intervals. The ICC's increased steadily from .828 in session one to .870 in session four. The ICC for pilot one was .838 with 95% confidence that the actual ICC fell within the range of .766 to .891. Established guidelines for evaluating levels of ICC state that when the reliability coefficient is between .75 and 1.00 (as these are) then the level of clinical significance is excellent (Cicchetti, 1994; Cicchetti & Sparrow, 1981; Fleiss, 1981).

Table 5

Percent Agreement Statistics for Pilot One Adherence Items by Individual Item

Item	% agreement
1	100%
2	100%
3	90%
4	100%
5	75%
6	90%
7	70%
8	65%
9	60%
10	90%
11	80%
12	65%
13	65%
14	40%
15	50%
16	55%
17	90%
18	65%
19	50%

Table 6

Problematic Adherence Items for Pilot One

Item	Rater feedback:	
	mean item description rating	% agreement
3	4.00	90%
4	4.00	100%
6	4.60	90%
8	4.80	65%
9	5.60	60%
12	5.40	65%
13	5.40	65%
14	4.00	40%
15	6.00	50%
16	4.80	55%
18	5.40	65%
19	4.60	50%

Note. Rater feedback rated as follows: 1 (*do not agree*), 2 (*barely agree*), 3 (*mildly agree*), 4 (*tend to agree*), 5 (*mostly agree*), 6 (*totally agree*).

The main purpose of calculating ICC was to provide a preliminary indication of interrater agreement for the HAACS overall, and as indicated it achieved an excellent level of clinical significance. However, a major aim of this pilot study was also to identify individual items that required revision to improve the measure. The data analysis section in Chapter 8 outlined the rationale for analysing the distributions of rater scores for individual items. Distribution graphs were produced (Appendix G) and

Table 7

Intraclass Correlation Coefficients for Pilot One Competence Items by Individual Session

Session	ICC	95% Confidence Interval	
		Lower	Upper
1	.828	.669	.925
2	.828	.668	.925
3	.842	.667	.933
4	.870	.739	.944
Overall	.838	.766	.891

reviewed to identify problematic items. The basis for an item being regarded problematic was that for a majority of the sessions, few raters agreed on the rating score, AND the scores were widely distributed. A two-step process was used to identify the problematic items for each session. Firstly, items were selected where three or fewer raters selected the same rating score. Secondly, if the distribution of all rating scores was within three consecutive scores for the same item, then the item was acceptable, otherwise it remained a problematic item for that session. Next, the problematic items for each of the four session were compared, and those items that were problematic for more than half the sessions were finally selected. This resulted in seven competence items being identified as problematic (items 3, 6, 7, 9, 11, 14, and 16).

Next, the items identified as problematic from the rater feedback questionnaire were compared with the seven items identified as problematic from the distribution analysis above. Table 8 shows that of the 10 items identified as problematic, four items

Table 8
Problematic Competence Items for Pilot One

Item	Rater feedback: mean item description rating	Rating distribution problem
3	4.00	3/4 sessions
4	4.40	0/4 sessions
6	4.80	3/4 sessions
7	5.20	3/4 sessions
9	4.60	3/4 sessions
11	5.20	3/4 sessions
14	4.40	3/4 sessions
16	5.00	3/4 sessions
18	4.80	0/4 sessions
19	4.00	0/4 sessions

Note. Rater feedback rated as follows: 1 (*do not agree*), 2 (*barely agree*), 3 (*mildly agree*), 4 (*tend to agree*), 5 (*mostly agree*), 6 (*totally agree*).

(i.e., 3, 6, 9, and 14) were problematic both from a clarity perspective (raters feedback) and from the actual ratings. A further three items (i.e., 4, 18, and 19) were identified by the raters feedback as unclear, although the same items did not meet problematic rating criteria for any of the four session. The remaining three items (i.e., 7, 11, and 16) were problematic from the actual rating distributions, although the rater’s feedback indicated

the items were clear. The implications and corrective steps taken are outlined in the discussion (Section 9.5) that follows.

9.4 Results - Expert Feedback

The measure was forwarded for substantive comment to Professor Keith Dobson, international collaborator on the Cognitive and Behavior Therapy Homework Project, and also to associated members of the research team at Massey University. The general feedback received from this process was extremely positive. It was felt that the TQR (summarising the guiding model for practice) was very comprehensive and there was a very good translation from the theoretically based model to the HAACS measure. The measure itself was thought to be very well formatted. The decision to use dichotomous ratings for adherence was concurred with, and preferred over other measures that had elected to use Likert scales to rate frequency (as a proxy for adherence). The decision to anchor all seven points on the Likert scale was particularly commended. It was acknowledged that this was a large undertaking, however the time was well spent as the descriptive anchors were very good and would improve the reliability of the measure.

Some specific wording changes were recommended to reduce ambiguity. These were consistent with the difficulties identified from analysing rater feedback (Section 9.2) and rating results (Section 9.3). The most significant recommendation was to include global rating scales for each of the three sections in the HAACS: review, design, and assign. This was recommended to assist with scoring of the HAACS, particularly as the context of the session could affect the scores on individual HAACS

items. For example, the homework administration may have been adapted appropriately based on the client conceptualization and presentation.

9.5 Discussion

Pilot study one provided preliminary evidence that the level of interrater agreement represented a good (bordering on excellent) level of clinical significance for the adherence construct, and an excellent level of clinical significance for the competence construct, according to generally accepted guidelines (Cicchetti, 1994; Cicchetti & Sparrow, 1981; Fleiss, 1981). These results were very pleasing in the context of a first pilot study for a newly developed measure. However a limitation to these findings is the limited quantity of data (i.e., five raters and four sessions rated).

In addition to providing preliminary evidence of interrater reliability, a key aim of the first pilot study was to evaluate whether the HAACS formatting, items and anchors were clear, unambiguous and easy to use. The analysis outlined in the results section identified that the measure could have been easier to use, and also contained some problematic adherence items (Table 6) and problematic competence items (Table 8). In reviewing the items that appeared problematic, cross-reference was made to individual rater feedback questionnaires (Appendix D), in which raters were asked to provide additional written comments if they had provided a low score for an item. A particular theme emerged, in that the raters found ambiguity and confusion between adherence items and competence anchors. They noted that the instructions and the training had emphasised the difference between adherence and competence, and that if there was no adherence then there could be no competence. For example, adherence item nine asked

if the therapist *collaboratively* selected/designed homework, but competence anchor one (representing adherence, but “poor” competence) stated the therapist selected/designed homework *without any contribution from the client*. These two statements were clearly in conflict. Similar confusion existed with a number of other items. As a result, all items and anchors were reviewed, and if appropriate were reworded to remove the ambiguity. In the above example, the word *collaboratively* was removed and the adherence item was reworded to ask *were homework tasks selected*. This removed the conflict with anchor one.

Other commentary from the feedback questionnaires suggested some confusion and lack of understanding of CBT terminology used in the measure (e.g., situational conceptualization versus individualized conceptualization). These comments were consistent with the rater feedback that the training did not fully prepare them, but could also reflect a degree of inexperience. Other comments suggested difficulties identifying from the DVD sessions whether particular items were indeed carried out. This again is suggestive of a lack of practical experience observing CBT and identifying technical aspects as they are completed in therapy. An implication is that the ability to use the HAACS effectively may require a greater level of experience than the raters used in the pilot study. This factor was underestimated, and suggests that the raters would have benefited from significantly enhanced training, and further practice sessions before undertaking the first pilot study. A further implication was that some items that were identified as problematic from pilot study one were not amended, but instead were tagged as requiring further explanation prior to running the second pilot study.

Table 9 provides a summary of the item and anchor descriptions that were reworded for the second revision of the HAACS, prior to pilot study two. The major changes to the original items related to the removal of the ambiguity between adherence and poor competence, as highlighted in the discussion section above. Other changes included correcting typing and formatting mistakes, improving the grammar, and general readability of item and anchor descriptions. The instructions were also reworded slightly to improve clarity.

Furthermore, three new global ratings were added to the second revision of the HAACS, as suggested by international collaborator on the Cognitive and Behavior Therapy Homework Project. These items were designed to provide raters with the opportunity to provide an overall rating for each of the three aspects of homework administration (review, design, and assign), taking into account the appropriateness of not adhering to certain items, and any other special or contextual factors.

In addition to the content changes noted in Table 9, a number of formatting changes took place with the intention of improving ease of use. Firstly, to assist the raters to identify key differences between anchors, the key words signifying changes between anchors were capitalised. For example, *Figure 10* shows how the capitalisation of the phrase “BOTH ... AS WELL AS” distinguished anchor five from the phrase “EITHER ... OR” in anchor four.

Table 9

Summary of Content Changes Incorporated into the Second Revision of the HAACS

Item	Item descriptions reworded	Anchor descriptions reworded
1	Adherence and competence	0, 1, 4
2	Adherence	-
3	Adherence and competence	0, 6
4	Adherence and competence	4, 5, 6, added a new n/a anchor
6	Adherence and competence	0, 1, 2, 3, 4, 5, 6
7	Adherence	-
8	Adherence and competence	0, 1
9	Adherence and competence	0, 4,5,6
10	Adherence	0, 3
12	Adherence	3, 4, 5, 6
14	Adherence and competence	-
15	Adherence	-
16	Adherence	-
17	Adherence and competence	-
18	Adherence	1
19	Adherence and competence	0, 1, 3, 4, 5, 6
20	New global item for therapist competence in "review"	-
21	New global item for therapist competence in "design"	-
22	New global item for therapist competence in "assign"	-

- | |
|--|
| <p>4 The therapist assisted the client to understand that the homework was broken into achievable CHUNKS that were manageable and within the client's control. The therapist ALSO assisted the client to understand how the homework was ALIGNED to EITHER the specific presenting problem in the current session, OR their overall treatment goals.</p> <p>5 The therapist assisted the client to understand that the homework was broken into achievable CHUNKS that were manageable and within the client's control. The therapist ALSO assisted the client to understand how the homework was ALIGNED to BOTH the specific presenting problem in the current session AS WELL AS their overall treatment goals.</p> |
|--|

Figure 10. Comparison of anchors 4 and 5 from Item 10 in the HAACS second revision.

A second formatting change was that the three different sections in the HAACS were copied on different coloured paper (yellow for review, pink for design, and blue for assign). In conjunction with this change, the three sections in the TQR were also colour coded to match the new colour coding in the HAACS and facilitate easy cross-reference for the raters. Furthermore, the reference to page numbers was removed from each item in the TQR. Instead the HAACS itself underwent reformatting of page numbers so that each item number corresponded to the same page number (i.e., item 1 was on page 1, item 9 was on page 9, etc.). Therefore, the items numbers used in the TQR corresponded to the same item and page number in the HAACS, again facilitating easier cross-referencing for the raters.

The revised TQR is reproduced in *Figure 11* below, in black and white (the original was colour coded). The second revision of the HAACS is attached in Appendix E, again in black and white (the original was colour coded).

Figure 11. Therapist Quick Reference - Adapted for rating the HAACS (version two).

Therapist's Quick Reference* - Adapted for Rating the HAACS

REVIEW	DESIGN	ASSIGN
<ol style="list-style-type: none"> 1. Discuss non-completion and quantity and quality of completion. 2. Provide verbal reinforcement for any portion carried-out. 3. Situational conceptualization to identify beliefs about the consequences, and their synthesis of learning. 4. Use individualized conceptualization to make sense of any portion of non-completed homework. 5. Problem solve practical obstacles. 	<ol style="list-style-type: none"> 6. Discuss new/revised homework at appropriate point(s) during session. 7. Guided discovery to identify coping strategies and beliefs. 8. Use disorder specific cognitive model and individualized conceptualization. 9. Collaboratively select task. 10. Present a rationale that aligns with the client's treatment goals. 11. Ask about client's ability and perceived task difficulty. 12. In-session practice of task. 13. Guided imagery to begin experiential learning. 14. Situational conceptualization to identify beliefs and situational triggers. 	<ol style="list-style-type: none"> 15. Ask client to summarize rationale in relation to therapy goals. 16. Collaborate to specify how the task will be practically possible (i.e., when, where, how often, and how long it will take). 17. Consider potential difficulties. 18. Emphasize learning 'experiment' focus. 19. Ask client to summarize task and obtain ratings of readiness, importance, and confidence (renegotiate if <70%).

• The item numbers above correspond to page numbers in the HAACS

*Therapist Quick Reference © Copyright 2005 by Nikolaos Kazantzis, Frank Deane, and Kevin Ronan. From the book "Using Homework Assignments in Cognitive Behavior Therapy" edited by Kazantzis, Deane, Ronan, & L'Abate (2005) published by Brunner-Routledge.

CHAPTER 10

Pilot Study 2

10.1 Introduction

The major purpose of pilot study two was to evaluate the impact of the changes that were made to the HAACS after pilot study one (Chapter 9). The process for pilot study two was similar to pilot study one. Five raters used the second revision of the HAACS measure to rate four CBT sessions recorded on DVD. The raters again completed a feedback questionnaire form with the results summarised in Section 10.2. The adherence rating scores were used to calculate percentage agreement statistics, and the competence rating scores were used to calculate inter-rater reliability and to identify the distribution of scores (Section 10.3). Given the quality of expert feedback received previously, expert feedback was not sought for pilot study two. Finally, Section 10.4 discusses the analysis of the results, and the resulting changes that were made to the HAACS.

10.2 Results - Rater Feedback

At the conclusion of all sessions, the raters once again completed the feedback questionnaire which was described previously (Chapters 8 and 9, and Appendix D). Again, the same criteria was used where a mean rating of less than five could indicate a problematic item. Table 10 provides a comparison of the rater responses to the first four general questions in pilot study two against the results obtained from pilot study one. The mean rating for each of the four questions had improved from pilot study one. The pilot study two responses ranged from 5.00 to 5.60, which meant that none of the

questions were considered problematic (compared with two problematic questions in pilot study one).

Table 10

Rater Feedback for Pilot Two General Questions, Compared With Pilot One

Item	Pilot two			Pilot one		
	Lowest rating	Highest rating	Mean rating	Lowest rating	Highest rating	Mean rating
The training fully prepared me for using the measure	4	6	5.00	3	6	4.60
The instructions were clear	4	6	5.20	4	6	5.00
The measure was clearly formatted	5	6	5.60	5	6	5.40
The measure was easy to use	3	6	5.00	2	5	4.00

Note. Items rated as follows: 1 (*do not agree*), 2 (*barely agree*), 3 (*mildly agree*), 4 (*tend to agree*), 5 (*mostly agree*), 6 (*totally agree*).

As with pilot study one, the raters again provided ratings for the clarity of the item and anchor descriptions. A comparison of pilot study two's results against pilot study one's results is shown in Table 11 for the item descriptions, and in Table 12 for the anchor descriptions.

In total only three item descriptions, or 14% (cf. 37% in pilot study one) were considered problematic. All of the item descriptions considered problematic in pilot study one had improved beyond the threshold, whereas item 7 which was previously considered acceptable was now considered problematic. The other two items considered problematic were two of the three new global rating questions.

Table 11

Rater Feedback for Pilot Two Item Description Ratings, Compared With Pilot One

Item	Pilot two Item description			Pilot one Item description		
	Lowest rating	Highest rating	Mean rating	Lowest rating	Highest rating	Mean rating
1	5	6	5.80	6	6	6.00
2	6	6	6.00	6	6	6.00
3	3	6	5.40	2	5	4.00
4	4	6	5.20	1	6	4.00
5	4	6	5.60	5	6	5.80
6	6	6	6.00	1	6	4.60
7	3	6	4.40	4	6	5.20
8	4	6	5.00	4	6	4.80
9	3	6	5.20	4	6	5.60
10	5	6	5.80	5	6	5.80
11	5	6	5.80	5	6	5.80
12	5	6	5.80	4	6	5.40
13	4	6	5.20	5	6	5.40
14	5	6	5.60	3	6	4.00
15	5	6	5.80	6	6	6.00
16	5	6	5.80	1	6	4.80
17	4	6	5.60	5	6	5.80
18	5	6	5.80	4	6	5.40
19	5	6	5.80	2	6	4.60
20 ^a	3	5	4.40			
21 ^a	3	5	4.40			
22 ^a	3	6	5.00			

Note. Items rated as follows: 1 (*do not agree*), 2 (*barely agree*), 3 (*mildly agree*), 4 (*tend to agree*), 5 (*mostly agree*), 6 (*totally agree*).

^a Items 20-22 were new global ratings added after pilot one, and therefore have no comparative data from pilot one.

Table 12

Rater Feedback for Pilot Two Anchor Description Ratings, Compared With Pilot One

Item	Pilot two Anchor description			Pilot one Anchor description		
	Lowest rating	Highest rating	Mean rating	Lowest rating	Highest rating	Mean rating
1	5	6	4.20	4	6	5.00
2	6	6	5.60	4	6	5.00
3	3	6	5.00	2	6	4.00
4	4	6	5.40	4	6	4.40
5	4	6	5.20	5	6	5.80
6	6	6	4.40	3	6	4.80
7	3	6	4.20	4	6	5.20
8	4	6	5.00	4	6	5.00
9	3	6	5.20	3	6	4.60
10	5	6	5.60	4	6	5.00
11	5	6	5.20	5	6	5.20
12	5	6	5.60	5	6	5.60
13	4	6	5.00	5	6	5.40
14	5	6	5.00	3	6	4.40
15	5	6	5.00	3	6	5.40
16	5	6	5.40	4	6	5.00
17	4	6	5.40	4	6	5.40
18	5	6	5.20	3	6	4.80
19	5	6	5.60	1	5	4.00

Note. Items rated as follows: 1 (*do not agree*), 2 (*barely agree*), 3 (*mildly agree*), 4 (*tend to agree*), 5 (*mostly agree*), 6 (*totally agree*). The new global ratings (items 20-22)

In pilot study one, seven of the anchor descriptions were considered problematic (37%), whereas this had dropped to just three anchor descriptions (16%) in pilot study two. Six of the seven previously problematic anchor descriptions were now acceptable, with item 6 remaining problematic. The two new anchor descriptions now consider

problematic were item 1, and item 7 (for which the item description was also considered problematic. These results will be evaluated in the context of the actual rating results in Section 10.3 below.

10.3 Results – Ratings Data

Adherence Data

Consistent with pilot study one, cross-tabulations were constructed for the adherence rating results for pilot study two. The data for pilot study two in total is shown in Table 13 below. It contains the same 760 pairings, however in comparison to pilot study one, more of the pairings fall within the agreement cells (i.e., yes-yes, and no-no) than in the disagreement cells (i.e., no-yes, and yes-no). As would be expected from such results, the agreement statistics for pilot study two improved across the board as shown in Table 14 below.

Table 13
Rater by Rater Cross-Tabulation for Pilot Two Adherence Items

		Rater-I		Total
		No	Yes	
Rater-II	No	104	50	154
	Yes	66	540	606
	Total	170	590	760

Each individual session increased in agreement, with the most notable improvement being session four, increasing from 72% to 94%. The sessions in pilot

study two ranged between 75% and 94%, with the total agreement statistic for pilot study two being 85%. Using the generally accepted guidelines for evaluating reliability statistics (Cicchetti, 1994; Cicchetti & Sparrow, 1981; Fleiss, 1981) all of the agreement statistics were in the range of excellent clinical significance (compared with good clinical significance in pilot study one).

Table 14
Percent Agreement Statistics for Pilot Two Adherence Items by Individual Session, Compared With Pilot One

Session	% Overall Agreement	
	Pilot Two	Pilot One
1	87%	78%
2	75%	72%
3	83%	74%
4	94%	72%
Overall	85%	74%

As with the first pilot study, agreement statistics were calculated for individual items. A comparison of pilot study two results against pilot study one is shown in Table 15. Previously, nine of the items (47%) were deemed problematic (less than 70% agreement), whereas in pilot study two this dropped to six items (32%). However, the composition of items considered problematic varied significantly from pilot study one. Four of the previous items remained problematic (items 13, 14, 15, and 18), two new items became problematic (item 3 from 90% to 65%, and item 5 from 75% to 60%), and five previously problematic items improved (items 8, 9, 12, 16, and 19). Unlike

Table 15

*Percent Agreement Statistics for Pilot Two Adherence Items by Individual Item,
Compared With Pilot One*

Item	% Overall Agreement	
	Pilot Two	Pilot One
1	100%	100%
2	100%	100%
3	65%	90%
4	90%	100%
5	60%	75%
6	100%	90%
7	85%	70%
8	100%	65%
9	100%	60%
10	85%	90%
11	90%	80%
12	80%	65%
13	50%	65%
14	50%	40%
15	65%	50%
16	70%	55%
17	75%	90%
18	55%	65%
19	90%	50%

Chapter 9, a table of problematic adherence items has not been produced, instead a discussion of these results is outlined in Section 10.4.

Competence Data

SPSS was used to calculate the ICC(2,5) for each of the four individual sessions and pilot study two overall. The results for pilot study two are shown in Table 16 together with the results from pilot study one. Unlike pilot study one where the ICC increased steadily from session one to four, in pilot study two the ICC dropped steadily from .808 in session one through to .740 in session three, before increasing significantly to .861 in the final session (very close to .870 achieved in the final session of the first pilot study). The overall ICC for pilot study two was .792 (cf. .838 for pilot study one). Although the ICC's were lower in pilot study two, they were all within the range of excellent clinical significance, except for session three which was in the good range (Cicchetti, 1994; Cicchetti & Sparrow, 1981; Fleiss, 1981).

Distribution graphs of rater responses were produced for pilot study two (Appendix G). Using the same analytical method outlined in Chapter 9, seven items were identified as problematic. However these were not all the same seven items identified as problematic in pilot study one. Items 3, 7, and 11 remained problematic, whereas items 1, 12, 13, and 18 became problematic (not in pilot study one), and items 6, 9, 14, and 16 that were problematic in pilot study one, were acceptable in the second pilot study. Consistent with the adherence results above, a table of problematic competence items has not been produced. Instead, a discussion of these results is outlined in Section 10.4.

Table 16

Intraclass Correlation Coefficients for Pilot Two Competence Items by Individual Session, Compared with Pilot One

Session	ICC	Pilot Two Lower ^a	Upper ^a	ICC	Pilot One Lower ^a	Upper ^a
1	.808	.643	.910	.828	.669	.925
2	.755	.549	.885	.828	.668	.925
3	.740	.520	.878	.842	.667	.933
4	.861	.732	.936	.870	.739	.944
Overall	.792	.708	.855	.838	.766	.891

^a "Lower" and "upper" refer to the boundaries of the 95% confidence interval

10.4 Discussion

Significant changes were made to the HAACS used in the first pilot study, following analysis of the pilot study one results. This included a comprehensive assessment of rater feedback, actual rating results, and expert feedback (Chapter 9). Given that background, the major purpose of pilot study two was to evaluate whether the changes to the HAACS represented an improvement.

The results of the rater feedback questionnaire clearly demonstrated an improvement over the pilot one HAACS. The raters indicated that the instructions were clear, the measure was clearly formatted and was easy to use. However, two of the three new global ratings (items 20 and 21) were viewed as problematic. Given that these items were new and therefore rated for the first time, the rater feedback comments were reviewed. Following discussion with the primary investigator, all three global

ratings (items 20, 21, and 22) were significantly reworded and reformatted. Similarly, items 6 and 7 were considered problematic by the raters, and were reviewed with the primary investigator. Item 6 was reworded and item 7 was significantly reformatted to improve their clarity. The rater feedback also indicated that item one had problematic anchor descriptions. The anchors were carefully reviewed with the primary investigator, however were not able to be simplified any further.

A limitation of relying on rater feedback in the second pilot study was that the raters were not 'blind' to the purpose of the pilot study, so may have been swayed by social desirability and a desire to provide a positive response to the questionnaire. However, partially offsetting this limitation was the 16 week gap between pilot studies one and two, which made it difficult for the raters to remember their previous ratings.

The adherence rating results were much improved with pilot study two achieving 85% agreement (deemed excellent) compared with 74% agreement (deemed good) in pilot study one. This was a pleasing result given the emphasis that was placed on rewording the adherence items to remove ambiguity. The competence rating results fell slightly, with the ICC falling from .838 for pilot study one to .792 for pilot study two. Although the ICC fell slightly, both statistics are deemed to be in the excellent range of clinical significance.

While the rater feedback and overall adherence and competence results were very pleasing, evaluation of adherence and competence statistics at the individual item level showed surprising variation between pilot studies one and two. There are a number of limitations that could explain these results. Firstly, there was a unexpected and

protracted 16 week delay between pilot studies one and two (see Chapter 8). This possibly contributed to a loss of learning, with some raters commenting that it was almost like looking at the measure for the first time again. Unlike the first pilot which was preceded by a full day training, the second pilot was preceded by a one hour recap, which included discussion of problematic items and changes to the measure. In retrospect, it would have been beneficial to hold another training day, given the length between the two pilot studies. It would also have been beneficial to have allowed extra time to conduct practice rating sessions (i.e., as was done during the training day prior to pilot study one). A further limitation in pilot study two was that one rater was unavailable for the full-day rating session, so received a separate update and conducted the ratings over two consecutive evenings (two days after other raters). This could have produced variance due to that rater inadvertently receiving different information.

Due to the limitations noted in the discussion section, it was decided that rater feedback (rather than individual item rating results) would guide any final changes to the HAACS. Table 17 provides a summary of the item and anchor descriptions that were reworded after pilot study two.

Items 6 was reworded, whereas items 7, 20, 21, and 22 were reworded and reformatted. It is believed that these final changes have greatly improved the clarity of the HAACS. In addition to the wording and format changes to the global rating scales, they were also relocated to the end of the appropriate section (i.e., review, design, assign) rather than all placed at the end of the measure.

Table 17

Summary of Content Changes Incorporated into the Final Revision of the HAACS

Item	Item descriptions reworded	Anchor descriptions reworded
6	Adherence and competence	0, 3, 4, 5, 6
7	Adherence and competence	0, 1, 2, 3, 4, 5, 6
20	Competence	-
21	Competence	-
22	Competence	-

The final version of the HAACS is attached in Appendix F, in black and white, although the actual HAACS is colour coded as described in Chapter 9.

CHAPTER 11

Discussion

Chapter 9 (pilot study one) and Chapter 10 (pilot study two) each contained discussion sections that related specifically to the results of that respective pilot study. This final discussion chapter is not intended to repeat or summarise the discussion from the previous chapters, but rather to discuss the limitations and findings of the present study overall, and the implications for future practice and research.

11.1 Limitations

The present study was limited to a preliminary evaluation as part of the development process, which involved generating items and anchors, evaluating and improving the clarity of those items and anchors, and providing a preliminary psychometric measure of interrater reliability. The next step required in the development of the HAACS is to undertake a full psychometric evaluation. A specific limitation in the present study was that a small dataset was used (five raters and four sessions). It is recommended that a power analysis be undertaken to determine an appropriate number of raters and sessions to be rated, which would then facilitate a more robust evaluation of reliability and validity. By utilising a larger dataset, a full psychometric evaluation could be undertaken, which in addition to providing a more robust measure of interrater reliability, could also include test-retest reliability, construct validity (e.g., item analysis), and concurrent validity (e.g., using homework items from measures such as the CTS, CTACS and THACS, and comparing them to the HAACS).

Furthermore, the raters in the present study were graduate clinical psychology students, whose major role was to use the measure and provide feedback to improve the clarity of the HAACS. The raters fulfilled this role very well, and they made a large contribution to the improvement in the HAACS during the course of the study. However, feedback received from the raters also highlighted the complexity of the HAACS and that a relatively high level of experience is required to competently use the HAACS. It is therefore recommended that suitably trained and experienced clinical supervisors are required to undertake the full psychometric evaluation.

Another limitation in the present study was that the CBT sessions rated were limited to clients with depression. It would be important to examine the ecological validity and clinical utility of the HAACS by testing whether the measure will generalise to populations other than depression. Furthermore, as homework is becoming increasingly common across a range of therapies, the HAACS could also form the basis for adaptations to therapies other than CBT.

11.2 Clinical Implications

It is anticipated that the HAACS measure will make a contribution to the field of clinical psychology with both clinical and empirical applications. A clinical application of the present study is that the HAACS could take a central role in both the initial training and ongoing supervision of CBT therapists. The guiding model for practice brought together the latest empirical and theoretical bases for using homework assignments in CBT, and the HAACS extends that information by providing behavioural anchors that describe various competence levels. The major benefit of the HAACS is that it not only details *what* should be done, but also provides detailed

descriptions of *how* it should be done. While the comprehensive nature of the HAACS can be considered a strength, its length could also have a downside. During the expert feedback process, it was noted that the HAACS was a very long measure which contained a lot of items regarding just one aspect of CBT, and would be difficult to use regularly in supervision. From a practitioner perspective it would be impractical to rate the full HAACS and use it in every supervision session. It is anticipated that the HAACS would best be used on an occasional basis to help identify specific areas that require input during supervision.

11.3 Empirical Implications

It is anticipated that the present study will form the foundation for a number of future empirical applications. The present study highlighted the significance of treatment-outcome studies in CBT, the emphasis of measuring therapist adherence and competence in delivering CBT, and the current emphasis on the use of homework assignments in CBT. These factors formed the basis for the development of the HAACS as a new measure for assessing therapist adherence and competence in administering homework assignments in CBT.

Once the HAACS has been suitable validated, further empirical applications could be explored. One such application is to determine whether scores on the HAACS correlate with client homework compliance, thus examining if therapist adherence and competence in using homework in CBT can predict client homework compliance. Further empirical applications include determining whether scores on the HAACS correlate with symptom improvement, and examining whether therapist adherence and competence in administering homework in CBT can predict treatment outcome.

11.4 Conclusion

In summary, the present study represents the first step in the development of the HAACS as a new measure for assessing therapist adherence and competence in administering homework assignments within CBT. The HAACS was developed from sound empirical and theoretical bases, and accordingly has excellent face and content validity. The detailed item and anchor development phase resulted in an initial measure that from the outset had good interrater reliability for the adherence construct, and excellent interrater reliability for the competence construct. The reiterative pilot testing process, in-depth rater and expert feedback, and detailed analysis of rating scores and distributions produced an improved measure that had excellent interrater reliability for both the adherence and competence constructs. A full psychometric evaluation to further validate the HAACS will be conducted within the context of the team Cognitive Behavior Therapy Homework Project. Following the validation, the HAACS will provide a significant contribution to the team research project aim of developing an understanding of the mechanism by which homework produces its effect in CBT.

REFERENCES

- Addis, M. E., & Jacobson, N. S. (2000). A closer look at the treatment rationale and homework compliance in cognitive behavioral therapy for depression. *Cognitive Therapy and Research*, 24, 313-326.
- Addis, M. E., & Krasnow, A. D. (2000). A national survey of practicing psychologists' attitudes toward psychotherapy treatment manuals. *Journal of Consulting and Clinical Psychology*, 68(2), 331-339.
- Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhl & J. Beckman (Eds.), *Action-control: From cognition to behavior* (pp. 11-39). Heidelberg: Springer.
- Ajzen, I. (1988). *Attitudes, personality, and behavior*. Chicago, IL: Dorsey Press.
- Ajzen, I., & Fishbein, M. (1977). Attitude-behavior relations: A theoretical analysis and review of empirical research. *Psychological Bulletin*, 84, 888-914.
- Armitage, C. J., & Conner, M. (2000). Social cognition models and health behaviour: A structured review. *Psychology and Health*, 15, 173-189.
- Badgio, P. C., Halperin, G. A., & Barber, J. P. (1999). Acquisition of adaptive skills: Psychotherapeutic change in cognitive and dynamic therapies. *Clinical Psychology Review*, 19, 721-737.
- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84, 191-215.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice hall.
- Bandura, A. (1989). Human agency in social cognitive theory. *American Psychologist*, 44, 1175-1184.

- Barber, J. P., Krakauer, I., Calvo, N., Badgio, P. C., & Faude, J. (1997). Measuring adherence and competence of dynamic therapists in the treatment of cocaine dependence. *Journal of Psychotherapy Practice and Research*, 6, 12-24.
- Barber, J. P., Liese, B. S., & Abrams, M. J. (2003). Development of the cognitive therapy adherence and competence scale. *Psychotherapy Research*, 13, 205-221.
- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Guilford Press.
- Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York: The Guilford Press.
- Beutler, L. E., Malik, M., Alimohamed, S., Harwood, T. M., Talebi, H., Noble, S., et al. (2004). Therapist variables. In *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (5th ed.). New York: John Wiley & Sons, Inc.
- Blackburn, I.-M., & Twaddle, V. (1996). *Cognitive therapy in action: A practitioner's casebook*. London: Souvenir Press.
- Blanchard, E. B., Nicholson, N. L., Radnitz, C. L., Steffek, B. D., Appelbaum, K. A., & Dentinger, M. P. (1991). The role of home practice in thermal biofeedback. *Journal of Consulting & Clinical Psychology*, 59, 507-512.
- Blanchard, E. B., Nicholson, N. L., Taylor, A. E., Steffek, B. D., Radnitz, C. L., & Appelbaum, K. A. (1991). The role of regular home practice in the relaxation treatment of tension headache. *Journal of Consulting & Clinical Psychology*, 59, 467-470.
- Bryant, M. J., Simons, A. D., & Thase, M. E. (1999). Therapist skill and patient variables in homework compliance: Controlling an uncontrolled variable in cognitive therapy outcome research. *Cognitive Therapy and Research*, 23, 381-399.

- Burns, D. D., & Nolen-Hoeksema, S. (1991). Coping styles, homework compliance, and the effectiveness of cognitive behavioral therapy. *Journal of Consulting & Clinical Psychology, 59*, 305-311.
- Burns, D. D., & Nolen-Hoeksema, S. (1992). Therapist empathy and recovery from depression in cognitive behavioral therapy: A structural equation model. *Journal of Consulting & Clinical Psychology, 60*, 441-449.
- Burns, D. D., & Spangler, D. L. (2000). Does psychotherapy homework lead to improvements in depression in cognitive-behavioral therapy or does improvement lead to increases in homework compliance? *Journal of Consulting and Clinical Psychology, 68*, 46-56.
- Cameron, L. D. (1997). Screening for cancer: Illness perceptions and illness worry. In K. J. Petrie & J. A. Weinman (Eds.), *Perceptions of health and illness: Current research and applications* (pp. 291-322). Amsterdam: Harwood Academic Publishers.
- Carr, A. (1997). Positive practice in family therapy. *Journal of Marital and Family Therapy, 23*, 271-293.
- Castonguay, L. G., Goldfried, M. R., Wiser, S., & Raue, P. J. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting & Clinical Psychology, 64*, 497-504.
- Catania, C. A. (1992). *Learning* (3rd ed.). Englewood Cliffs, NJ: Prentice-Hall.
- Chambless, D. L., Sanderson, W. C., Shoham, V., Johnston, S. B., Pope, K. S., Crits-Christoph, P., et al. (1996). An update on empirically validated therapies. *The Clinical Psychologist, 49*, 5-18.
- Cicchetti, D. V. (1994). Guidelines, criteria, and rules of thumb for evaluating normed and standardized assessment instruments in psychology. *Psychological Assessment, 6*, 284-290.

- Cicchetti, D. V., & Sparrow, S. S. (1981). Developing criteria for establishing interrater reliability of specific items: Applications to assessment of adaptive behavior. *American Journal of Mental Deficiency, 84*, 127-137.
- Conner, M., & Norman, P. (1996). The role of social cognition in health behaviours. In M. Conner & P. Norman (Eds.), *Predicting health behaviour: research and practice with social cognition models* (pp. 1-22). Buckingham, England: Open University Press.
- Cox, D. J., Tisdelle, D. A., & Culbert, J. P. (1988). Increasing adherence to behavioral homework assignments. *Journal of Behavioral Medicine, 11*, 519-522.
- DeRubeis, R. J., & Feeley, M. (1990). Determinants of change in cognitive therapy for depression. *Cognitive Therapy and Research, 14*, 469-482.
- Detweiler, J. B., & Whisman, M. A. (1999). the role of homework assignments in cognitive therapy for depression: Potential methods for enhancing adherence. *Clinical Psychology: Science and Practice, 6*(3), 267-282.
- DiClemente, C. C., Prochaska, J. O., Fairhurst, S. K., Velicer, W. F., Velasquez, M. M., & Rossi, J. S. (1991). The process of smoking cessation: An analysis of procontemplation, contemplation, and preparation stages of change. *Journal of Consulting and Clinical Psychology, 59*, 295-304.
- Dimidjian, S., Hollon, S. D., Dobson, K. S., Schmalting, K., Kohlenberg, R., McGlinchey, J. B., et al. (2003). *Behavioral activation, cognitive therapy, and antidepressant medication in the treatment of major depression: Design and acute phase outcomes*. Paper presented at the annual meetings of the Association for the Advancement of Behavior Therapy, Boston, MA.
- Dobson, K. S., Dimidjian, S., Hollon, S. D., Schmalting, K., Kohlenberg, R., & Dunner, D. (2003). *Behavioral activation, cognitive therapy, and antidepressant medication in the treatment of major depression: Follow-up phase outcomes*. Paper presented at the

Annual meetings of the Association for the Advancement of Behavior Therapy,
Boston, MA.

Dobson, K. S., & Kazantzis, N. (2003). The therapist in cognitive-behavioral therapy:

Introduction to a special section. *Psychotherapy Research*, 13, 131-134.

Dunlap, K. (1932). *Habits, their making and unmaking*. New York: Liveright.

Edelman, R. E., & Chambless, D. L. (1995). Adherence during sessions and homework in
cognitive-behavioral group treatment of social phobia. *Behavior Research And
Therapy*, 33, 573-577.

Elkin, I., Parloff, M. B., Hadley, S. W., & Autry, J. H. (1985). NIMH treatment of depression
collaborative research program: Background and research plan. *Archives of General
Psychiatry*, 42, 305-316.

Fehm, L., & Fehm-Wolfsdorf, G. (2001). Homework as therapeutic intervention: Exception
or everyday practice? [German]. *Psychotherapeut*, 46, 386-390.

Fehm, L., & Kazantzis, N. (in press). Attitudes and use of homework assignments in therapy:
A survey of German psychotherapists. *Clinical Psychology and Psychotherapy*.

Fleiss, J. L. (1981). *Statistical methods for rates and proportions* (2nd ed.). New York:
Wiley.

Garfield, S. L. (1998). Some comments on empirically supported treatments. *Journal of
Consulting & Clinical Psychology*, 61, 121-125.

Greenberg, L. S., Watson, J. C., & Goldman, R. (Eds.). (1988). *Process-experiential therapy
of depression: Handbook of experiential psychotherapy*. New York: The Guilford
Press.

Greenberger, D., & Padesky, C. A. (1995). *Mind over mood: Change how you feel by
changing the way you think*. New York: The Guilford Press.

- Gregory, R. J. (2000). *Psychological testing: History, principles, and applications* (3rd ed.). Boston: Allyn and Bacon, Inc.
- Harmon, T. M., Nelson, R. O., & Hayes, S. C. (1980). Self-monitoring of mood versus activity by depressed clients. *Journal of Consulting & Clinical Psychology*, 48, 30-38.
- Heckhausen, H. (1991). *Motivation and action*. Berlin: Springer.
- Herzberg, A. (1941). Short-term treatment of neurosis by graduated tasks. *British Journal of Medical Psychology*, 29, 36-51.
- Hollon, S. D., & Beck, A. T. (2004). Cognitive and cognitive behavioral therapies. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (5th ed., pp. 447-192). New York: John Wiley & Sons, Inc.
- Hollon, S. D., Evans, M. D., Auerbach, A., DeRubeis, R. J., Elkin, I., Lowery, H. A., et al. (1984). *Development of a system for rating therapies for depression: Differentiating cognitive therapy, interpersonal psychotherapy, and clinical management pharmacotherapy*. Unpublished manuscript.
- Horne, R., & Weinman, J. (1998). Predicting treatment adherence: An overview of theoretical models. In L. B. Myers & K. Midence (Eds.), *Adherence to treatment in medical conditions* (pp. 25-50). Amsterdam: Harwood Academic Publishers.
- Jacobson, N. S., Dobson, K. S., Truax, P. A., Addis, M. E., Koerner, K., Gollan, J. K., et al. (1996). A component analysis of cognitive-behavioral treatment for depression. *Journal of Consulting and Clinical Psychology*, 64(2), 295-304.
- Jacobson, N. S., & Gortner, E. T. (2000). Can depression be de-medicalized in the 21st century: Scientific revolutions, counter-revolutions and the magnetic field of normal science. *Behavior Research And Therapy*, 38, 103-117.
- Janz, N., & Becker, M. H. (1984). The health belief model: A decade later. *Health Education Quarterly*, 11, 1-47.

- Kanfer, F. H., & Phillips, J. S. (1966). A survey of current behavior and a proposal for classification. *Archives of General Psychiatry*, 15, 114-128.
- Kanfer, F. H., & Phillips, J. S. (1970). *Learning foundations of behavior therapy*. New York: John Wiley & Sons, Inc.
- Kazadin, A. E., & Mascitelli, S. (1982). Covert and overt rehearsal and homework practice in developing assertiveness. *Journal of Consulting & Clinical Psychology*, 50, 250-258.
- Kazantzis, N. (2000). Power to detect homework effects in psychotherapy outcome research. *Journal of Consulting and Clinical Psychology*, 68(1), 166-170.
- Kazantzis, N. (2003). Therapist competence in cognitive and behaviour therapies: Review of the contemporary empirical evidence. *Behavior Change*, 20, 1-12.
- Kazantzis, N. (in press). Introduction and overview. In N. Kazantzis, F. P. Deane, K. R. Ronan & L. L'Abate (Eds.), *Using Homework Assignments in Cognitive-Behavior Therapy*: Brunner-Routledge.
- Kazantzis, N., Busch, R., Ronan, K. R., & Merrick, P. L. (2004). *Mental health practioners' use and perceived importance of homework assignments in psychotherapy*. Manuscript submitted for publication.
- Kazantzis, N., & Deane, F. P. (1998). Theoretical orientations of New Zealand psychologists: An international comparison. *Journal of Psychotherapy Integration*, 8(2), 97-113.
- Kazantzis, N., & Deane, F. P. (1999). Psychologists' use of homework assignments in clinical practice. *Professional Psychology: Research and Practice*, 30, 581-585.
- Kazantzis, N., Deane, F. P., & Ronan, K. R. (2000). Homework assignments in cognitive and behavioral therapy: A meta-analysis. *Clinical Psychology: Science and Practice*, 7(2), 189-202.

- Kazantzis, N., Deane, F. P., Ronan, K. R., & Lampropoulos, G. K. (in press). Empirical Foundations. In N. Kazantzis, F. P. Deane, K. R. Ronan & L. L'Abate (Eds.), *Using Homework Assignments in Cognitive-Behavior Therapy*. Brunner-Routledge.
- Kazantzis, N., & L'Abate, L. (in press). Theoretical foundations. In N. Kazantzis, F. P. Deane, K. R. Ronan & L. L'Abate (Eds.), *Using Homework Assignments in Cognitive-Behavior Therapy*. Brunner-Routledge.
- Kazantzis, N., & Lampropoulos, G. K. (2002). The use of homework in psychotherapy: An introduction. *Psychotherapy in Practice*, 58(5), 487-488.
- Kazantzis, N., Lampropoulos, G. K., & Deane, F. P. (2003). *A national survey of therapists' attitudes towards using homework in psychotherapy*. Manuscript submitted for publication.
- Kazantzis, N., Lampropoulos, G. K., & Deane, F. P. (2004). *A national survey of psychologists attitudes towards homework assignments*. Manuscript submitted for publication.
- Kazantzis, N., MacEwan, J., & Datillio, F. M. (in press). A Guiding model for practice. In N. Kazantzis, F. P. Deane, K. R. Ronan & L. L'Abate (Eds.), *Using Homework Assignments in Cognitive-Behavior Therapy*. Brunner-Routledge.
- Kazantzis, N., & Ronan, K. R. (in press). Integrating between-session (homework) activities into psychotherapy [Special Issue]. *Journal of Psychotherapy Integration*.
- Kazantzis, N., Ronan, K. R., & Deane, F. P. (2001). Concluding causation from correlation: Comment on Burns and Spangler (2000). *Journal of Consulting and Clinical Psychology*, 69, 1079-1083.
- Kendall, P. C., & Chambless, D. L. (1998). Empirically supported psychological therapies [Special Section]. *Journal of Consulting and Clinical Psychology*, 66, 1-167.

- Kornblith, S. J., Rehm, L. P., O'Hara, M. W., & Lamparski, D. M. (1983). The contribution of self-reinforcement training and behavioral assignments to the efficacy of self-control therapy for depression. *Cognitive Therapy and Research*, 7, 499-528.
- Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (5th ed., pp. 139-193). New York: John Wiley & Sons, Inc.
- Leventhal, H. (1970). Findings and theory in the study of fear communications. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 3, pp. 119-186). New York: Academic Press.
- Leventhal, H., Meyer, D., & Nerenz, D. R. (1980). The common sense representation of illness danger. In S. Rachman (Ed.), *Contributions to medical psychology* (Vol. 2, pp. 7-30). Oxford: Pergamon Press.
- Leventhal, H., Nerenz, D. R., & Steele, D. J. (1984). Illness representations and coping with health threats. In A. Baum, S. E. Taylor & J. E. Singer (Eds.), *Handbook of psychology and health* (Vol. 4, pp. 219-252). Hillsdale, NJ.: Lawrence Erlbaum Associates Inc.
- Liese, B. S., Barber, J. P., & Beck, A. T. (1995). *The cognitive therapy adherence and competence scale*. Unpublished instrument, Kansas City, Kansas: University of Kansas Medical Centre.
- Luborsky, L., & DeRubeis, R. J. (1984). The use of psychotherapy treatment manuals: A small revolution in psychotherapy research style. *Clinical Psychology Review*, 4, 5-14.
- Marks, I. M., Lelliott, P., Basoglu, M., Noshirvani, H., Monteiro, W., Cohen, D., et al. (1988). Clomipramine, self-exposure, and therapist-aided exposure for obsessive-compulsive rituals. *British Journal of Psychiatry*, 152, 522-534.

- Martin, G., & Pear, J. (2003). *Behavior Modification: What it is and how to do it* (7th ed.). New Jersey: Prentice-Hall, Inc.
- Masters, W. H., & Johnson, V. E. (1970). *Human sexual inadequacy*. Boston: Little Brown.
- McGlinchey, J. B., & Dobson, K. S. (2003). Treatment fidelity for cognitive-behavioral therapies for depression. *Journal of Cognitive Psychotherapy*, 17(4), 300-312.
- Milne, D., Claydon, T., Blackburn, I.-M., James, I., & Sheikh, A. (2001). Rationale for a new measure of competence in therapy. *Behavioural and Cognitive Psychotherapy*, 29, 21-33.
- Neimeyer, R. A., & Feixas, G. (1990). The role of homework and skill acquisition in the outcome of group cognitive therapy for depression. *Behavior Therapy*, 21, 281-292.
- Padesky, C. A. (1999). Therapist beliefs: Protocols, personalities and guided exercises [Cassette]. Huntington Beach, California: Center for Cognitive Therapy.
- Padesky, C. A., & Greenberger, D. (1995). *Clinician's guide to mind over mood*. New York: The Guilford Press.
- Park, J., Mataix-Cols, D., Marks, I. M., Ngamthipwatthana, T., Marks, M., Araya, R., et al. (2001). Two-year follow-up after a randomised controlled trial of self- and clinician-accompanied exposure for hobia/panic disorders. *British Journal of Psychiatry*, 178, 543-548.
- Patchett-Anderson, L. S. (1997). *Clinical psychologists' opinions about and uses of tests, assessment, and clinical intervention applications*. Unpublished Masters Thesis, Massey University, Palmerston North, New Zealand.
- Persons, J. B. (1989). *Cognitive therapy in practice: A case formulation approach*. New York: Norton.

- Persons, J. B., & Bertagnolli, A. (1999). Inter-rater reliability of cognitive-behavioral case formulations of depression: A replication. *Cognitive Therapy and Research*, 23, 271-283.
- Persons, J. B., Burns, D. D., & Perloff, J. M. (1988). Predictors of dropout and outcome in cognitive therapy for depression in a private practice setting. *Cognitive Therapy and Research*, 12, 557-575.
- Persons, J. B., Davidson, J., & Tompkins, M. A. (2001). *Essential Components of Cognitive-Behavior Therapy for Depression*. Washington, DC: American Psychological Association.
- Petty, R. E., & Cacioppo, J. T. (1981). *Attitudes and persuasion: Classic and contemporary approaches*. Dubuque, IA: Wm. C. Brown.
- Petty, R. E., & Cacioppo, J. T. (1986). *Communication and persuasion: Central and peripheral routes of attitude change*. New York: Springer Verlag.
- Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change in smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51, 390-395.
- Prochaska, J. O., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing the traditional boundaries of change* (Vol. 51). Homewood, IL.: J. Irwin.
- Prochaska, J. O., & DiClemente, C. C. (1986). Toward a comprehensive model of change. In W. E. Miller & N. Heather (Eds.), *Treating addictive behaviors* (pp. 3-27). London: Plenum Press.
- Rogers, R. W. (1983). Cognitive and physiological processes in fear appeals and attitude change: A revised theory of protection motivation. In J. T. Cacioppo & R. E. Petty (Eds.), *Social psychophysiology* (pp. 153-176). New York: Guilford.

- Rogers, R. W., & Prentice-Dunn, S. (1997). Protection motivation theory. In D. S. Gochman (Ed.), *Handbook of health behavior research* (Vol. 1, pp. 113-132). New York: Plenum Press.
- Rosenstock, I. M. (1974). Historical origins of the health belief model. *Health Education Monographs*, 2, 1-8.
- Scheel, M. J., Hanson, W. E., & Razzhavaikina, T. I. (2004). The process of recommending homework in psychotherapy: A review of therapist delivery methods, client acceptability, and factors that affect compliance. *Psychotherapy: Theory, Research, Practice, Training*, 41(1), 38-55.
- Schwarzer, R. (1992). Self-efficacy in the adoption and maintenance of health behaviors: Theoretical approaches and a new model. In R. Schwarzer (Ed.), *Self-efficacy: Thought control and action* (pp. 217-243). London: Hemisphere.
- Shaw, B. F., & Dobson, K. S. (1988). Competency judgments in the training and evaluation of psychotherapists. *Journal of Consulting and Clinical Psychology*, 56, 666-672.
- Shelton, J. L., & Levy, R. L. (1981). *Behavioral assignments and treatment compliance: A handbook of clinical strategies*. Champaign, IL: Research Press.
- Shrout, P. E., & Fleiss, J. L. (1979). Intraclass correlations: Uses in assessing rater reliability. *Psychological Bulletin*, 86, 420-428.
- Silverman, W. H. (1996). Cookbooks, manuals, and paint by numbers: Psychotherapy in the 90's. *Psychotherapy*, 33, 207-215.
- Skinner, B. F. (1974). *About behaviorism*. New York: Knopf.
- Startup, M., & Edmonds, J. (1994). Compliance with homework assignments in cognitive-behavioral psychotherapy for depression: Relation to outcome and methods of enhancement. *Cognitive Therapy and Research*, 18, 567-579.

- Streiner, D. L., & Norman, G. R. (1995). *Health measurement scales: A practical guide to their development and use* (2nd ed.). New York: Oxford University Press.
- Thase, M. E., & Callan, J. A. (in press). The role of homework in cognitive behavior therapy of depression. *Journal of Psychotherapy Integration*.
- Tompkins, M. A. (2002). Guidelines for enhancing homework compliance. *Journal of Clinical Psychology, 58*, 565-576.
- Uebersax, J. S. (2003). *Statistical methods for rater agreement*. Retrieved 11 May, 2004, from <http://ourworld.compuserve.com/homepages/jsuebersax/agree.htm>
- Vallis, T. M., Shaw, B. F., & Dobson, K. S. (1986). The cognitive therapy scale: Psychometric properties. *Journal of Consulting and Clinical Psychology, 54*, 381-385.
- Vincent, A. H. (2002). Measurement issues in determining interrater agreement (Doctoral thesis, University of Oklahoma, 2002). *Dissertation Abstracts International, 63*(3-B), 1607. (UMI No. AAT 3045846).
- Waltz, J., Addis, M. E., Koerner, K., & Jacobson, N. S. (1993). Testing the integrity of a psychotherapy protocol: Assessment of adherence and competence. *Journal of Consulting and Clinical Psychology, 61*, 620-630.
- Weinstein, N. D. (1988). The precaution adoption process. *Health Psychology, 7*, 355-386.
- Weinstein, N. D., Lyon, J. E., Sandman, P. M., & Cuite, C. L. (1998). Experimental evidence for stages of health behavior change: The precaution adoption process model applied to home radon testing. *Health Psychology, 17*, 445-453.
- Weinstein, N. D., Rothman, A. J., & Sutton, S. R. (1998). Stage theories of health behavior. *Health Psychology, 17*, 290-299.

- Wolpe, J. (1985). Systematic desensitization. In A. S. Bellack & M. Hersen (Eds.), *Dictionary of Behavior Therapy Techniques* (pp. 215-219). New York: Pergamon Press.
- Worthington, E. L., Jr. (1986). Client compliance with homework directives during counselling. *Journal of Counseling Psychology*, 33, 124-130.
- Young, J., & Beck, A. T. (1980). *Cognitive therapy scale: Rating manual*. (Available from the Beck Institute for Cognitive Therapy and Research, GSB Building, One Belmont Avenue, Suite 700, Bala Cynwyd, PA 19004-1610).

APPENDIX A
HAACS - TRAINING VERSION

HAACS

Homework Adherence And Competence Scale

Assessing Therapist Adherence and Competence in Using Homework Assignments within Cognitive Behavior Therapy

Nikolaos Kazantzis
Paul Wedge
Keith S. Dobson

Draft 1

HAACS

Therapist Adherence

Instructions: This adherence rating scale consists of 20 items regarding therapists' integration of homework assignments in cognitive behavior therapy. Please note that your rating on this form is to indicate whether these aspects were carried out by the therapist (i.e., adherence) to any extent. This is different from rating how well the therapist undertook each item (i.e., competence). Please consider each item carefully, and tick either "yes" or "no" to indicate whether the therapist ENGAGED in each aspect. Please select only one response option for any question.

HOMEWORK REVIEW This section covers the therapist behaviors involved in reviewing homework from the previous session, and typically occurs early in the session.

		Yes	No
AR1	Did the therapist make enquiries and discuss previously assigned homework tasks?	<input type="checkbox"/>	<input type="checkbox"/>
AR2	Did the therapist provide appropriate verbal reinforcement (i.e., praise) for any portion of the homework task carried out?	<input type="checkbox"/>	<input type="checkbox"/>
AR3	Did the therapist use a situational conceptualization (e.g., identify thoughts, behaviors, emotions, physiology) to identify the client's beliefs about the consequences of having engaged in the homework task and their synthesis of learning?	<input type="checkbox"/>	<input type="checkbox"/>
AR4	Did the therapist obviously use an individualized conceptualization to make sense of any portion of non-completed homework (i.e., linked doing the task to the client's automatic thoughts, underlying assumptions and rules, or core beliefs)?	<input type="checkbox"/>	<input type="checkbox"/>
AR5	Did the therapist attempt to problem solve practical obstacles to the homework task?	<input type="checkbox"/>	<input type="checkbox"/>

HOMEWORK DESIGN This section covers the therapist behaviors involved in collaboratively deciding what homework will be carried out during the next week, and typically occurs throughout the session.

		Yes	No
AD1	Did the therapist discuss a new/ revised homework task at an appropriate point(s) during the session?	<input type="checkbox"/>	<input type="checkbox"/>
AD2	Did the therapist use guided discovery to identify the client's coping strategies and beliefs related to the homework task?	<input type="checkbox"/>	<input type="checkbox"/>
AD3	Did the therapist obviously integrate a disorder-specific cognitive model with the individualized conceptualization in the design of the homework task?	<input type="checkbox"/>	<input type="checkbox"/>
AD4	Did the therapist collaboratively select/design the homework task?	<input type="checkbox"/>	<input type="checkbox"/>
AD5	Did the therapist present a rationale for the homework task that aligned with the client's goals for treatment?	<input type="checkbox"/>	<input type="checkbox"/>
AD6	Did the therapist ask about the client's ability and perceived difficulty of the homework task?	<input type="checkbox"/>	<input type="checkbox"/>
AD7	Did the therapist facilitate in-session practice of the homework task?	<input type="checkbox"/>	<input type="checkbox"/>
AD8	Did the therapist use guided imagery to begin experiential learning for the homework task?	<input type="checkbox"/>	<input type="checkbox"/>
AD9	Did the therapist use a situational conceptualization to help identify the client's beliefs and situational triggers for carrying out the homework task in specific situations?	<input type="checkbox"/>	<input type="checkbox"/>

HOMEWORK ASSIGN

This section covers the therapist behaviors involved in determining how the homework assignment/s will be practically carried out, and typically occurs near the end of the session

	Yes	No
AA1 Did the therapist ask the client to summarize the rationale for the homework task in relation to therapy goals?	<input type="checkbox"/>	<input type="checkbox"/>
AA2 Did the therapist collaborate with the client to specify how the homework task will be practically integrated into the client's life (i.e., specification of when, where, how often, how long)?	<input type="checkbox"/>	<input type="checkbox"/>
AA3 Did the therapist consider potential difficulties of the homework task?	<input type="checkbox"/>	<input type="checkbox"/>
AA4 Did the therapist emphasize the homework task as having a learning 'experiment' focus (e.g., a no-lose scenario, partial completion is helpful, seeing what works and what doesn't)?	<input type="checkbox"/>	<input type="checkbox"/>
AA5 Did the therapist ask the client to summarize the homework task and obtain an indication of the client's readiness, importance, or confidence?	<input type="checkbox"/>	<input type="checkbox"/>

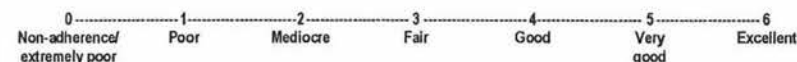
HAACS

Therapist Competence

Instructions:

This competence rating scale consists of 20 items regarding therapists' integration of homework assignments in cognitive behavior therapy. Please note that your rating on this form is to indicate HOW WELL the therapist undertook each item (i.e., competence). This is different from rating whether these aspects were attempted by the therapist (i.e., adherence). Adherence is a necessary BUT NOT SUFFICIENT condition for competence. This means that if adherence for the same item was rated "no" for a therapist behavior, then the therapist cannot be rated higher than "0" for competence. Please consider each item carefully, and record the appropriate number in the rating box to indicate how well the therapist carried out each aspect.

Each item has seven descriptive response options. Underpinning the response options is a seven point Likert scale ranging from 0 (non-adherence/extremely poor) to 6 (excellent). In the first instance, please use the individual anchors to determine the rating for each item. However, if you are having difficulty deciding on a rating using the detailed response options (e.g., the individual descriptions do not seem to easily fit the session being rated), then refer to the underlying Likert scale. If several items seem to apply equally well, record the lowest number for that item, and provide only a single rating number for any item (e.g., if considering recording "3-4", record it as a "3").



HOMEWORK REVIEW

This section covers the therapist behaviors involved in reviewing homework from the previous session, and typically occurs early in the session

CR1 How well did the therapist make enquiries and discuss previously assigned homework tasks?

Rating

- The therapist did not make any enquiries, or discuss previously assigned homework.
- The therapist made a cursory enquiry about previous homework completion, but did not discuss it (i.e., no exploration of the client's responses).
- The therapist enquired about previous homework completion, and made an attempt to elicit feedback from the client but this was not successful (e.g., the therapist used closed questions, or did not allow sufficient time for a response).
- The therapist enquired about previous homework, and elicited some general feedback from the client. For instance, the client gave a vague response such as "I completed most of it" and this response was taken at face value and was not explored further (e.g., "Can you tell me more about the parts you completed?" and then "Can you tell me about the parts you had difficulty with or did not complete?").
- The therapist enquired about previous homework and identified exactly what portion of the homework what was completed and what was not completed. However, the discussion focused either on the completed homework or the non-completed homework.
- The therapist identified and discussed both completed and non-completed homework. However, in discussing completed homework, the focus was more on the quantity of what was completed (i.e., the extent of completion), rather than the quality (i.e., degree of client learning or skill acquisition, such as mastery in completing a thought record effectively, or testing out beliefs in behavioral experiments).
- Both the quantity (i.e., the extent of completion and non-completion) and quality (i.e., degree of client learning or skill acquisition, such as mastery in completing a thought record effectively, or testing out beliefs in behavioral experiments) of homework completion was discussed. The therapist facilitated a highly effective discussion to elicit the client's learning from the homework task (e.g., using Socratic questioning).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

CR2 How well did the therapist provide appropriate verbal reinforcement (i.e., praise) for any portion of the homework task carried out?

Rating

- The therapist did not provide verbal reinforcement for any portion of the homework carried out.
- Verbal reinforcement was given that was very brief and limited in relation to the portion of homework completed, or excessive praise was given for low completion.
- Some verbal reinforcement was given but this was not clearly linked to the portion of homework completed, or excessive praise was given for low completion.
- Appropriate verbal reinforcement was given for most portions of the homework completed.
- Appropriate verbal reinforcement was given for all portions of the homework completed.
- Appropriate praise and encouragement was given for all portions of the homework completed. The therapist appeared clearly enthusiastic in acknowledging and validating the client's efforts.
- Appropriate praise and encouragement was given for all portions of the homework completed. The therapist appeared clearly enthusiastic in acknowledging and validating the client's efforts. Encouragement was given for the client extending/generalizing the homework task to extend skill acquisition/apply task to more challenging problems.

CR3 How well did the therapist use a situational conceptualization (e.g., identify thoughts, behaviors, emotions, physiology) to identify the client's beliefs about the consequences of having engaged in the homework task and their synthesis of learning?

Rating

- The therapist did not use a situational conceptualization to identify beliefs about the consequences and their synthesis of learning.
- An undeveloped situational conceptualization was arrived at (i.e., the therapist completely interpreted on behalf of the client).
- A vague, brief and incomplete situational conceptualization was arrived at (i.e., the therapist mostly interpreted for the client's experiences rather than eliciting information).
- A partially developed situational conceptualization was arrived at (i.e., the therapist elicited some information and interpreted other information). No automatic thoughts or beliefs about the consequences, or synthesis of learning were identified.
- A situational conceptualization facilitated the identification of salient (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as triggers for homework completion.
- A situational conceptualization facilitated the identification of salient (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as triggers for homework completion. The therapist also elicited beliefs about the homework (i.e., difficulty, sense of pleasure, sense of mastery).
- A situational conceptualization facilitated the identification of salient (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as triggers for homework completion. The therapist also elicited beliefs about the homework (i.e., difficulty, sense of pleasure, sense of mastery), as well as consequences and their synthesis of learning (i.e., relevance, match with therapy goals, benefits, perceived progress).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

CR4 How well did the therapist obviously use an individualized conceptualization to make sense of any portion of non-completed homework (i.e., linked doing the task to the client's automatic thoughts, underlying assumptions and rules, or core beliefs)?

Rating

- The therapist did not use an individualized conceptualization to make sense of any portion of non-completed homework.
- The therapist labeled/interpreted the portion of non-completed homework rather than facilitating the client's own understanding through collaborative discussion.
- The therapist focused on one individualized conceptualization component (i.e., either core beliefs, or conditional rules and assumptions, or automatic thoughts). The therapist used this information to label/interpret the portion of non-completed homework rather than facilitating the client's own understanding.
- The therapist made limited use of an individualized conceptualization, including some but not all of the following aspects: core beliefs, conditional rules and assumptions, and automatic thoughts. The therapist used this information to reach a vague understanding of homework non-completion.
- The therapist facilitated a discussion that made reasonable use of an individualized conceptualization, including some but not all aspects of: core beliefs, conditional rules and assumptions, and automatic thoughts. This led to a reasonable understanding of the client's beliefs about the homework task, and homework non-completion.
- The therapist facilitated a discussion that made good use of an individualized conceptualization, including all aspects of: core beliefs, conditional rules and assumptions, and automatic thoughts. This led to a clear understanding of the client's beliefs about the homework task, and homework non-completion.
- The therapist facilitated a discussion that made full use of an individualized conceptualization, including core beliefs, conditional rules and assumptions, and automatic thoughts in several situations, which were linked to overall treatment goals. This led to a very clear understanding of the client's beliefs about the homework task, the portion of non-completed homework, AS WELL AS the generalization of the task to other situations.

CR5 How well did the therapist attempt to problem solve practical obstacles to the homework task?

Rating

- The therapist did not attempt to problem solve practical obstacles.
- The therapist provided solutions of their own accord, without any contribution from the client.
- The therapist provided solutions of their own accord, with only a cursory contribution sought from the client. (e.g., "Does that sound okay to you?")
- The therapist attempted to problem solve practical obstacles with some collaboration (i.e., the therapist provided some solutions themselves and elicited some input from the client).
- The therapist facilitated a discussion that identified the actual practical obstacles. Some potential solutions were generated and considered. The client arrived at a vague plan to overcome the obstacles.
- The therapist facilitated a discussion that identified the actual practical obstacles. A range of potential solutions were generated and considered. The client arrived at clear behavioral strategies to overcome the practical obstacles.
- The therapist facilitated a discussion that identified the actual practical obstacles, as well as a consideration of other potential obstacles that may have occurred. A full range of potential solutions were generated and considered. The client arrived at clear behavioral strategies to overcome the practical obstacles, as well as behavioral strategies for considering changing circumstances (e.g., bringing an outside activity indoors, testing beliefs in several situations, applying interpersonal skills to a range of relationships/interactions).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

HOMEWORK DESIGN This section covers the therapist behaviors involved in collaboratively deciding what homework will be carried out during the next week, and typically occurs throughout the session

CD1 How well did the therapist discuss a new/ revised homework task at an appropriate point(s) during the session?

Rating

- 0 The therapist did not discuss a new/ revised homework task during the session.
- 1 The therapist briefly discussed a new/ revised homework task at the end of the session.
- 2 The therapist allowed sufficient time for a discussion on a new/ revised homework task at the end of the session, but this was not linked to in-session content or therapy goals.
- 3 The therapist allowed sufficient time for a discussion on a new/ revised homework task at the end of the session, and this WAS linked to either in-session content or therapy goals.
- 4 The therapist allowed sufficient time for a discussion on a new/ revised homework task at the end of the session, and this WAS linked to BOTH in-session content or therapy goals.
- 5 The therapist took the opportunity to discuss a new/ revised homework task appropriately during the course of the session, as well as at the end of the session. The new/ revised homework WAS linked to BOTH in-session content or therapy goals.
- 6 The therapist took the opportunity to discuss a new/ revised homework task appropriately during the course of the session, as well as at the end of the session. The new/ revised homework WAS linked to BOTH in-session content or therapy goals. The therapist was able to engage the client in discussion effectively, used novel and tailored presentation of the new task, even when confronted with interpersonal difficulties (e.g., client avoidance, perfectionism, demanding interpersonal style).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

CD2 Did the therapist use guided discovery to identify the client's coping strategies and beliefs related to the homework task?

Rating

- 0 The therapist did not use guided discovery to identify the client's coping strategies and beliefs related to the homework task.
- 1 The therapist used ineffective questioning (e.g., closed questions or broad questions, but these did not uncover new information) and provided interpretive answers rather than guiding the client's own understanding about coping strategies and beliefs.
- 2 The therapist used some (not all) components of the guided discovery process: (i) asked some informational questions, (ii) listened empathically and provided some reflections, (iii) provided some summaries of the information discovered, and (iv) asked some synthesizing or analytical questions. However they were used in a cursory, inappropriate, or ineffective manner (e.g., inaccurate reflections or summaries). The therapist used interpretive answers rather than guiding the client's own learning, and was unable to identify coping strategies and beliefs (e.g., "If you think X, then surely Y is?").
- 3 The therapist used all four components of the guided discovery process: (i) asked some informational questions, (ii) listened empathically and provided some reflections, (iii) provided some summaries of the information discovered, and (iv) asked some synthesizing or analytical questions, but was ineffective in identifying coping strategies and beliefs.
- 4 The therapist used all four components of the guided discovery process reasonably effectively: (i) asked informational questions which uncovered some information outside the client's awareness, (ii) listened empathically and provided some accurate and appropriate reflections, (iii) provided some accurate summaries of the information discovered, and (iv) asked some synthesizing or analytical questions, which enabled some client learning. In using this process the therapist facilitated the identification of a few coping strategies and beliefs.
- 5 The therapist used all four components of the guided discovery process effectively: (i) asked appropriate informational questions which uncovered information outside the client's awareness, (ii) listened empathically and provided accurate and appropriate reflections, (iii) accurately summarized the information discovered at appropriate times, and (iv) asked synthesizing or analytical questions which enabled the client's own learning. In using this process the therapist facilitated the identification of a number of coping strategies and beliefs.
- 6 The therapist appeared genuinely curious and inquisitive, and used all four components of the guided discovery process very effectively: (i) asked several appropriate informational questions which uncovered significant information outside the client's awareness, (ii) listened empathically and provided accurate and appropriate reflections, (iii) accurately summarized the information discovered at appropriate times, and (iv) asked highly appropriate synthesizing or analytical questions which enabled the client's own learning. In using this process the therapist facilitated the identification of a number of highly credible coping strategies and beliefs.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

CD3 How well did the therapist obviously integrate a disorder-specific cognitive model with the individualized conceptualization in the design of the homework task?

Rating

- The therapist did not discuss a disorder-specific cognitive model or individualized conceptualization in the homework design
- The therapist mentioned the disorder-specific cognitive model but did not elaborate on how it was relevant to the client's presentation.
- The therapist integrated some but not all aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to one aspect of the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies).
- The therapist integrated some but not all aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to more than one aspect of the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies).
- The therapist integrated most aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to most aspects of the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies).
- The therapist integrated all aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to all aspects of the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies).
- The therapist integrated all aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to all aspects of the client's individualized conceptualization (e.g., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies). The therapist was able to integrate all this information with the client's presenting problems evidenced in tactful responses to client's interpersonal style (e.g., critical, competitive, suspicious, controlling, exaggerative).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

CD4 How well did the therapist collaboratively select/design the homework task?

Rating

- The therapist did not collaboratively select/design a homework task.
- The therapist selected/designed the homework task without any contribution of the client.
- The therapist only sought a cursory contribution from the client in selecting/designing the homework task. (e.g., "Does that sound okay to you?").
- The therapist involved the client in the selection/design of the homework task, but at times reverted to a directive rather than collaborative approach, especially in the final decision.
- The therapist involved the client in selecting/designing the homework task (e.g., facilitated a discussion rather than provided direct answers, discussed a few possible homework tasks, or collaboratively discussed the advantages and disadvantages of the possible homework tasks).
- The therapist encouraged the client to view the process of selecting/designing the homework task as the therapist and client working together as a team. The therapist also actively involved the client in selecting the homework task (e.g., facilitated a discussion rather than provided direct answers, discussed several possible homework tasks, elicited and explored the client's thoughts and feelings about the possible homework tasks, or collaboratively discussed the advantages and disadvantages of the possible homework tasks).
- The therapist encouraged the client to view the process of selecting/designing the homework task as the therapist and client working together as a team. The therapist also actively involved the client in selecting the homework task (e.g., facilitated a discussion rather than provided direct answers, discussed a full range of possible homework tasks, elicited and explored the client's thoughts and feelings about the possible homework tasks, and collaboratively discussed the advantages and disadvantages of the possible homework tasks (i.e., based on prior experience, benefits experienced by others, collaboration and encouragement from therapist). The therapist and client decided on a homework task that built upon existing client skills and strategies, and the client was encouraged to take on more responsibility for designing/ selecting tasks.

CD5 How well did the therapist present a rationale for the homework task that aligned with the client's goals for treatment?

Rating

- The therapist did not present a rationale for the homework.
- The therapist presented a brief rationale but failed to relate it to the client's treatment goals.
- The therapist presented a rationale for the homework task with some mention of the client's treatment goals, however this was presented without any input (and understanding) from the client.
- The therapist assisted the client to understand how the homework task was aligned to either the specific presenting problem in the current session.
- The therapist assisted the client to understand that the task was broken into achievable chunks that were manageable and within the client's control. The therapist also assisted the client to understand how the homework task was aligned to EITHER the specific presenting problem in the current session, OR their overall treatment goals.
- The therapist assisted the client to understand that the task was broken into achievable chunks that were manageable and within the client's control. The therapist also assisted the client to understand how the homework task was aligned to both the specific presenting problem in the current session AS WELL AS their overall treatment goals.
- The therapist assisted the client to understand that the task was broken into achievable chunks that were manageable and within the client's control. The therapist also assisted the client to understand how the homework task was aligned to both the specific presenting problem in the current session AS WELL AS their overall treatment goals, AND obtained feedback from the client on the rationale. The therapist ALSO provided empirical evidence to support the rationale or the homework task.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

CD6 How well did the therapist ask about the client's ability and perceived difficulty of the homework task?

Rating

- 0 The therapist did not ask about the client's ability and perceived difficulty of the task.
- 1 The therapist made a cursory enquiry about the client's ability and perceived difficulty of the task, but did not discuss it any further.
- 2 The therapist enquired about the client's ability and perceived difficulty of the task, and made an ineffective attempt to elicit feedback from the client (e.g., the therapist did not listen to the client's responses, asked closed questions, questions did not follow the client's responses).
- 3 The therapist enquired about the client's ability and perceived difficulty of the task, and elicited a general statement from the client, for example, the client was vague and said "Sure, I can do it" and this response was taken at face value and not probed any further.
- 4 The therapist enquired about the client's ability and perceived difficulty of the task, and through Socratic questioning identified a broad issue (e.g., "That thought record looks too hard. There is so much to complete"). However, the therapist then provided their own solutions to resolve the issues raised (e.g., "Okay, just complete the first three columns of the thought record").
- 5 The therapist enquired about the client's ability and perceived difficulty of the task, and through Socratic questioning identified specific issues (e.g., in addition to feeling overwhelmed by the entire thought record, it transpired that the client had difficulty distinguishing emotions and thoughts on thought record). Through further exploration the therapist and client collaboratively resolved the issue (e.g., the therapist and client worked on automatic thoughts in-session, and/or the homework was redesigned to focus on practicing the identification emotions as distinct from automatic thoughts).
- 6 The therapist enquired about the client's ability and perceived difficulty of the task, and through Socratic questioning identified specific issues. Through further exploration the therapist and client collaboratively resolved the issue. The therapist also elicited additional client learning from the discussion, for example, the client learnt that breaking items into smaller chunks was less overwhelming, and also identified an underlying rule (e.g., "I've failed if I can't work things out for myself").

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

CD7 How well did the therapist facilitate in-session practice of the homework task?

Rating

- 0 The therapist did not provide the opportunity for in-session practice of the task.
- 1 The therapist briefly demonstrated or explained (i.e., modeled or instructed) the task that provided no opportunity for the clients to learn from their own practice.
- 2 The therapist provided only a brief opportunity for in-session practice. The therapist tended to focus on correcting the client's mistakes and provided limited positive reinforcement. The therapist did not discuss any learning points from the practice.
- 3 The therapist provided a reasonable opportunity for in-session practice. The therapist provided appropriate verbal reinforcement (i.e., shaping successive approximations of skill), and gave some constructive guidance when the client needed assistance. However, the therapist used a directive/punitive rather than collaborative approach in discussing learning points from the practice.
- 4 The therapist provided a good opportunity for in-session practice, using the method/s most appropriate for the client and the specific task. The therapist provided some positive reinforcement (i.e., shaping successive approximations of skill) and gave some constructive guidance when the client needed assistance. The therapist was encouraging when discussing learning points from the in-session practice.
- 5 The therapist provided an excellent opportunity for in-session practice, using the method/s most appropriate for the client and the specific task. The therapist provided enthusiastic reinforcement (i.e., shaping successive approximations of skill), and gave warm, genuine, constructive guidance when the client needed assistance. The therapist facilitated learning from the specific practice, asked the client for feedback on the experience, and asked the client to write down the learning points.
- 6 The therapist provided an excellent opportunity for in-session practice, using the method/s most appropriate for the client and the specific task. The therapist provided enthusiastic reinforcement (i.e., shaping successive approximations of skill), and gave warm, genuine, constructive guidance when the client needed assistance. The therapist facilitated learning from the specific practice, asked the client for feedback on the experience, and asked the client to write down the learning points.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

CD8 How well did the therapist use guided imagery to begin experiential learning for the homework task?

Rating

- 0 The therapist did not use guided imagery in homework design.
- 1 The therapist used guided imagery ineffectively (i.e., affect was not generated, client had difficulty staying on track, etc). Feedback was not sought throughout the exercise, and at the completion, the therapist did not facilitate any experiential learning from the imagery practice.
- 2 The therapist provided an opportunity for guided imagery, but was unable to use this to assist the client with some experiential learning of the homework task (i.e., client completed imagery but did not gain an experience of completing the task).
- 3 The therapist facilitated the client in using guided imagery, and this was reasonably effective in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified). However, imagery was ineffective in providing the client with some experiential learning of the homework task (i.e., client completed imagery but did not gain an experience of completing the task).
- 4 The therapist facilitated the client in using guided imagery, and this was reasonably effective in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified), AND the client gained some experiential learning of the homework task (i.e., experienced the outcome of having engaged in the homework task).
- 5 The therapist facilitated the client in using guided imagery, and this was reasonably effective in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified), AND the client gained some experiential learning of the homework task (i.e., experienced the outcome of having engaged in the homework task). The therapist focused on skill acquisition and discussed with the client how the task could be extended to more complex skills (i.e., shaping).
- 6 The therapist facilitated the client in using guided imagery, and this was reasonably effective in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified), AND the client gained some experiential learning of the homework task (i.e., experienced the outcome of having engaged in the homework task). The therapist focused on skill acquisition and discussed with the client how the task could be extended to more complex skills (i.e., shaping). In feedback, the therapist and client also discussed the application of the task across different situations (i.e., generalization and maintenance).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

CD9 How well did the therapist use a situational conceptualization to help identify the client's beliefs and situational triggers for carrying out the homework task in specific situations?

Rating

- 0 The therapist did not use a situational conceptualization to help identify the client's beliefs and situational triggers for carrying out the task in specific situations.
- 1 An undeveloped situational conceptualization was arrived at (i.e., the therapist completely interpreted on behalf of the client).
- 2 A vague, brief and incomplete situational conceptualization was arrived at (i.e., the therapist mostly interpreted for the client rather than eliciting information).
- 3 A partially developed situational conceptualization was arrived at (i.e., the therapist elicited some information and interpreted other information). This proved ineffective in identifying the client's beliefs and situational triggers.
- 4 A partially developed situational conceptualization was arrived at (i.e., the therapist elicited some information and interpreted other information). Emotions, behaviors, and physiology were identified to the use of the homework, but no cognitive triggers or beliefs were identified.
- 5 A situational conceptualization facilitated the client's identification of salient (i.e., emotionally laden) automatic thoughts that served as triggers for homework completion. Emotions, behaviors, and physiology were also identified.
- 6 A situational conceptualization facilitated the client's identification of a salient (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as triggers for homework completion. The therapist ALSO discussed the triggers to the use of homework in several situations, AND elicited beliefs about the homework (i.e., difficulty, obstacles).

HOMEWORK ASSIGN This section covers the therapist behaviors involved in determining how the homework assignment/s will be practically carried out, and typically occurs near the end of the session.

CA1 How well did the therapist ask the client to summarize the rationale for the homework task in relation to therapy goals?

Rating

- 0 The therapist did not ask the client to summarize the rationale for the task in relation to therapy goals.
- 1 The therapist summarized the rationale for the task, with little or no input from the client.
- 2 The therapist attempted to involve the client in summarizing the rationale for the task in relation to therapy goals, but used a directive rather than collaborative approach.
- 3 The therapist involved the client in summarizing the rationale for the task in relation to therapy goals.
- 4 The therapist involved the client in summarizing the rationale for the task in relation to most pertinent therapy goals. That is, the homework was discussed in terms of the specific behavior changes that would be expected to result from progress towards this goal.
- 5 The therapist skillfully involved the client in summarizing the rationale for the task in relation to most pertinent therapy goals. That is, the homework was discussed in terms of the specific behavior changes that would be expected to result from progress towards this goal, and this process was lead by the client.
- 6 The therapist skillfully involved the client in summarizing the rationale for the task in relation to most pertinent therapy goals. That is, the homework was discussed in terms of the specific behavior changes that would be expected to result from progress towards this goal, and this process was lead by the client. In discussion with the therapist, the client demonstrated a clear understanding of the homework and was able to place the current homework in context of current and overall goals for therapy. The therapist skill was evidenced by their adaptation of this discussion to the client's interpersonal style.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

CA2 How well did the therapist collaborate with the client to specify how the homework task will be practically integrated into the client's life (i.e., specification of when, where, how often, how long)?

Rating

- The therapist did not collaborate to specify how the task would be practically integrated into the client's life.
- The therapist directed how the task could be practically integrated into the client's life, without any contribution from the client.
- The therapist reached a vague outline of how the task could be practically integrated into the client's life, with little collaboration (i.e., the therapist provided some specifics themselves and elicited some input from the client).
- The therapist facilitated a discussion which resulted in the client being able to state with some behavioral specificity how the task could be practically integrated into the client's life in some of the following areas: when, where, how often, and how long.
- The therapist facilitated a discussion which resulted in the client being able to state with some behavioral specificity how the task could be practically integrated into the client's life in most of the following areas: when, where, how often, and how long.
- The therapist facilitated a discussion which resulted in the client being able to state with a high degree of behavioral specificity how the task could be practically integrated into the client's life in all of the following areas: when, where, how often, and how long. If the client was unable to be specific in any area, the therapist gently guided the client to a specific resolution.
- The therapist skillfully elicited a description of how the homework would be practically implemented from the client. A high degree of behavioral specificity was achieved in all the following areas: when, where, how often, and how long. If the client was unable to be specific in any area, the therapist gently guided the client to a specific resolution. The therapist also anticipated potential difficulties in communication and resolved them (e.g., misinterpretation of the process in achieving specificity, misinterpretation of the meaning of specificity, such as using a thought record 'when' automatic thoughts occur).

CA3 How well did the therapist consider potential difficulties of the homework task?

Rating

- The therapist did not attempt to consider potential difficulties.
- The therapist provided potential difficulties of their own accord, without any contribution from the client.
- The therapist generally provided potential difficulties of their own accord, with only a cursory contribution sought from the client (e.g., 'So that would be difficult, wouldn't it?').
- The therapist attempted to consider potential difficulties with some collaboration (i.e., the therapist provided some potential difficulties themselves and elicited some input from the client).
- The therapist facilitated a discussion that identified some potential difficulties, and some potential solutions were also generated and considered. The client arrived at a vague plan to overcome the potential difficulties.
- The therapist facilitated a discussion that identified most potential difficulties, and a range of potential solutions were generated and considered. The client arrived at a clear plan to overcome the potential difficulties that included specific behaviors (e.g., 'My days are really busy next week, so I will set the alarm clock 30 minutes earlier on Tuesday morning and read the booklet before starting the day's other activities').
- The therapist facilitated a discussion that identified the potential difficulties, and a full range of potential solutions were generated and considered. The client arrived at a clear plan to overcome the potential difficulties that included specific behaviors, and behavioral strategies for considering changing circumstances (e.g., if unable to complete a task in a single sitting, then breaking it into smaller chunks and completing it over 2-3 sittings).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

CA4 How well did the therapist emphasize the homework task as having a learning 'experiment' focus (e.g., a no-lose scenario, partial completion is helpful, seeing what works and what doesn't)?

Rating

- The therapist did not emphasize the task as a learning 'experiment' focus.
- The therapist specified or intimated there was a 'correct' actual outcome from the homework task (i.e., could pass or fail), rather than emphasizing the learning 'experiment' focus.
- The therapist did not focus on actual outcomes, but was vague about the learning outcome (i.e., 'It will be useful') but did not elaborate any further.
- The therapist briefly explained the homework task as a learning experiment (i.e., to test out an idea or skill), rather than guided the client to their own learning.
- The therapist framed the homework task as a learning 'experiment'. Most of the following points emerged from the discussion: there is no right or wrong (no failure or grading); it is a no-lose situation for the client; in any experiment the outcome is not known; there is a learning from every homework task no matter what the actual outcome; any information from the experiment is useful to further help with the treatment.
- The therapist used guided discovery to uncover the client's beliefs about the outcomes of the homework task, and then used Socratic questioning and hypothetical examples to facilitate the client to view the homework task as a learning experiment (i.e., gaining client's previous experiences of learning and applying them to the homework). Most of the following points emerged from the discussion: there is no right or wrong (no failure or grading); it is a no-lose situation for the client; in any experiment the outcome is not known; there is a learning from every homework task no matter what the actual outcome; any information from the experiment is useful to further help with the treatment.
- The therapist used guided discovery to uncover the client's beliefs about the outcomes of the homework task, and then used Socratic questioning and hypothetical examples to facilitate the client to view the homework task as a learning experiment. Most of the following points emerged from the discussion: there is no right or wrong (no failure or grading); it is a no-lose situation for the client; in any experiment the outcome is not known; there is a learning from every homework task no matter what the actual outcome; any information from the experiment is useful to further help with the treatment. The therapist also discussed the benefits (e.g., new skill acquisition, reduction in distressing thoughts, better treatment outcome) versus the costs of performing the homework task (e.g., time, energy, short-term distress).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

CA5 How well did the therapist ask the client to summarize the homework task and obtain an indication of the client's readiness, importance, or confidence?

Rating

- 0 The therapist did not ask the client to summarize the task or obtain an indication of readiness, importance, or confidence.
- 1 The therapist summarized the task, without any contribution from the client, and no readiness, importance, or confidence indication/ ratings obtained.
- 2 The therapist attempted to involve the client in summarizing the task and obtained separate indications/ ratings for readiness, importance, or confidence, with only a cursory contribution sought from the client. (e.g., "Does about 80% sound right to you?").
- 3 The therapist involved the client in summarizing the task and obtained a vague readiness, importance, or confidence indication/ rating (e.g., the client said "I'd give that a very high rating"), with some collaboration (i.e., the therapist provided some information themselves and elicited some input from the client).
- 4 The client summarized the task and to provided an indication/ rating of readiness, importance, and confidence.
- 5 The client summarized the task and provided a specific ratings for readiness, importance, or confidence. If the rating was low (i.e., <70%) the client was gently guided to identify what it would take to increase their rating.
- 6 The therapist made use of Socratic questioning, which enabled the client to actively summarize the task and provide separate ratings for readiness, importance, and/or confidence. If the task summary was incomplete, the client was gently guided to its completion, or the task was modified with decreased demands. If the confidence rating was low (i.e., <70%) the client was gently guided to identify what it would take to increase their confidence level. The therapist also explored overly confident ratings (e.g., an immediate or persistent statement of 100%) to identify possible social desirability responses.

APPENDIX B
TRAINING MATERIAL

Homework Assignment Adherence & Competence Scale (HAACS)

Training Pack

Dr Nikolaos Kazantzis
Paul Wedge
October 2004

Overview of today

- Welcome, housekeeping, and introductions
- Context: The CBT Homework Project & Thesis overview
- Practice Exercise: What we know about homework
- What is homework?
- Homework Administration
- Therapist's Quick Reference
- The HAACS: Overview, terminology and general rating considerations
- Practice Exercise: Using the HAACS
- Discussion, wrap up, and next steps

Introductions

- Name
- What are you doing this year (e.g., work, study, etc)
- CBT Papers taken (e.g., 707, 761, and ...?)
- Clinical training and experience
- And how about something personal ...
 - One thing you really like, and one thing you really dislike

Context: The CBT Homework Project

- Initiated at School of Psychology, Massey University
- Core research team of Nikolaos Kazantzis (PI), Kevin Ronan, Frank Deane, Luciano L'Abate, and other international collaborators
- To develop an understanding of the mechanism by which homework produces its effect in cognitive behavioral therapy
- Several broad objectives ...

Context: The CBT Homework Project

- Several broad objectives ...
 1. Conventional and statistical reviews of the empirical literature to clarify current knowledge
 2. Survey psychologists use of homework assignments in clinical practice to determine necessity and utility of future research
 3. Design a theoretical model and treatment manual for the use of homework assignments in therapy
 4. Design conceptually-driven methods of assessing homework completion and therapist competence in using homework assignments, and evaluate their psychometric properties
 5. Conduct prospective process and treatment-outcome research to evaluate the utility of the theoretical model and treatment manual

Context: Thesis Objectives

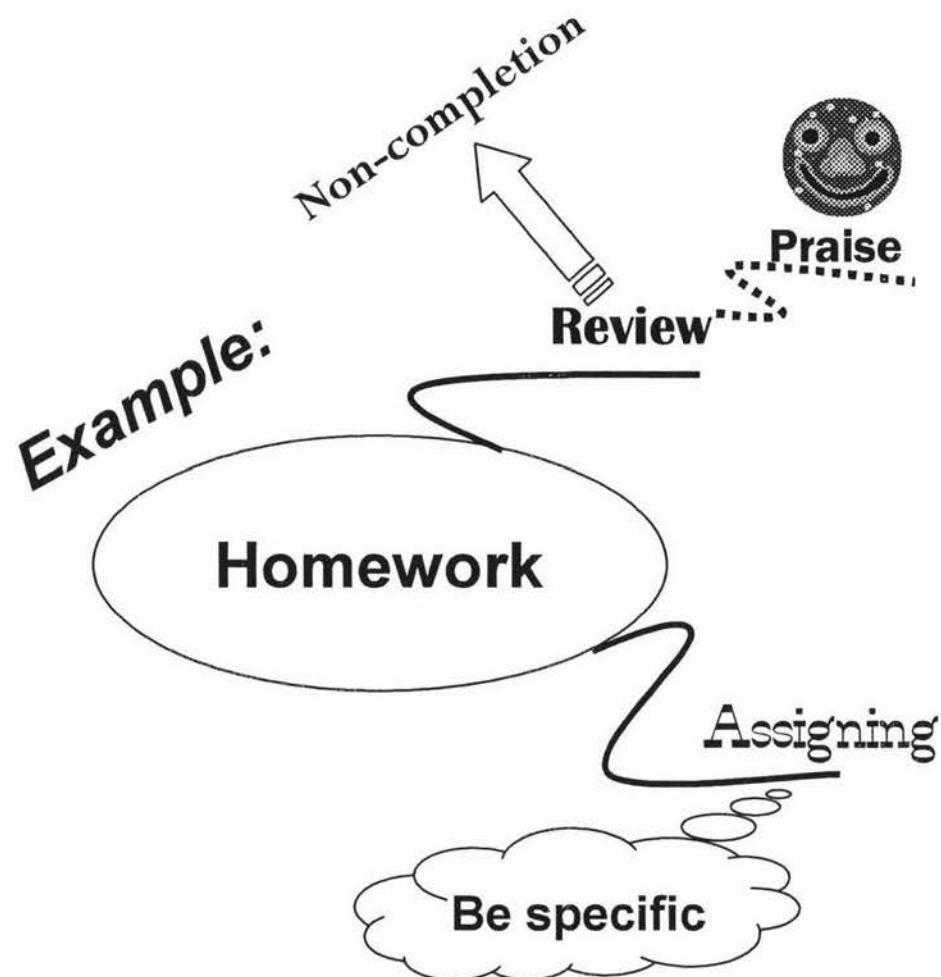
- Empirical support for homework
- Theoretical bases of homework
- Guiding model for practice
- Existing measures of therapist adherence and competence
- Develop a new measure
- Undertake a preliminary evaluation
- Discuss findings and implications for future research

Context: Thesis Method

- Develop measure – 1st draft
- Expert feedback
- Training
- Pilot study#1
- Analysis
 - IRR, distribution of responses, rater feedback, expert feedback
- Revise measure – 2nd draft
- Pilot Study #2
- Analysis
 - IRR, distribution of responses, rater feedback, expert feedback
- Revise measure – final draft

Practice Exercise: Homework in CBT

- An exercise to activate your existing knowledge!
- Collaboratively draw a mind-map
- EVERYTHING you know about homework
- Use others' ideas to stimulate new ideas
- Use colour
- Use pictures
- Be creative
- HAVE FUN



What is Homework?

“Homework assignments are planned therapeutic activities undertaken by clients between therapy sessions. Their content are derived primarily from the empirically supported cognitive behavioral therapy model for the particular presenting problem, but are tailored for the client based on an individualized conceptualization. Deigned collaboratively, homework assignments are focused on the client’s goals for therapy. Homework assignments represent the main process by which clients experience behavior and cognitive therapeutic change, practice and maintain new skills and techniques, and experiment with new behaviors. Homework assignments also provide an opportunity for clients to collect information regarding their thoughts, moods, physiology, and behaviors in different situations, and to read information related to therapy and their presenting problems.”

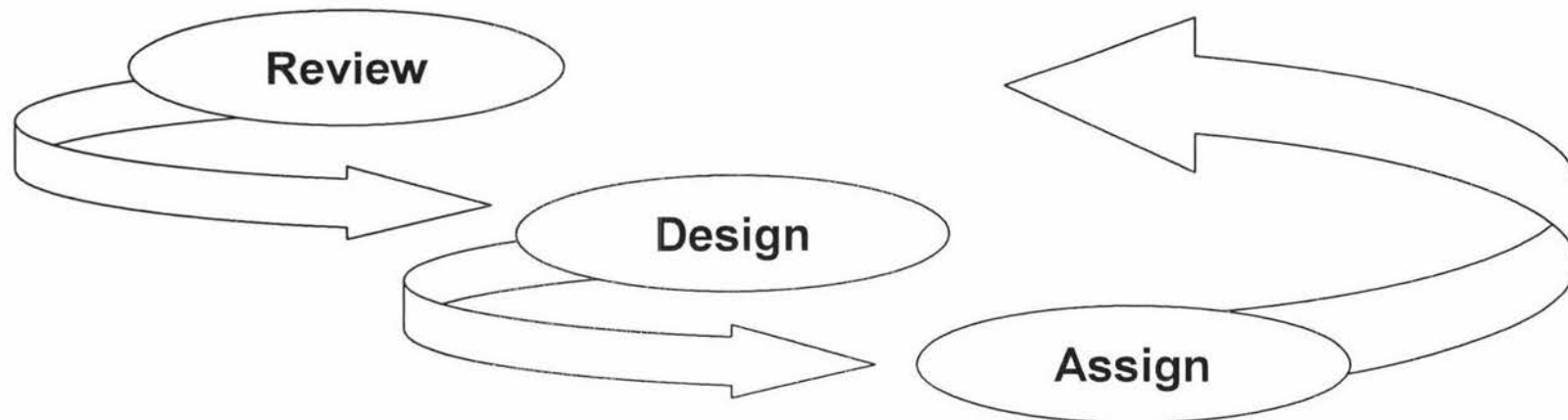
Please do not cite: Kazantzis, N.. (in press). Introduction and overview. In N. Kazantzis, F. P. Deane, K. R. Ronan & L. L'Abate (Eds.), *Using Homework Assignments in Cognitive-Behavior Therapy*: Brunner-Routledge.

Homework Administration

- Homework is an essential feature of CBT
- Homework administration is embedded within overall CBT session structure
 - Brief update and mood check
 - Bridge from previous session
 - Setting agenda
 - Review of homework assigned in the previous session
 - Discussion of issues on the agenda (include designing 'new' homework)
 - Assigning 'new' homework
 - Session feedback

Homework Administration

- Works best within a model of therapy with a 10/40/10 split of the therapy hour
 - First 10 minutes involve Homework *Review*
 - Next 40 minutes involve therapy proper and Homework *Design*
 - Last 10 minutes involve *Assigning* 'new' Homework
- Then the 'cycle' repeats in the next therapy session



Therapist Quick Reference* - **REVIEW**

- Discuss non-completion and **quantity and quality** of completion
- Provide verbal reinforcement for any portion carried-out
- Situational conceptualization to identify beliefs about the consequences, and their synthesis of learning
- Use individualized conceptualization to make sense of any portion of non-completed homework
- Problem solve practical obstacles
- Record homework completion in session notes

Therapist Quick Reference* - **DESIGN**

- Guided discovery to identify coping strategies and beliefs
- Use disorder specific cognitive model and individualized conceptualization
- Collaboratively select task
- Present a rationale that aligns with the client's treatment goals
- Ask about client's ability and perceived task difficulty
- In-session practice of task
- Guided imagery to begin experiential learning
- Situational conceptualization to identify beliefs and situational triggers

*Therapist Quick Reference © Copyright 2005 by Nikolaos Kazantzis, Frank Deane, and Kevin Ronan. From the book "Using Homework Assignments in Cognitive Behavior Therapy" edited by Kazantzis, Deane, Ronan, & L'Abate (2005) published by Brunner-Routledge.

Therapist Quick Reference* - **ASSIGN**

- Ask client to summarize rationale in relation to therapy goals
- Collaborate to specify how the task will be practically possible (i.e., when, where, how often, and how long it will take)
- Consider potential difficulties
- Emphasize learning 'experiment' focus
- Ask client to summarize task and obtain ratings of readiness, importance, and confidence (renegotiate if <70%)
- Make a written note of the homework for the client (or use homework form)

HAACS: Overview

- The measure is conceptually driven
- Items are based on a guiding model and the Therapist's Quick Reference
- Each item is rated for both adherence (in one section) and competence (in a second section)
- Both sections are divided into three sub-areas: review (5-6 items), design (8 items), and assign (5-6 items)
- Adherence is rated dichotomously (i.e., “yes” or “no”)
- Competence is rated on a 7-point Likert scale (from 0 = ‘extremely poor’ to 6 = ‘excellent’), with each individual point descriptively anchored

HAACS: Adherence vs. Competence

- Please remember that adherence is different from competence
 - **adherence** refers to whether the therapist **engaged in**, or **attempted**, a particular behaviour
 - **competence** refers to **how well** the therapist performed the behaviour
- Also, adherence is a necessary but not sufficient condition for competence
 - this means if there is no adherence (i.e., the therapist did not undertake or display any behaviours for an item) , then there can be no competence (i.e., a rating of “0”)
 - but even if there was adherence, this does necessarily mean that competence is high; it could be anywhere from extremely poor through to excellent

HAACS: Terminology

- To use the HAACS effectively, raters should have knowledge and understanding of some key terminology:
 - Adherence
 - Competence
 - Collaboration
 - Interpretation
 - Situational conceptualization
 - Individualized conceptualization
 - Automatic thoughts
 - Underlying assumptions and rules
 - Core beliefs
 - Behavioural experiments
 - Guided discovery
 - Disorder-specific cognitive models
 - Guided imagery
 - Experiential learning
 - Thought record
 - Socratic questioning

HAACS: General Rating Considerations

- Please beware of the 'halo' effect
 - Providing overall positive ratings for all items, based on only one particular aspect or behaviour that was done very well
- ... and the 'horns' effect
 - Providing overall negative ratings for all items based on only one particular aspect or behaviour that was done very poorly
- Please also beware of leniency, severity and central tendency effects
 - i.e. a tendency to rate either at the high, low, or central parts of the rating scale, respectively

HAACS: General Rating Considerations

- Some ideas which may help:
 - please try and rate each item on its own merit
 - for competence items, please try and use the full range of the Likert scale (i.e., use the descriptive anchors as your guide)
 - try and remember that even though a therapist may appear generally very good, it does not mean that they necessarily **adhere** to all items in any one session
 - Similarly, it is also likely that even though a therapist generally has very good **competence**, they may also still receive some low ratings on some items (e.g., it is difficult to do everything very well all of the time!).

Practice: Rating a CBT session

Discussion, Wrap-up, Next Steps

APPENDIX C
HAACS - PILOT ONE VERSION

HAACS

Homework Adherence And Competence Scale

Assessing Therapist Adherence and Competence in Using Homework Assignments within Cognitive Behavior Therapy

Nikolaos Kazantzis
Paul Wedge
Keith S. Dobson

Pilot One Version

HAACS

Therapist Adherence and Competence

Instructions:

This therapist adherence and competence rating scale consists of 19 items regarding therapists' integration of homework assignments in cognitive behavior therapy. Items 1-5 cover therapist behaviors for REVIEWING homework. Items 6-14 cover therapist behaviors for DESIGNING homework. Items 15-19 cover therapist behaviors for ASSIGNING homework.

Every individual item starts on a new page, and has two clearly identifiable questions; adherence (i.e. "DID the therapist ...") and competence (i.e. "HOW WELL did the therapist ..."). The adherence question for each item is labeled with an 'a' (e.g., 1a, 2a, 3a, etc.), and the competence question for each item is labeled with a 'b' (e.g., 1b, 2b, 3b, etc.).

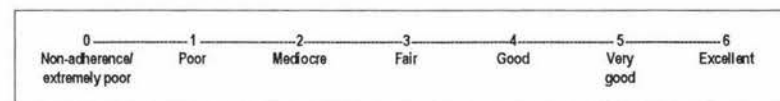
(a) Adherence

Please note that your rating for the *adherence* questions (i.e., the 'a' questions) is to indicate whether these aspects were carried out by the therapist (i.e., adherence) to any extent. This is different from rating how well the therapist undertook each item (i.e., competence). For each item, please consider the adherence question carefully, and tick either 'yes' or 'no' to indicate whether the therapist ENGAGED to any extent in each aspect. Please select only one response option for any question.

(b) Competence

Please note that your rating for the *competence* questions (i.e., the 'b' questions) is to indicate HOW WELL the therapist undertook each item (i.e., competence). This is different from rating whether these aspects were attempted by the therapist (i.e., adherence). Adherence is a necessary BUT NOT SUFFICIENT condition for competence. This means that if adherence was rated "no" for a therapist behavior, then the therapist competence cannot be rated higher than "0" for the same item. For each item, please consider the competence question carefully, and record the appropriate number in the rating box to indicate how well the therapist carried out each aspect.

Each competence question has seven descriptive response options. Underpinning these response options is a seven point Likert scale ranging from 0 (*non-adherence/extremely poor*) to 6 (*excellent*). This Likert scale is printed at the top of every page for your reference.



In the first instance, please use the descriptive response options to determine the rating for each item. However, if you are having difficulty deciding on a rating (e.g., the response options descriptions do not seem to easily fit the session being rated), then refer to the underlying Likert scale. If several items seem to apply equally well, record the lowest number for that item, and provide only a single rating number for any item (e.g., if considering recording "3-4", record it as a "3"). Please provide a rating for every item.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

HOMEWORK REVIEW Items 1-5 cover the therapist behaviors involved in reviewing homework from the previous session, and typically occurs early in the session.

Item 1

1a DID the therapist make enquiries and discuss previously assigned homework tasks? Yes ☐ No ☐

1b HOW WELL did the therapist make enquiries and discuss previously assigned homework tasks? Rating

- 0 The therapist did not make any enquiries, or discuss previously assigned homework.
- 1 The therapist made a cursory enquiry about previous homework completion, but did not discuss it (i.e., no exploration of the client's responses).
- 2 The therapist enquired about previous homework completion, and made an attempt to elicit feedback from the client but this was not successful (e.g., the therapist used closed questions, or did not allow sufficient time for a response).
- 3 The therapist enquired about previous homework, and elicited some general feedback from the client. For instance, the client gave a vague response such as "I completed most of it" and this response was taken at face value and was not explored further (e.g., "Can you tell me more about the parts you completed?" and then "Can you tell me about the parts you had difficulty with or did not complete?").
- 4 The therapist enquired about previous homework and identified exactly what portion of the homework what was completed and what was not completed. However, the discussion focused either on the completed homework or the non-completed homework.
- 5 The therapist identified and discussed both completed and non-completed homework. However, in discussing completed homework, the focus was more on the quantity of what was completed (i.e., the extent of completion), rather than the quality (i.e., degree of client learning or skill acquisition, such as mastery in completing a thought record effectively, or testing out beliefs in behavioral experiments).
- 6 Both the quantity (i.e., the extent of completion and non-completion) and quality (i.e., degree of client learning or skill acquisition, such as mastery in completing a thought record effectively, or testing out beliefs in behavioral experiments) of homework completion was discussed. The therapist facilitated a highly effective discussion to elicit the client's learning from the homework task (e.g., using Socratic questioning).

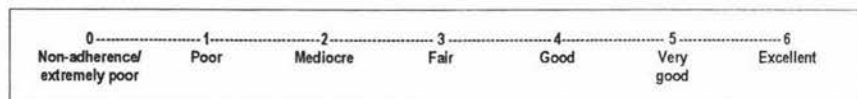
0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

Item 2

2a DID the therapist provide appropriate verbal reinforcement (i.e., praise) for any portion of the homework task carried out? Yes ☐ No ☐

2b HOW WELL did the therapist provide appropriate verbal reinforcement (i.e., praise) for any portion of the homework task carried out? Rating

- 0 The therapist did not provide verbal reinforcement for any portion of the homework carried out.
- 1 Verbal reinforcement was given that was very brief and limited in relation to the portion of homework completed, or excessive praise was given for low completion.
- 2 Some verbal reinforcement was given but this was not clearly linked to the portion of homework completed, or excessive praise was given for low completion.
- 3 Appropriate verbal reinforcement was given for most portions of the homework completed.
- 4 Appropriate verbal reinforcement was given for all portions of the homework completed.
- 5 Appropriate praise and encouragement was given for all portions of the homework completed. The therapist appeared clearly enthusiastic in acknowledging and validating the client's efforts.
- 6 Appropriate praise and encouragement was given for all portions of the homework completed. The therapist appeared clearly enthusiastic in acknowledging and validating the client's efforts. Encouragement was given for the client extending/ generalizing the homework task to extend skill acquisition/ apply task to more challenging problems.

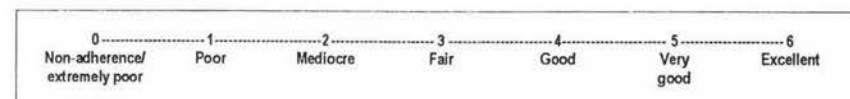


Item 3

3a DID the therapist use a situational conceptualization (e.g., identify thoughts, behaviors, emotions, physiology) to identify the client's beliefs about the consequences of having engaged in the homework task and their synthesis of learning? Yes ☐ No ☐

3b HOW WELL did the therapist use a situational conceptualization (e.g., identify thoughts, behaviors, emotions, physiology) to identify the client's beliefs about the consequences of having engaged in the homework task and their synthesis of learning? Rating

- The therapist did not use a situational conceptualization to identify beliefs about the consequences and their synthesis of learning.
- An undeveloped situational conceptualization was arrived at (i.e., the therapist completely interpreted on behalf of the client).
- A vague, brief and incomplete situational conceptualization was arrived at (i.e., the therapist mostly interpreted for the client's experiences rather than eliciting information).
- A partially developed situational conceptualization was arrived at (i.e., the therapist elicited some information and interpreted other information). No automatic thoughts or beliefs about the consequences, or synthesis of learning were identified.
- A situational conceptualization facilitated the identification of salient (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as triggers for homework completion.
- A situational conceptualization facilitated the identification of salient (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as triggers for homework completion. The therapist also elicited beliefs about the homework (i.e., difficulty, sense of pleasure, sense of mastery).
- A situational conceptualization facilitated the identification of salient (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as triggers for homework completion. The therapist also elicited beliefs about the homework (i.e., difficulty, sense of pleasure, sense of mastery), as well as consequences and their synthesis of learning (i.e., relevance, match with therapy goals, benefits, perceived progress).



Item 4

4a DID the therapist obviously use an individualized conceptualization to make sense of any portion of non completed homework (i.e., linked doing the task to the client's automatic thoughts, underlying assumptions and rules, or core beliefs)? Yes ☐ No ☐

4b HOW WELL did the therapist obviously use an individualized conceptualization to make sense of any portion of non completed homework (i.e., linked doing the task to the client's automatic thoughts, underlying assumptions and rules, or core beliefs)? Rating

- The therapist did not use an individualized conceptualization to make sense of any portion of non-completed homework.
- The therapist labeled/ interpreted the portion of non-completed homework rather than facilitating the client's own understanding through collaborative discussion.
- The therapist focused on one individualized conceptualization component (i.e., either core beliefs, or conditional rules and assumptions, or automatic thoughts). The therapist used this information to label/ interpreted the portion of non-completed homework rather than facilitating the client's own understanding.
- The therapist made limited use of an individualized conceptualization, including some but not all of the following aspects: core beliefs, conditional rules and assumptions, and automatic thoughts. The therapist used this information to reach a vague understanding of homework non-completion.
- The therapist facilitated a discussion that made reasonable use of an individualized conceptualization, including some but not all aspects of: core beliefs, conditional rules and assumptions, and automatic thoughts. This led to a reasonable understanding of the client's beliefs about the homework task, and homework non-completion.
- The therapist facilitated a discussion that made good use of an individualized conceptualization, including all aspects of: core beliefs, conditional rules and assumptions, and automatic thoughts. This led to a clear understanding of the client's beliefs about the homework task, and homework non-completion.
- The therapist facilitated a discussion that made full use of an individualized conceptualization, including core beliefs, conditional rules and assumptions, and automatic thoughts in several situations, which were linked to overall treatment goals. This led to a very clear understanding of the client's beliefs about the homework task, the portion of non-completed homework, AS WELL AS the generalization of the task to other situations.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

Item 5

5a DID the therapist attempt to problem solve practical obstacles to the homework task? Yes ☐ No ☐

5b HOW WELL did the therapist attempt to problem solve practical obstacles to the homework task? Rating

- 0 The therapist did not attempt to problem solve practical obstacles.
- 1 The therapist provided solutions of their own accord, without any contribution from the client.
- 2 The therapist provided solutions of their own accord, with only a cursory contribution sought from the client. (e.g., "Does that sound okay to you?").
- 3 The therapist attempted to problem solve practical obstacles with some collaboration (i.e., the therapist provided some solutions themselves and elicited some input from the client).
- 4 The therapist facilitated a discussion that identified the actual practical obstacles. Some potential solutions were generated and considered. The client arrived at a vague plan to overcome the obstacles.
- 5 The therapist facilitated a discussion that identified the actual practical obstacles. A range of potential solutions were generated and considered. The client arrived at clear behavioral strategies to overcome the practical obstacles.
- 6 The therapist facilitated a discussion that identified the actual practical obstacles, as well as a consideration of other potential obstacles that may have occurred. A full range of potential solutions were generated and considered. The client arrived at clear behavioral strategies to overcome the practical obstacles, as well as behavioral strategies for considering changing circumstances (e.g., bringing an outside activity indoors, testing beliefs in several situations, applying interpersonal skills to a range of relationships/interactions).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

HOMEWORK DESIGN

Items 6-14 cover the therapist behaviors involved in collaboratively deciding what homework will be carried out during the next week, and typically occurs throughout the session

Item 6

6a DID the therapist discuss a new/ revised homework task at an appropriate point(s) during the session? Yes ☐ No ☐

6b HOW WELL did the therapist discuss a new/ revised homework task at an appropriate point(s) during the session? Rating

- 0 The therapist did not discuss a new/ revised homework task during the session.
- 1 The therapist briefly discussed a new/ revised homework task at the end of the session.
- 2 The therapist allowed sufficient time for a discussion on a new/ revised homework task at the end of the session, but this was not linked to in-session content or therapy goals.
- 3 The therapist allowed sufficient time for a discussion on a new/ revised homework task at the end of the session, and this WAS linked to either in-session content or therapy goals.
- 4 The therapist allowed sufficient time for a discussion on a new/ revised homework task at the end of the session, and this WAS linked to BOTH in-session content or therapy goals.
- 5 The therapist took the opportunity to discuss a new/ revised homework task appropriately during the course of the session, as well as at the end of the session. The new/ revised homework WAS linked to BOTH in-session content or therapy goals.
- 6 The therapist took the opportunity to discuss a new/ revised homework task appropriately during the course of the session, as well as at the end of the session. The new/ revised homework WAS linked to BOTH in-session content or therapy goals. The therapist was able to engage the client in discussion effectively, used novel and tailored presentation of the new task, even when confronted with interpersonal difficulties (e.g., client avoidance, perfectionism, demanding interpersonal style).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

Item 7

7a DID the therapist use guided discovery to identify the client's coping strategies and beliefs related to the homework task? Yes ☐ No ☐

7b HOW WELL did the therapist use guided discovery to identify the client's coping strategies and beliefs related to the homework task? Rating

- 0 The therapist did not use guided discovery to identify the client's coping strategies and beliefs related to the homework task.
- 1 The therapist used ineffective questioning (e.g., closed questions or broad questions, but these did not uncover new information) and provided interpretive answers rather than guiding the client's own understanding about coping strategies and beliefs.
- 2 The therapist used some (not all) components of the guided discovery process: (i) asked some informational questions, (ii) listened empathically and provided some reflections, (iii) provided some summaries of the information discovered, and (iv) asked some synthesizing or analytical questions. However they were used in a cursory, inappropriate, or ineffective manner (e.g., inaccurate reflections or summaries). The therapist used interpretive answers rather than guiding the client's own learning, and was unable to identify coping strategies and beliefs (e.g., "If you think X, then surely Y is?").
- 3 The therapist used all four components of the guided discovery process: (i) asked some informational questions, (ii) listened empathically and provided some reflections, (iii) provided some summaries of the information discovered, and (iv) asked some synthesizing or analytical questions, but was ineffective in identifying coping strategies and beliefs.
- 4 The therapist used all four components of the guided discovery process reasonably effectively: (i) asked informational questions which uncovered some information outside the client's awareness, (ii) listened empathically and provided some accurate and appropriate reflections, (iii) provided some accurate summaries of the information discovered, and (iv) asked some synthesizing or analytical questions, which enabled some client learning. In using this process the therapist facilitated the identification of a few coping strategies and beliefs.
- 5 The therapist used all four components of the guided discovery process effectively (i) asked appropriate informational questions which uncovered information outside the client's awareness, (ii) listened empathically and provided accurate and appropriate reflections, (iii) accurately summarized the information discovered at appropriate times, and (iv) asked synthesizing or analytical questions which enabled the client's own learning. In using this process the therapist facilitated the identification of a number of coping strategies and beliefs.
- 6 The therapist appeared genuinely curious and inquisitive, and used all four components of the guided discovery process very effectively: (i) asked several appropriate informational questions which uncovered significant information outside the client's awareness, (ii) listened empathically and provided accurate and appropriate reflections, (iii) accurately summarized the information discovered at appropriate times, and (iv) asked highly appropriate synthesizing or analytical questions which enabled the client's own learning. In using this process the therapist facilitated the identification of a number of highly credible coping strategies and beliefs.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

Item 8

8a DID the therapist obviously integrate a disorder-specific cognitive model with the individualized conceptualization in the design of the homework task? Yes ☐ No ☐

8b HOW WELL did the therapist obviously integrate a disorder-specific cognitive model with the individualized conceptualization in the design of the homework task? Rating

- 0 The therapist did not discuss a disorder-specific cognitive model or individualized conceptualization in the homework design.
- 1 The mentioned the disorder-specific cognitive model but did not elaborate on how it was relevant to the client's presentation.
- 2 The therapist integrated some but not all aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to one aspect of the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies).
- 3 The therapist integrated some but not all aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to more than one aspect the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies).
- 4 The therapist integrated most aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to most aspects the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies).
- 5 The therapist integrated all aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to all aspects of the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies).
- 6 The therapist integrated all aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to all aspects of the client's individualized conceptualization (e.g., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies). The therapist was able to integrate all this information with the client's presenting problems evidenced in tactful responses to client's interpersonal style (e.g., critical, competitive, suspicious, controlling, exaggerative).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

Item 9

9a DID the therapist collaboratively select/design the homework task?

Yes ☐ No ☐

9b HOW WELL did the therapist collaboratively select/design the homework task?

Rating

- The therapist did not collaboratively select/design a homework task.
- The therapist selected/designed the homework task without any contribution of the client.
- The therapist only sought a cursory contribution from the client in selecting/designing the homework task. (e.g., "Does that sound okay to you?").
- The therapist involved the client in the selection/design of the homework task, but at times reverted to a directive rather than collaborative approach, especially in the final decision.
- The therapist involved the client in selecting/designing the homework task (e.g., facilitated a discussion rather than provided direct answers, discussed a few possible homework tasks, or collaboratively discussed the advantages and disadvantages of the possible homework tasks).
- The therapist encouraged the client to view the process of selecting/designing the homework task as the therapist and client working together as a team. The therapist also actively involved the client in selecting the homework task (e.g., facilitated a discussion rather than provided direct answers, discussed several possible homework tasks, elicited and explored the client's thoughts and feelings about the possible homework tasks, or collaboratively discussed the advantages and disadvantages of the possible homework tasks).
- The therapist encouraged the client to view the process of selecting/designing the homework task as the therapist and client working together as a team. The therapist also actively involved the client in selecting the homework task (e.g., facilitated a discussion rather than provided direct answers, discussed a full range of possible homework tasks, elicited and explored the client's thoughts and feelings about the possible homework tasks, and collaboratively discussed the advantages and disadvantages of the possible homework tasks (i.e., based on prior experience, benefits experienced by others, collaboration and encouragement from therapist). The therapist and client decided on a homework task that built upon existing client skills and strategies, and the client was encouraged to take on more responsibility for designing/ selecting tasks.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

Item 10

10a DID the therapist present a rationale for the homework task that aligned with the client's goals for treatment?

Yes ☐ No ☐

10b HOW WELL did the therapist present a rationale for the homework task that aligned with the client's goals for treatment?

Rating

- The therapist did not present a rationale for the homework.
- The therapist presented a brief rationale but failed to relate it to the client's treatment goals.
- The therapist presented a rationale for the homework task with some mention of the client's treatment goals, however this was presented without any input (and understanding) from the client.
- The therapist assisted the client to understand how the homework task was aligned to either the specific presenting problem in the current session.
- The therapist assisted the client to understand that the task was broken into achievable chunks that were manageable and within the client's control. The therapist also assisted the client to understand how the homework task was aligned to EITHER the specific presenting problem in the current session, OR their overall treatment goals.
- The therapist assisted the client to understand that the task was broken into achievable chunks that were manageable and within the client's control. The therapist also assisted the client to understand how the homework task was aligned to both the specific presenting problem in the current session AS WELL AS their overall treatment goals.
- The therapist assisted the client to understand that the task was broken into achievable chunks that were manageable and within the client's control. The therapist also assisted the client to understand how the homework task was aligned to both the specific presenting problem in the current session AS WELL AS their overall treatment goals, AND obtained feedback from the client on the rationale. The therapist ALSO provided empirical evidence to support the rationale or the homework task.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

Item 11

11a DID the therapist ask about the client's ability and perceived difficulty of the homework task?

Yes ☐ No ☐

11b HOW WELL did the therapist ask about the client's ability and perceived difficulty of the homework task?

Rating

- The therapist did not ask about the client's ability and perceived difficulty of the task.
- The therapist made a cursory enquiry about the client's ability and perceived difficulty of the task, but did not discuss it any further.
- The therapist enquired about the client's ability and perceived difficulty of the task, and made an ineffective attempt to elicit feedback from the client (e.g., the therapist did not listen to the client's responses, asked closed questions, questions did not follow the client's responses).
- The therapist enquired about the client's ability and perceived difficulty of the task, and elicited a general statement from the client, for example, the client was vague and said "Sure, I can do it" and this response was taken at face value and not probed any further.
- The therapist enquired about the client's ability and perceived difficulty of the task, and through Socratic questioning identified a broad issue (e.g., "That thought record looks too hard. There is so much to complete"). However, the therapist then provided their own solutions to resolve the issues raised (e.g., "Okay, just complete the first three columns of the thought record").
- The therapist enquired about the client's ability and perceived difficulty of the task, and through Socratic questioning identified specific issues (e.g., in addition to feeling overwhelmed by the entire thought record, it transpired that the client had difficulty distinguishing emotions and thoughts on thought record). Through further exploration the therapist and client collaboratively resolved the issue (e.g., the therapist and client worked on automatic thoughts in-session, and/or the homework was redesigned to focus on practicing the identification emotions as distinct from automatic thoughts).
- The therapist enquired about the client's ability and perceived difficulty of the task, and through Socratic questioning identified specific issues. Through further exploration the therapist and client collaboratively resolved the issue. The therapist also elicited additional client learning from the discussion, for example, the client learnt that breaking items into smaller chunks was less overwhelming, and also identified an underlying rule (e.g., "I've failed if I can't work things out for myself").

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

Item 12

12a DID the therapist facilitate in-session practice of the homework task?

Yes ☐ No ☐

12b HOW WELL did the therapist facilitate in-session practice of the homework task?

Rating

- The therapist did not provide the opportunity for in-session practice of the task.
- The therapist briefly demonstrated or explained (i.e., modeled or instructed) the task that provided no opportunity for the clients to learn from their own practice.
- The therapist provided only a brief opportunity for in-session practice. The therapist tended to focus on correcting the client's mistakes and provided limited positive reinforcement. The therapist did not discuss any learning points from the practice.
- The therapist provided a reasonable opportunity for in-session practice. The therapist provided appropriate verbal reinforcement (i.e., shaping successive approximations of skill), and gave some constructive guidance when the client needed assistance. However, the therapist used a directive/ punitive rather than collaborative approach in discussing learning points from the practice.
- The therapist provided a good opportunity for in-session practice, using the method/s most appropriate for the client and the specific task. The therapist provided some positive reinforcement (i.e., shaping successive approximations of skill) and gave some constructive guidance when the client needed assistance. The therapist was encouraging when discussing learning points from the in-session practice.
- The therapist provided an excellent opportunity for in-session practice, using the method/s most appropriate for the client and the specific task. The therapist provided enthusiastic reinforcement (i.e., shaping successive approximations of skill), and gave warm, genuine, constructive guidance when the client needed assistance. The therapist facilitated learning from the specific practice, asked the client for feedback on the experience, and asked the client to write down the learning points.
- The therapist provided an excellent opportunity for in-session practice, using the method/s most appropriate for the client and the specific task. The therapist provided enthusiastic reinforcement (i.e., shaping successive approximations of skill), and gave warm, genuine, constructive guidance when the client needed assistance. The therapist facilitated learning from the specific practice, asked the client for feedback on the experience, and asked the client to write down the learning points.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

Item 13

13a DID the therapist use guided imagery to begin experiential learning for the homework task? Yes ☐ No ☐

13b HOW WELL did the therapist use guided imagery to begin experiential learning for the homework task? Rating

- 0 The therapist did not use guided imagery in homework design.
- 1 The therapist used guided imagery ineffectively (i.e., affect was not generated, client had difficulty staying on track, etc). Feedback was not sought throughout the exercise, and at the completion, the therapist did not facilitate any experiential learning from the imagery practice.
- 2 The therapist provided an opportunity for guided imagery, but was unable to use this to assist the client with some experiential learning of the homework task (i.e., client completed imagery but did not gain an experience of completing the task).
- 3 The therapist facilitated the client in using guided imagery, and this was reasonably effective in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified). However, imagery was ineffective in providing the client with some experiential learning of the homework task (i.e., client completed imagery but did not gain an experience of completing the task).
- 4 The therapist facilitated the client in using guided imagery, and this was reasonably effective in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified), AND the client gained some experiential learning of the homework task (i.e., experienced the outcome of having engaged in the homework task).
- 5 The therapist facilitated the client in using guided imagery, and this was reasonably effective in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified), AND the client gained some experiential learning of the homework task (i.e., experienced the outcome of having engaged in the homework task). The therapist focused on skill acquisition and discussed with the client how the task could be extended to more complex skills (i.e., shaping).
- 6 The therapist facilitated the client in using guided imagery, and this was reasonably effective in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified), AND the client gained some experiential learning of the homework task (i.e., experienced the outcome of having engaged in the homework task). The therapist focused on skill acquisition and discussed with the client how the task could be extended to more complex skills (i.e., shaping). In feedback, the therapist and client also discussed the application of the task across different situations (i.e., generalization and maintenance).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

Item 14

14a DID the therapist use a situational conceptualization to help identify the client's beliefs and situational triggers for carrying out the homework task in specific situations? Yes ☐ No ☐

14b HOW WELL did the therapist use a situational conceptualization to help identify the client's beliefs and situational triggers for carrying out the homework task in specific situations? Rating

- 0 The therapist did not use a situational conceptualization to help identify the client's beliefs and situational triggers for carrying out the task in specific situations.
- 1 An undeveloped situational conceptualization was arrived at (i.e., the therapist completely interpreted on behalf of the client).
- 2 A vague, brief and incomplete situational conceptualization was arrived at (i.e., the therapist mostly interpreted for the client rather than eliciting information).
- 3 A partially developed situational conceptualization was arrived at (i.e., the therapist elicited some information and interpreted other information). This proved ineffective in identifying the client's beliefs and situational triggers.
- 4 A partially developed situational conceptualization was arrived at (i.e., the therapist elicited some information and interpreted other information). Emotions, behaviors, and physiology were identified to the use of the homework, but no cognitive triggers or beliefs were identified.
- 5 A situational conceptualization facilitated the client's identification of salient (i.e., emotionally laden) automatic thoughts that served as triggers for homework completion. Emotions, behaviors, and physiology were also identified.
- 6 A situational conceptualization facilitated the client's identification of a salient (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as triggers for homework completion. The therapist ALSO discussed the triggers to the use of homework in several situations, AND elicited beliefs about the homework (i.e., difficulty, obstacles).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

HOMEWORK ASSIGN

Items 15-19 cover the therapist behaviors involved in determining how the homework assignment/s will be practically carried out, and typically occurs near the end of the session.

Item 15

15a DID the therapist ask the client to summarize the rationale for the homework task in relation to therapy goals? Yes ☐ No ☐

15b HOW WELL did the therapist ask the client to summarize the rationale for the homework task in relation to therapy goals? Rating

- 0 The therapist did not ask the client to summarize the rationale for the task in relation to therapy goals.
- 1 The therapist summarized the rationale for the task, with little or no input from the client.
- 2 The therapist attempted to involve the client in summarizing the rationale for the task in relation to therapy goals, but used a directive rather than collaborative approach.
- 3 The therapist involved the client in summarizing the rationale for the task in relation to therapy goals.
- 4 The therapist involved the client in summarizing the rationale for the task in relation to most pertinent therapy goals. That is, the homework was discussed in terms of the specific behavior changes that would be expected to result from progress towards this goal.
- 5 The therapist skillfully involved the client in summarizing the rationale for the task in relation to most pertinent therapy goals. That is, the homework was discussed in terms of the specific behavior changes that would be expected to result from progress towards this goal, and this process was lead by the client.
- 6 The therapist skillfully involved the client in summarizing the rationale for the task in relation to most pertinent therapy goals. That is, the homework was discussed in terms of the specific behavior changes that would be expected to result from progress towards this goal, and this process was lead by the client. In discussion with the therapist, the client demonstrated a clear understanding of the homework and was able to place the current homework in context of current and overall goals for therapy. The therapist skill was evidenced by their adaptation of this discussion to the client's interpersonal style.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

Item 16

16a DID the therapist collaborate with the client to specify how the homework task will be practically integrated into the client's life (i.e., specification of when, where, how often, how long)? Yes ☐ No ☐

16b HOW WELL did the therapist collaborate with the client to specify how the homework task will be practically integrated into the client's life (i.e., specification of when, where, how often, how long)? Rating

- 0 The therapist did not collaborate to specify how the task would be practically integrated into the client's life.
- 1 The therapist directed how the task could be practically integrated into the client's life, without any contribution from the client.
- 2 The therapist reached a vague outline of how the task could be practically integrated into the client's life, with little collaboration (i.e., the therapist provided some specifics themselves and elicited some input from the client).
- 3 The therapist facilitated a discussion which resulted in the client being able to state with some behavioral specificity how the task could be practically integrated into the client's life in some of the following areas: when, where, how often, and how long.
- 4 The therapist facilitated a discussion which resulted in the client being able to state with some behavioral specificity how the task could be practically integrated into the client's life in most of the following areas: when, where, how often, and how long.
- 5 The therapist facilitated a discussion which resulted in the client being able to state with a high degree of behavioral specificity how the task could be practically integrated into the client's life in all of the following areas: when, where, how often, and how long. If the client was unable to be specific in any area, the therapist gently guided the client to a specific resolution.
- 6 The therapist skillfully elicited a description of how the homework would be practically implemented from the client. A high degree of behavioral specificity was achieved in all the following areas: when, where, how often, and how long. If the client was unable to be specific in any area, the therapist gently guided the client to a specific resolution. The therapist also anticipated potential difficulties in communication and resolved them (e.g., misinterpretation of the process in achieving specificity, misinterpretation of the meaning of specificity, such as using a thought record "when" automatic thoughts occur).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

Item 17

17a DID the therapist consider potential difficulties of the homework task? Yes ☐ No ☐

17b HOW WELL did the therapist consider potential difficulties of the homework task? Rating

- The therapist did not attempt to consider potential difficulties.
- The therapist provided potential difficulties of their own accord, without any contribution from the client.
- The therapist generally provided potential difficulties of their own accord, with only a cursory contribution sought from the client. (e.g., "So that would be difficult, wouldn't it?").
- The therapist attempted to consider potential difficulties with some collaboration (i.e., the therapist provided some potential difficulties themselves and elicited some input from the client).
- The therapist facilitated a discussion that identified some potential difficulties, and some potential solutions were also generated and considered. The client arrived at a vague plan to overcome the potential difficulties.
- The therapist facilitated a discussion that identified most potential difficulties, and a range of potential solutions were generated and considered. The client arrived at a clear plan to overcome the potential difficulties that included specific behaviors (e.g., "My days are really busy next week, so I will set the alarm clock 30 minutes earlier on Tuesday morning and read the booklet before starting the day's other activities").
- The therapist facilitated a discussion that identified the potential difficulties, and a full range of potential solutions were generated and considered. The client arrived at a clear plan to overcome the potential difficulties that included specific behaviors, and behavioral strategies for considering changing circumstances (e.g., if unable to complete a task in a single sitting, then breaking it into smaller chunks and completing it over 2-3 sittings).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

Item 18

18a DID the therapist emphasize the homework task as having a learning 'experiment' focus (e.g., a no-lose scenario, partial completion is helpful, seeing what works and what doesn't)? Yes ☐ No ☐

18b HOW WELL did the therapist emphasize the homework task as having a learning 'experiment' focus (e.g., a no-lose scenario, partial completion is helpful, seeing what works and what doesn't)? Rating

- The therapist did not emphasize the task as a learning 'experiment' focus.
- The therapist specified or intimated there was a 'correct' actual outcome from the homework task (i.e. could pass or fail), rather than emphasizing the learning 'experiment' focus.
- The therapist did not focus on actual outcomes, but was vague about the learning outcome (i.e., "it will be useful") but did not elaborate any further.
- The therapist briefly explained the homework task as a learning experiment (i.e., to test out an idea or skill), rather than guided the client to their own learning.
- The therapist framed the homework task as a learning 'experiment'. Most of the following points emerged from the discussion: there is no right or wrong (no failure or grading); it is a no-lose situation for the client; in any experiment the outcome is not known; there is a learning from every homework task no matter what the actual outcome; any information from the experiment is useful to further help with the treatment.
- The therapist used guided discovery to uncover the client's beliefs about the outcomes of the homework task, and then used Socratic questioning and hypothetical examples to facilitate the client to view the homework task as a learning experiment (i.e., gaining client's previous experiences of learning and applying them to the homework). Most of the following points emerged from the discussion: there is no right or wrong (no failure or grading); it is a no-lose situation for the client; in any experiment the outcome is not known; there is a learning from every homework task no matter what the actual outcome; any information from the experiment is useful to further help with the treatment. The therapist also discussed the benefits (e.g., new skill acquisition, reduction in distressing thoughts, better treatment outcome) versus the costs of performing the homework task (e.g., time, energy, short-term distress).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very good	Excellent

Item 19

19a DID the therapist ask the client to summarize the homework task and obtain an indication of the client's readiness, importance, or confidence?

Yes ☐ No ☐

19b HOW WELL did the therapist ask the client to summarize the homework task and obtain an indication of the client's readiness, importance, or confidence?

Rating

- 0 The therapist did not ask the client to summarize the task or obtain an indication of readiness, importance, or confidence.
- 1 The therapist summarized the task, without any contribution from the client, and no readiness, importance, or confidence indication/ ratings obtained.
- 2 The therapist attempted to involve the client in summarizing the task and obtained separate indications/ ratings for readiness, importance, or confidence, with only a cursory contribution sought from the client. (e.g., "Does about 80% sound right to you?").
- 3 The therapist involved the client in summarizing the task and obtained a vague readiness, importance, or confidence indication/ rating (e.g., the client said "I'd give that a very high rating"), with some collaboration (i.e., the therapist provided some information themselves and elicited some input from the client).
- 4 The client summarized the task and to provided an indication/ rating of readiness, importance, and confidence.
- 5 The client summarized the task and provided a specific ratings for readiness, importance, or confidence. If the rating was low (i.e., <70%) the client was gently guided to identify what it would take to increase their rating.
- 6 The therapist made use of Socratic questioning, which enabled the client to actively summarize the task and provide separate ratings for readiness, importance, and/or confidence. If the task summary was incomplete, the client was gently guided to its completion, or the task was modified with decreased demands. If the confidence rating was low (i.e., <70%) the client was gently guided to identify what it would take to increase their confidence level. The therapist also explored overly confident ratings (e.g., an immediate or persistent statement of 100%) to identify possible social desirability responses.

APPENDIX D
RATER FEEDBACK QUESTIONNAIRE

**HAACS
Pilot Study 1
16 October 2004**

RATER FEEDBACK QUESTIONNAIRE

The purpose of the pilot study for the HAACS is to evaluate the first draft of the measure, in terms of its usability from a rater's perspective. The pilot study is not intended to be a critique of the CBT sessions being evaluated, but rather a critique of the HAACS measure itself.

Therefore, in completing this rater feedback questionnaire, please try and focus your critique on the HAACS measure, rather than aspects of the particular CBT sessions that were rated.

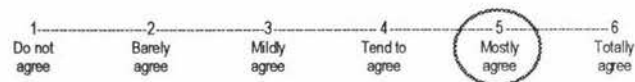
On pages 2-3, four general areas of the HAACS measure are covered:

1. Training
2. Instructions
3. Format
4. Ease of use

Then from page 4 onwards, a single page is allocated to each item, with two areas covered:

1. The item description
2. The descriptive anchors within the item

For each of the statements that follow, please circle the option on the six point Likert scale to indicate the extent that YOU AGREE with the statement, i.e.,



Following your rating, a space is provided for you to provide any constructive feedback that will assist with the revision of either the measure in general (including training), or the specific items and anchors. Please provide any feedback that you think would improve the usability of the measure in future.

GENERAL

The TRAINING FULLY PREPARED ME for using the measure:



Please provide any comments that may improve future training (particularly important if you have rated a "3" or lower:

The INSTRUCTIONS were CLEAR:



Please provide any comments that may help with the measure revision (particularly if you have rated your agreement a "3" or lower:

GENERAL

The MEASURE was CLEARLY FORMATTED:

1-----2-----3-----4-----5-----6
 Do not Barely Mildly Tend to Mostly Totally
 agree agree agree agree agree agree

Please provide any comments that may help with the measure revision (particularly if you have rated your agreement a "3" or lower:

ITEM 1

The DESCRIPTION for ITEM 1 was CLEAR (i.e., UNAMBIGUOUS):

1-----2-----3-----4-----5-----6
 Do not Barely Mildly Tend to Mostly Totally
 agree agree agree agree agree agree

Please provide any comments that may help with the measure revision (particularly if you have rated your agreement a "3" or lower:

The MEASURE was EASY TO USE:

1-----2-----3-----4-----5-----6
 Do not Barely Mildly Tend to Mostly Totally
 agree agree agree agree agree agree

Please provide any comments that may help with the measure revision (particularly if you have rated your agreement a "3" or lower:

The ANCHORS for ITEM 1 were CLEAR (i.e., UNAMBIGUOUS):

1-----2-----3-----4-----5-----6
 Do not Barely Mildly Tend to Mostly Totally
 agree agree agree agree agree agree

Please provide any comments that may help with the measure revision (particularly if you have rated your agreement a "3" or lower:

ITEM 2

The DESCRIPTION for ITEM 2 was CLEAR (i.e., UNAMBIGUOUS):

1-----2-----3-----4-----5-----6
Do not Barely Midly Tend to Mostly Totally
agree agree agree agree agree agree

Please provide any comments that may help with the measure revision (particularly if you have rated your agreement a "3" or lower:

The ANCHORS for ITEM 2 were CLEAR (i.e., UNAMBIGUOUS):

1-----2-----3-----4-----5-----6
Do not Barely Midly Tend to Mostly Totally
agree agree agree agree agree agree

Please provide any comments that may help with the measure revision (particularly if you have rated your agreement a "3" or lower:

ITEM 3

The DESCRIPTION for ITEM 3 was CLEAR (i.e., UNAMBIGUOUS):

1-----2-----3-----4-----5-----6
Do not Barely Midly Tend to Mostly Totally
agree agree agree agree agree agree

Please provide any comments that may help with the measure revision (particularly if you have rated your agreement a "3" or lower:

The ANCHORS for ITEM 3 were CLEAR (i.e., UNAMBIGUOUS):

1-----2-----3-----4-----5-----6
Do not Barely Midly Tend to Mostly Totally
agree agree agree agree agree agree

Please provide any comments that may help with the measure revision (particularly if you have rated your agreement a "3" or lower:

**The same format was repeated
for items 4-19**

APPENDIX E
HAACS - PILOT TWO VERSION

HAACS

Homework Adherence and Competence Scale

Nikolaos Kazantzis
Paul Wedge
Keith S. Dobson

Second Draft

HAACS

Homework Adherence and Competence Scale

Instructions:

This therapist adherence and competence rating scale consists of 22 items regarding therapists' integration of homework assignments in cognitive behavior therapy (CBT). Items 1-5 cover therapist behaviors in REVIEWING previously assigned homework. Items 6-14 cover therapist behaviors in DESIGNING new or revised homework. Items 15-19 cover therapist behaviors in ASSIGNING how the new or revised homework will be practically carried out. Please note that although the items are categorized into these three conceptually different groupings, they are often not so clearly delineated during a CBT session. Finally, items 20-22 cover overall ratings for reviewing, designing and assigning homework respectively.

Every individual item begins on a new page, and has two clearly identifiable questions; adherence (e.g., "DID the therapist ..." or "WAS a ...") and competence (i.e. "HOW WELL did the therapist ..."). The adherence question for each item is labeled with an 'a' (e.g., 1a, 2a, etc.), and the competence question for each item is labeled with a 'b' (e.g., 1b, 2b, etc.).

(a) Adherence

Please note that your rating for the *adherence* questions (i.e., the 'a' questions) is to indicate whether these aspects were carried out in the session to any extent. This is different from rating how well the therapist undertook each item (i.e., competence). For each adherence item, please consider the question carefully, and tick either "yes" or "no" to indicate whether the particular aspect was CARRIED OUT irrespective of how well it was done. Please select only one response option for any question.

(b) Competence

Please note that your rating for the *competence* questions (i.e., the 'b' questions) is to indicate HOW WELL the therapist undertook each item. This is different from rating whether these aspects were carried out by the therapist (i.e., adherence). Adherence is a necessary BUT NOT SUFFICIENT condition for competence. This means that if adherence was rated "no" for a therapist behavior, then the therapist competence cannot be rated higher than "0" for the same item. Conversely, any competence rating between 1 and 6 necessitates a "yes" adherence rating. These "rules" provide a double check that you are rating adherence and competence correctly. For each item, please consider the competence question carefully, and record the appropriate number in the rating box to indicate how well the therapist carried out each aspect.

Each competence question has seven descriptive response options. In the first instance, please use the descriptive response options to determine the rating for each item. Please be aware that these response options build in complexity from 0 to 6, with each increment adding more complex or additional requirements. To qualify for the higher rating, then all of the components of that descriptive response option must be met. If this is not the case then please revert to the next lowest option in which the criteria are fully met. However, if you are having difficulty deciding on a rating (e.g., the response options descriptions do not seem to easily fit the session being rated), then use the 7-point Likert scale ranging from 0 (*non-adherence/extremely poor*) to 6 (*excellent*).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

If several items seem to apply equally well, record the lowest number (e.g., if considering recording "3-4", record it as a "3"). Please provide a single rating for every item.

HOMework REVIEW

Items 1-5 cover the therapist behaviors involved in reviewing homework from the previous session, and typically occurs early in the session.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 1

1a DID the therapist discuss the completion of previously assigned homework to any extent? Yes ☐ No ☐

1b HOW WELL did the therapist discuss the completion of previously assigned homework? Competence Rating

- 0 The therapist DID NOT discuss previously assigned homework.
- 1 The therapist made a CURSORY ENQUIRY about previous homework completion, but DID NOT ENGAGE the client (i.e., no exploration of the client's responses).
- 2 The therapist ENQUIRED about previous homework completion, and made an attempt to elicit feedback from the client but this was NOT SUCCESSFUL (e.g., the therapist used closed questions, or did not allow sufficient time for a response).
- 3 The therapist ENQUIRED about previous homework, and elicited some GENERAL FEEDBACK from the client. For instance, the client gave a vague response such as "I completed most of it" and this response was taken at face value and was not explored further (e.g., "Can you tell me more about the parts you completed?" and then "Can you tell me about the parts you had difficulty with or did not complete?").
- 4 The therapist ENQUIRED about previous homework and IDENTIFIED EXACTLY what portion of the homework was completed and what was not completed. However, the discussion focused EITHER on the completed homework OR the non-completed homework.
- 5 The therapist IDENTIFIED and DISCUSSED BOTH completed AND non-completed homework. However, in discussing completed homework, the focus was MORE on the quantity of what was completed (i.e., the extent of completion), RATHER THAN the quality (i.e., degree of client learning or skill acquisition, such as mastery in completing a thought record effectively, or testing out beliefs in behavioral experiments).
- 6 BOTH the quantity (i.e., the extent of completion and non-completion) AND quality (i.e., degree of client learning or skill acquisition, such as mastery in completing a thought record effectively, or testing out beliefs in behavioral experiments) of homework completion was discussed. The therapist facilitated a highly effective discussion to elicit the CLIENT'S LEARNING from the homework task (e.g., using Socratic questioning).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 2

2a DID the therapist provide verbal reinforcement (i.e., praise) for any portion of the homework carried out? Yes ☐ No ☐

2b HOW WELL did the therapist provide appropriate verbal reinforcement (i.e., praise) for any portion of the homework carried out? Competence Rating

- 0 The therapist DID NOT provide verbal reinforcement for any portion of the homework carried out.
- 1 Verbal reinforcement was given that was VERY BRIEF AND LIMITED in relation to the portion of homework completed, OR excessive praise was given for low completion.
- 2 SOME verbal reinforcement was given but this was NOT CLEARLY LINKED to the portion of homework completed, OR excessive praise was given for low completion.
- 3 Appropriate verbal reinforcement was given for MOST portions of the homework completed.
- 4 Appropriate verbal reinforcement was given for ALL portions of the homework completed.
- 5 Appropriate praise AND encouragement was given for ALL portions of the homework completed. The therapist ALSO appeared clearly enthusiastic in acknowledging and validating the client's efforts.
- 6 Appropriate praise AND encouragement was given for ALL portions of the homework completed. The therapist ALSO appeared clearly enthusiastic in acknowledging and validating the client's efforts. Encouragement was given for the client EXTENDING/ GENERALIZING the homework task to extend skill acquisition/ apply task to more challenging problems.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 3

3a WAS a situational conceptualization (e.g., thoughts, behaviors, emotions, physiology) used in reviewing previously assigned homework? Yes ☐ No ☐

3b HOW WELL did the therapist use a situational conceptualization (e.g., thoughts, behaviors, emotions, physiology) to review previously assigned homework (i.e., identify the client's beliefs about having engaged in the homework to synthesize their learning)? Competence Rating

- 0 A situational conceptualization WAS NOT used in reviewing previously assigned homework.
- 1 An UNDEVELOPED situational conceptualization was arrived at (i.e., the therapist completely interpreted on behalf of the client).
- 2 A VAGUE, brief and incomplete situational conceptualization was arrived at (i.e., the therapist mostly interpreted for the client's experiences rather than eliciting information).
- 3 A PARTIALLY DEVELOPED situational conceptualization was arrived at (i.e., the therapist elicited some information and interpreted other information). NO automatic thoughts OR beliefs about the consequences, OR synthesis of learning were identified.
- 4 A situational conceptualization facilitated the IDENTIFICATION OF salient (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as the TRIGGERS for homework completion.
- 5 A situational conceptualization facilitated the IDENTIFICATION OF salient (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as the TRIGGERS for homework completion. The therapist ALSO elicited beliefs about the homework (i.e., difficulty, sense of pleasure, sense of mastery).
- 6 A situational conceptualization facilitated the IDENTIFICATION OF salient (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as the TRIGGERS for homework completion. The therapist ALSO elicited beliefs about the homework (i.e., difficulty, sense of pleasure, sense of mastery), AS WELL AS their synthesis of learning (i.e., relevance, match with therapy goals, benefits, perceived progress).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 4

4a WAS an individualized conceptualization used to make sense of any portion of non-completed homework (i.e., linked non-completion to the client's automatic thoughts, underlying assumptions and rules, or core beliefs)? Yes ☐ No ☐ n/a ☐

4b HOW WELL did the therapist use an individualized conceptualization to make sense of any portion of non-completed homework (i.e., linked non-completion to the client's automatic thoughts, underlying assumptions and rules, or core beliefs)? Competence Rating

N/a There was NO NON-COMPLETED homework (i.e., all homework was completed).

- 0 The therapist DID NOT use an individualized conceptualization to make sense of any portion of non-completed homework.
- 1 The therapist LABELED/ INTERPRETED the portion of non-completed homework RATHER THAN facilitating the client's own understanding through collaborative discussion.
- 2 The therapist FOCUSED on one individualized conceptualization component (i.e., either core beliefs, or conditional rules and assumptions, or automatic thoughts). The therapist used this information to LABEL/ INTERPRET the portion of non-completed homework RATHER THAN facilitating the client's own understanding.
- 3 The therapist made LIMITED use of an individualized conceptualization, including SOME but NOT ALL of the following aspects: core beliefs, conditional rules and assumptions, and automatic thoughts. The therapist used this information to reach a VAGUE understanding of homework non-completion.
- 4 The therapist facilitated a discussion that made REASONABLE use of an individualized conceptualization, including SOME but NOT ALL aspects of: core beliefs, conditional rules and assumptions, and automatic thoughts. This led to a REASONABLE understanding of the client's beliefs about the homework task that contributed to non-completion.
- 5 The therapist facilitated a discussion that made GOOD USE of an individualized conceptualization, including ALL ASPECTS of: core beliefs, conditional rules and assumptions, and automatic thoughts. This led to a CLEAR understanding of the client's beliefs about the homework task that contributed to non-completion.
- 6 The therapist facilitated a discussion that made FULL USE of an individualized conceptualization, including ALL ASPECTS of: core beliefs, conditional rules and assumptions, and automatic thoughts IN several situations, which were LINKED to overall treatment goals. This led to a VERY CLEAR understanding of the client's beliefs about the homework task that contributed to non-completion, AS WELL AS the generalization of the task to other situations.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 5

5a DID the therapist attempt to problem solve practical obstacles to the homework? Yes ☐ No ☐

5b HOW WELL did the therapist attempt to problem solve practical obstacles to the homework? Competence Rating

- 0 The therapist DID NOT attempt to problem solve practical obstacles.
- 1 The therapist PROVIDED solutions of their own accord, WITHOUT any contribution from the client.
- 2 The therapist PROVIDED solutions of their own accord, with only a CURSORY contribution sought from the client. (e.g., "Does that sound okay to you?").
- 3 The therapist ATTEMPTED to problem solve practical obstacles with SOME collaboration (i.e., the therapist provided some solutions themselves and elicited some input from the client).
- 4 The therapist FACILITATED a discussion that IDENTIFIED the actual practical obstacles. SOME potential solutions were generated and considered. The client arrived at a VAGUE plan to overcome the obstacles.
- 5 The therapist FACILITATED a discussion that IDENTIFIED the actual practical obstacles. A RANGE of potential solutions were generated and considered. The client arrived at CLEAR behavioral strategies to overcome the practical obstacles.
- 6 The therapist FACILITATED a discussion that IDENTIFIED the actual practical obstacles, AS WELL AS a consideration of other potential obstacles that may have occurred. A FULL RANGE of potential solutions were generated and considered. The client arrived at CLEAR behavioral strategies to overcome the practical obstacles, AS WELL AS behavioral strategies for considering changing circumstances (e.g., bringing an outside activity indoors, testing beliefs in several situations, applying interpersonal skills to a range of relationships/interactions).

HOMEWORK
DESIGN

Items 6-14 cover the therapist behaviors involved in collaboratively deciding what homework will be carried out during the next week, and typically occurs throughout the session.

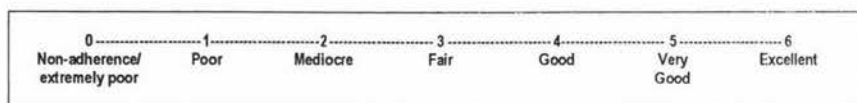
0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 6

6a WAS any new or revised homework discussed during the session? Yes ☐ No ☐

6b HOW WELL did the therapist discuss new or revised homework during the session? Competence Rating

- 0 New or revised homework was NOT discussed during the session.
- 1 The therapist BRIEFLY discussed new or revised homework.
- 2 The therapist allowed SUFFICIENT TIME for a discussion of new or revised homework, BUT only at the END of the session.
- 3 The therapist allowed SUFFICIENT TIME for a discussion of new or revised homework, DURING the course of the session (AND POSSIBLY at the end of the session). HOWEVER, the homework WAS NOT linked to in-session content or therapy goals.
- 4 The therapist allowed SUFFICIENT TIME for a discussion of new or revised homework BOTH during the course of the session, AS WELL AS at the end of the session. The homework WAS linked to EITHER in-session content OR therapy goals.
- 5 The therapist allowed SUFFICIENT TIME for a discussion of new or revised homework BOTH during the course of the session, AS WELL AS at the end of the session. The homework WAS linked to BOTH in-session content AND therapy goals.
- 6 The therapist allowed SUFFICIENT TIME for a discussion of new or revised homework BOTH during the course of the session, AS WELL AS at the end of the session. The homework WAS linked to BOTH in-session content AND therapy goals. The therapist was ALSO able to engage the client in discussion effectively, used novel and tailored presentation of the homework, even when confronted with interpersonal difficulties (e.g., client avoidance, perfectionism, demanding interpersonal style).

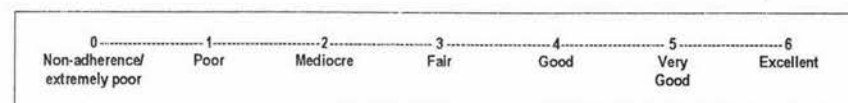


Item 7

7a DID the therapist use any aspects of guided discovery to identify the client's coping strategies and beliefs related to the homework? Yes ☐ No ☐

7b HOW WELL did the therapist use guided discovery to identify the client's coping strategies and beliefs related to the homework? Competence Rating

- The therapist DID NOT use any aspects of guided discovery to identify the client's coping strategies and beliefs related to the homework.
- The therapist used INEFFECTIVE questioning (e.g., closed questions or broad questions, but these did not uncover new information) and provided INTERPRETIVE answers RATHER THAN guiding the client's own understanding about coping strategies and beliefs.
- The therapist used SOME but NOT ALL components of the guided discovery process: (i) asked SOME informational questions, (ii) listened empathically and provided SOME reflections, (iii) provided SOME summaries of the information discovered, and (iv) asked SOME synthesizing or analytical questions. HOWEVER they were used in a cursory, inappropriate, or ineffective manner (e.g., inaccurate reflections or summaries). The therapist used INTERPRETIVE answers RATHER THAN guiding the client's own learning, and was UNABLE to identify coping strategies and beliefs (e.g., "If you think X, then surely Y is?").
- The therapist used ALL FOUR components of the guided discovery process: (i) asked SOME informational questions, (ii) listened empathically and provided SOME reflections, (iii) provided SOME summaries of the information discovered, and (iv) asked SOME synthesizing or analytical questions, but was INEFFECTIVE in identifying coping strategies and beliefs.
- The therapist used ALL FOUR components of the guided discovery process REASONABLY EFFECTIVELY: (i) asked informational questions which UNCOVERED SOME information outside the client's awareness, (ii) listened empathically and provided SOME accurate AND appropriate reflections, (iii) provided SOME ACCURATE summaries of the information discovered, and (iv) asked SOME synthesizing or analytical questions which enabled SOME client learning. In using this process the therapist facilitated the identification of A FEW coping strategies and beliefs.
- The therapist used ALL FOUR components of the guided discovery process EFFECTIVELY: (i) asked APPROPRIATE informational questions which UNCOVERED information outside the client's awareness, (ii) listened empathically and provided accurate AND appropriate reflections, (iii) ACCURATELY summarized the information discovered at APPROPRIATE times, and (iv) ASKED synthesizing or analytical questions which enabled the CLIENT'S own learning. In using this process the therapist facilitated the identification of A NUMBER OF coping strategies and beliefs.
- The therapist APPEARED genuinely curious and inquisitive, and used ALL FOUR components of the guided discovery process VERY EFFECTIVELY: (i) asked SEVERAL APPROPRIATE informational questions which UNCOVERED SIGNIFICANT information outside the client's awareness, (ii) listened empathically and provided accurate AND appropriate reflections, (iii) ACCURATELY summarized the information discovered at APPROPRIATE times, and (iv) asked HIGHLY APPROPRIATE synthesizing or analytical questions which enabled the CLIENT'S own learning. In using this process the therapist facilitated the identification of A NUMBER OF HIGHLY CREDIBLE coping strategies and beliefs.



Item 8

8a DID the therapist integrate a disorder-specific cognitive model with the individualized conceptualization in designing homework? Yes ☐ No ☐

8b HOW WELL did the therapist integrate a disorder-specific cognitive model with the individualized conceptualization in designing homework? Competence Rating

- The therapist DID NOT discuss a disorder-specific cognitive model or individualized conceptualization in designing homework.
- The therapist MENTIONED the disorder-specific cognitive model BUT did not elaborate on how it was relevant to the client's presentation.
- The therapist integrated SOME but NOT ALL aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to ONE ASPECT of the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies).
- The therapist integrated SOME but NOT ALL aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to MORE THAN ONE aspect the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies).
- The therapist integrated MOST aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to MOST aspects the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies).
- The therapist integrated ALL aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to ALL aspects of the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies). The therapist was ALSO able to integrate all this information with the client's presenting problems, evidenced in tactful responses to client's interpersonal style (e.g., critical, competitive, suspicious, controlling, exaggerative).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 9

9a WERE homework tasks selected for completion before the next session? Yes ☐ No ☐

9b HOW WELL did the therapist collaboratively select homework tasks for completion before the next session? Competence Rating

- 0 Homework tasks were NOT selected during the session.
- 1 The therapist selected homework tasks WITHOUT any contribution of the client.
- 2 The therapist only sought a CURSORY contribution from the client in selecting homework tasks (e.g., "Does that sound okay to you?").
- 3 The therapist INVOLVED the client in the selection of homework tasks, BUT at times reverted to a DIRECTIVE rather than collaborative approach, especially in the final decision.
- 4 The therapist INVOLVED the client in the selection of homework tasks (E.G., facilitated a DISCUSSION rather than provided direct answers). A FEW possible homework tasks were discussed, AS WELL AS a FEW advantages and disadvantages of the possible homework tasks.
- 5 The therapist encouraged the client to view the process of selecting homework tasks as the therapist and client working together as a TEAM. The therapist also ACTIVELY INVOLVED the client in selecting homework tasks (e.g., facilitated a discussion rather than provided direct answers). SEVERAL possible homework tasks were discussed, AND the client's thoughts and feelings about the possible homework tasks were elicited and explored, AND SEVERAL advantages and disadvantages of the possible homework tasks were discussed.
- 6 The therapist encouraged the client to view the process of selecting homework tasks as the therapist and client working together as a TEAM. The therapist also ACTIVELY INVOLVED the client in selecting homework tasks (e.g., facilitated a discussion rather than provided direct answers). A FULL RANGE of possible homework tasks were discussed, AND the client's thoughts and feelings about the possible homework tasks were elicited and explored, AND A FULL RANGE of advantages and disadvantages of the possible homework tasks were discussed (i.e., based on prior experience, benefits experienced by others). The therapist and client ALSO decided on homework tasks that built upon existing client skills and strategies, AND the client was encouraged to take on more responsibility for selecting homework tasks.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 10

10a DID the therapist present any rationale for the homework? Yes ☐ No ☐

10b HOW WELL did the therapist present a rationale for the homework that aligned with the client's goals for treatment? Rating

- 0 The therapist DID NOT present any rationale for the homework.
- 1 The therapist presented a BRIEF rationale but FAILED to relate it to the client's treatment goals.
- 2 The therapist presented a RATIONALE for the homework with SOME mention of the client's treatment goals, however this was presented WITHOUT any input (and understanding) from the client.
- 3 The therapist assisted the client to understand how the homework was ALIGNED to the specific presenting problem in the current session.
- 4 The therapist assisted the client to understand that the homework was broken into achievable CHUNKS that were manageable and within the client's control. The therapist ALSO assisted the client to understand how the homework was ALIGNED to EITHER the specific presenting problem in the current session, OR their overall treatment goals.
- 5 The therapist assisted the client to understand that the homework was broken into achievable CHUNKS that were manageable and within the client's control. The therapist ALSO assisted the client to understand how the homework was ALIGNED to BOTH the specific presenting problem in the current session AS WELL AS their overall treatment goals.
- 6 The therapist assisted the client to understand that the homework was broken into achievable CHUNKS that were manageable and within the client's control. The therapist ALSO assisted the client to understand how the homework was ALIGNED to BOTH the specific presenting problem in the current session AS WELL AS their overall treatment goals, AND obtained feedback from the client on the rationale. The therapist ALSO provided empirical evidence to support the rationale for the homework.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 11

11a DID the therapist ask about the client's ability and perceived difficulty of the homework? Yes ☐ No ☐

11b HOW WELL did the therapist ask about the client's ability and perceived difficulty of the homework? Rating

- 0 The therapist DID NOT ask about the client's ability and perceived difficulty of the task.
- 1 The therapist made a CURSORY enquiry about the client's ability and perceived difficulty of the task, but did not discuss it any further.
- 2 The therapist ENQUIRED about the client's ability and perceived difficulty of the task, and made an INEFFECTIVE attempt to elicit feedback from the client (e.g., the therapist did not listen to the client's responses, asked closed questions, questions did not follow the client's responses).
- 3 The therapist ENQUIRED about the client's ability and perceived difficulty of the task, and elicited a GENERAL STATEMENT from the client, for example, the client was vague and said "Sure, I can do it" and this response was taken at face value and NOT explored any further.
- 4 The therapist ENQUIRED about the client's ability and perceived difficulty of the task, and through Socratic questioning identified a BROAD ISSUE (e.g., "That thought record looks too hard. There is so much to complete"). HOWEVER, the therapist then provided their own solutions to resolve the issues raised (e.g., "Okay, just complete the first three columns of the thought record").
- 5 The therapist ENQUIRED about the client's ability and perceived difficulty of the task, and through Socratic questioning identified SPECIFIC ISSUES (e.g., in addition to feeling overwhelmed by the entire thought record, it transpired that the client had difficulty distinguishing emotions and thoughts on thought record). Through further EXPLORATION the therapist and client collaboratively RESOLVED the issue (e.g., the therapist and client worked on automatic thoughts in-session, and/or the homework was redesigned to focus on practicing the identification emotions as distinct from automatic thoughts).
- 6 The therapist ENQUIRED about the client's ability and perceived difficulty of the task, and through Socratic questioning identified SPECIFIC ISSUES. Through further EXPLORATION the therapist and client collaboratively RESOLVED the issue. The therapist ALSO elicited ADDITIONAL CLIENT LEARNING from the discussion, for example, the client learnt that breaking items into smaller chunks was less overwhelming, and also identified an underlying rule (e.g., "I've failed if I can't work things out for myself").

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 12

12a WAS ANY attempt made to facilitate in-session homework practice? Yes ☐ No ☐

12b HOW WELL did the therapist facilitate in-session homework practice? Rating

- 0 The therapist DID NOT provide the opportunity for in-session practice of the homework.
- 1 The therapist briefly DEMONSTRATED or EXPLAINED (i.e., modeled or instructed) the homework, that provided no opportunity for the clients to learn from their own practice.
- 2 The therapist PROVIDED only a BRIEF opportunity for in-session practice. The therapist tended to FOCUS on correcting the client's mistakes AND provided LIMITED positive reinforcement. The therapist DID NOT discuss any learning points from the practice.
- 3 The therapist PROVIDED SOME opportunity for in-session practice. The therapist provided SOME positive reinforcement (i.e., shaping successive approximations of skill), AND gave SOME constructive guidance when the client needed assistance. HOWEVER, the therapist used a DIRECTIVE rather than collaborative approach in discussing learning points from the practice.
- 4 The therapist PROVIDED SOME opportunity for in-session practice. The therapist provided SOME positive reinforcement (i.e., shaping successive approximations of skill), AND gave SOME constructive guidance when the client needed assistance. The therapist and client COLLABORATIVELY discussed learning points from the in-session practice.
- 5 The therapist PROVIDED a GOOD opportunity for in-session practice, using the METHOD/S most appropriate for the client and the specific task. The therapist provided POSITIVE reinforcement (i.e., shaping successive approximations of skill) AND gave CONSTRUCTIVE guidance when the client needed assistance. The therapist was ENCOURAGING when COLLABORATIVELY discussing learning points from the in-session practice.
- 6 The therapist PROVIDED CONSIDERABLE opportunity for in-session practice, using the METHOD/S most appropriate for the client and the specific task. The therapist provided ENTHUSIASTIC positive reinforcement (i.e., shaping successive approximations of skill), AND gave WARM, GENUINE, CONSTRUCTIVE guidance when the client needed assistance. The therapist was ENCOURAGING when COLLABORATIVELY discussing learning points from the in-session practice. The therapist ALSO asked the client for FEEDBACK on the experience, and asked the client to WRITE down the learning points.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 13

13a DID the therapist use guided imagery to begin experiential learning for the homework in-session? Yes ☐ No ☐

13b HOW WELL did the therapist use guided imagery to begin experiential learning for the homework in-session? Rating

- 0 The therapist DID NOT use guided imagery in homework design.
- 1 The therapist used guided imagery **INEFFECTIVELY** (i.e., affect was not generated, client had difficulty staying on track, etc). Feedback was NOT sought throughout the exercise, and at the completion, the therapist DID NOT facilitate any experiential learning from the imagery practice.
- 2 The therapist provided an **OPPORTUNITY** for guided imagery, but was **UNABLE** to use this to assist the client with some experiential learning of the homework task (i.e., client completed imagery but did not gain an experience of completing the task).
- 3 The therapist **FACILITATED** the client in using guided imagery, and this was **REASONABLY EFFECTIVE** in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified). **HOWEVER**, imagery was **INEFFECTIVE** in providing the client with some experiential learning of the homework task (i.e., client completed imagery but did not gain an experience of completing the task).
- 4 The therapist **FACILITATED** the client in using guided imagery, and this was **REASONABLY EFFECTIVE** in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified), **AND** the client gained **SOME** experiential learning of the homework task (i.e., experienced the outcome of having engaged in the homework task).
- 5 The therapist **FACILITATED** the client in using guided imagery, and this was **EFFECTIVE** in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified), **AND** the client gained **SOME** experiential learning of the homework task (i.e., experienced the outcome of having engaged in the homework task). The therapist **ALSO** focused on skill acquisition **AND** discussed with the client how the task could be extended to more complex skills (i.e., shaping).
- 6 The therapist **FACILITATED** the client in using guided imagery, and this was **EFFECTIVE** in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified), **AND** the client gained **SOME** experiential learning of the homework task (i.e., experienced the outcome of having engaged in the homework task). The therapist **ALSO** focused on skill acquisition **AND** discussed with the client how the task could be extended to more complex skills (i.e., shaping). In feedback, the therapist and client **ALSO** discussed the application of the task across different situations (i.e., generalization and maintenance).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 14

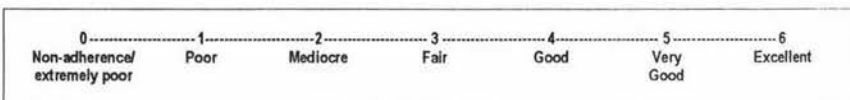
14a DID the therapist use a situational conceptualization to help identify the client's beliefs and triggers (i.e., emotional, behavioral, physiological) for carrying out the homework in specific situations? Yes ☐ No ☐

14b HOW WELL did the therapist use a situational conceptualization to help identify the client's beliefs and triggers (i.e., emotional, behavioral, physiological) for carrying out the homework in specific situations? Rating

- 0 The therapist did not use a situational conceptualization to help identify the client's beliefs and situational triggers for carrying out the homework in specific situations.
- 1 An undeveloped situational conceptualization was arrived at (i.e., the therapist completely interpreted on behalf of the client).
- 2 A vague, brief and incomplete situational conceptualization was arrived at (i.e., the therapist mostly interpreted for the client rather than eliciting information).
- 3 A partially developed situational conceptualization was arrived at (i.e., the therapist elicited some information and interpreted other information). This proved ineffective in identifying the client's beliefs and situational triggers.
- 4 A partially developed situational conceptualization was arrived at (i.e., the therapist elicited some information and interpreted other information). Emotions, behaviors, and physiology were identified to the use of homework, but no cognitive triggers or beliefs were identified.
- 5 A situational conceptualization facilitated the client's identification of salient (i.e., emotionally laden) automatic thoughts that served as triggers for homework completion. Emotions, behaviors, and physiology were also identified.
- 6 A situational conceptualization facilitated the client's identification of a salient (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as triggers for homework completion. The therapist **ALSO** discussed the triggers to the use of homework in several situations, **AND** elicited beliefs about the homework (i.e., difficulty, obstacles).

HOMEWORK ASSIGN

Items 15-19 cover the therapist behaviors involved in determining how the homework assignment/s will be practically carried out, and typically occurs near the end of the session.

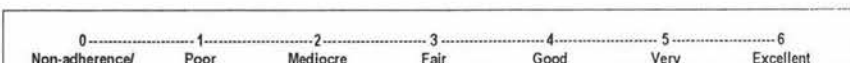


Item 15

15a WAS there any attempt to summarize the rationale for the homework in relation to therapy goals? Yes ☐ No ☐

15b HOW WELL did the therapist ask the client to summarize the rationale for the homework in relation to therapy goals? Rating

- 0 The therapist DID NOT ask the client to summarize the rationale for the task in relation to therapy goals.
- 1 The therapist summarized the rationale for the task, with LITTLE OR NO INPUT from the client.
- 2 The therapist ATTEMPTED to involve the client in summarizing the rationale for the task in relation to therapy goals, but used a DIRECTIVE rather than collaborative approach.
- 3 The therapist INVOLVED the client in summarizing the rationale for the task in relation to GENERAL therapy goals.
- 4 The therapist INVOLVED the client in summarizing the rationale for the task in relation to MOST PERTINENT therapy goals. That is, the homework was discussed in terms of the SPECIFIC behavior changes that would be expected to result from progress towards this goal.
- 5 The therapist SKILLFULLY INVOLVED the client in summarizing the rationale for the task in relation to MOST PERTINENT therapy goals. That is, the homework was discussed in terms of the SPECIFIC behavior changes that would be expected to result from progress towards this goal, AND this process was LEAD by the client.
- 6 The therapist SKILLFULLY INVOLVED the client in summarizing the rationale for the task in relation to MOST PERTINENT therapy goals. That is, the homework was discussed in terms of the SPECIFIC behavior changes that would be expected to result from progress towards this goal, AND this process was LEAD by the client. FURTHERMORE, in discussion with the therapist, the client demonstrated a clear understanding of the homework and was able to place the current homework in context of current and overall goals for therapy. The therapist skill was evidenced by their adaptation of this discussion to the client's interpersonal style.



extremely poor

Good

Item 16

16a WAS there any attempt to specify how the homework will be practically integrated into the client's life (i.e., specification of when, where, how often, how long)? Yes ☐ No ☐

16b HOW WELL did the therapist collaborate with the client to specify how the homework will be practically integrated into the client's life (i.e., specification of when, where, how often, how long)? Rating

- 0 The therapist DID NOT collaborate to specify how the task would be practically integrated into the client's life.
- 1 The therapist DIRECTED how the task could be practically integrated into the client's life, WITHOUT any contribution from the client.
- 2 The therapist reached a VAGUE outline of how the task could be practically integrated into the client's life, with SOME collaboration (i.e., the therapist provided some specifics themselves and elicited some input from the client).
- 3 The therapist FACILITATED a discussion which resulted in the client being able to state with SOME behavioral specificity how the task could be practically integrated into the client's life in ONE of the following areas: when, where, how often, and how long.
- 4 The therapist FACILITATED a discussion which resulted in the client being able to state with SOME behavioral specificity how the task could be practically integrated into the client's life in TWO-THREE of the following areas: when, where, how often, and how long.
- 5 The therapist FACILITATED a discussion which resulted in the client being able to state with a HIGH DEGREE of behavioral specificity how the task could be practically integrated into the client's life in ALL of the following areas: when, where, how often, and how long. IF the client was unable to be specific in any area, the therapist gently GUIDED the client to a specific resolution.
- 6 The therapist SKILLFULLY ELICITED a description of how the homework would be practically implemented from the client. A HIGH DEGREE of behavioral specificity was achieved in ALL the following areas: when, where, how often, and how long. IF the client was unable to be specific in any area, the therapist gently GUIDED the client to a specific resolution. The therapist ALSO anticipated potential difficulties in communication and resolved them (e.g., misinterpretation of the process in achieving specificity, misinterpretation of the meaning of specificity, such as using a thought record "when" automatic thoughts occur).

0-----1-----2-----3-----4-----5-----6
 Non-adherence/ Poor Mediocre Fair Good Very Excellent
 extremely poor

Item 17

17a WAS there any consideration of potential difficulties for completing the homework? Yes No
☐ ☐

17b HOW WELL did the therapist consider potential difficulties for completing the homework? Rating

- 0 The therapist DID NOT attempt to consider potential difficulties.
- 1 The therapist PROVIDED potential difficulties of their own accord, WITHOUT any contribution from the client.
- 2 The therapist GENERALLY PROVIDED potential difficulties of their own accord, with only a CURSORY CONTRIBUTION sought from the client. (e.g., "So that would be difficult, wouldn't it?").
- 3 The therapist attempted to consider potential difficulties with some collaboration (i.e., the therapist provided some potential difficulties themselves and elicited some input from the client).
- 4 The therapist FACILITATED a discussion that identified SOME potential difficulties, AND SOME potential solutions were also generated and considered. The client arrived at a VAGUE plan to overcome the potential difficulties.
- 5 The therapist FACILITATED a discussion that identified MOST potential difficulties, AND a RANGE of potential solutions were generated and considered. The client arrived at a CLEAR plan to overcome the potential difficulties that included SPECIFIC behaviors (e.g., "My days are really busy next week, so I will set the alarm clock 30 minutes earlier on Tuesday morning and read the booklet before starting the day's other activities").
- 6 The therapist FACILITATED a discussion that identified ALL the potential difficulties, and a FULL RANGE of potential solutions were generated and considered. The client arrived at a CLEAR plan to overcome the potential difficulties that included SPECIFIC behaviors, AND behavioral STRATEGIES for considering changing circumstances (e.g., if unable to complete a task in a single sitting, then breaking it into smaller chunks and completing it over 2-3 sittings).

0-----1-----2-----3-----4-----5-----6
 Non-adherence/ Poor Mediocre Fair Good Very Excellent
 extremely poor

Item 18

18a WAS there ANY attempt to explain the outcome from the homework as having a learning 'experiment' focus? Yes No
☐ ☐

18b HOW WELL did the therapist emphasize the homework as having a learning 'experiment' focus (e.g., a no-lose scenario, partial completion is helpful, seeing what works and what doesn't)? Rating

- 0 The therapist DID NOT emphasize the task as a learning 'experiment' focus.
- 1 In ATTEMPTING to explain a learning 'experiment' focus of the homework task, the therapist specified or intimated there was a 'CORRECT' actual outcome (i.e. could pass or fail).
- 2 The therapist did not focus on actual outcomes, but was VAGUE about the learning outcome (i.e., "it will be useful") but did not elaborate any further.
- 3 The therapist BRIEFLY explained the homework task as a learning experiment (i.e., to test out an idea or skill), rather than guided the client to their own learning.
- 4 The therapist FRAMED the homework task as a learning 'experiment'. MOST of the following points emerged from the discussion: there is no right or wrong (no failure or grading); it is a no-lose situation for the client; in any experiment the outcome is not known; there is a learning from every homework task no matter what the actual outcome; any information from the experiment is useful to further help with the treatment.
- 5 The therapist used guided discovery to uncover the CLIENT'S BELIEFS about the outcomes of the homework task, and then used Socratic questioning and hypothetical examples to facilitate the CLIENT to view the homework task as a learning experiment (i.e., gaining client's previous experiences of learning and applying them to the homework). MOST of the following points emerged from the discussion: there is no right or wrong (no failure or grading); it is a no-lose situation for the client; in any experiment the outcome is not known; there is a learning from every homework task no matter what the actual outcome; any information from the experiment is useful to further help with the treatment.
- 6 The therapist used guided discovery to uncover the CLIENT'S BELIEFS about the outcomes of the homework task, and then used Socratic questioning and hypothetical examples to facilitate the CLIENT to view the homework task as a learning experiment (i.e., gaining client's previous experiences of learning and applying them to the homework). MOST of the following points emerged from the discussion: there is no right or wrong (no failure or grading); it is a no-lose situation for the client; in any experiment the outcome is not known; there is a learning from every homework task no matter what the actual outcome; any information from the experiment is useful to further help with the treatment. The therapist ALSO discussed the BENEFITS (e.g., new skill acquisition, reduction in distressing thoughts, better treatment outcome) VERSUS the COSTS of performing the homework task (e.g., time, energy, short-term distress).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 19

19a WAS there ANY attempt to summarize the homework? Yes ☐ No ☐

19b HOW WELL did the therapist ask the client to summarize the homework and obtain an indication of homework-related readiness, importance, and/ or confidence? Rating

- There was NO summary of the homework task AND NO indication of readiness, importance, or confidence.
- The therapist summarized the task, WITHOUT any contribution from the client, AND DID NOT obtain any indication of readiness, importance, or confidence.
- The therapist ATTEMPTED to involve the client in summarizing the task AND obtained separate indications for readiness, importance, or confidence, with only a CURSORY contribution sought from the client. (e.g., "Does about 80% sound right to you?").
- The therapist INVOLVED the client in summarizing the task and obtained a VAGUE indication of readiness, importance, or confidence (e.g., the client said "I'd give that a very high rating").
- The therapist FACILITATED the client to SUMMARIZE the task AND provide an indication of readiness, importance, and confidence.
- The therapist USED Socratic questioning, which enabled the client to SUMMARIZE the task AND provide SPECIFIC ratings for EACH OF readiness, importance, or confidence. IF the task summary was incomplete, the client was gently guided to its completion. IF the rating was low (i.e., <70%) the client was gently guided to identify what it would take to increase their rating.
- The therapist USED Socratic questioning, which enabled the client to ACTIVELY SUMMARIZE the task AND provide SPECIFIC ratings for EACH OF readiness, importance, and confidence. IF the task summary was incomplete, the client was gently guided to its completion, OR the task was modified with decreased demands. IF the confidence rating was low (i.e., <70%) the client was gently guided to identify what it would take to increase their confidence level. The therapist ALSO explored overly confident ratings (e.g., an immediate or persistent statement of 100%) to identify possible social desirability responses.

OVERALL RATINGS

Items 20-22 cover overall ratings for the therapist's competence in reviewing, designing, and assigning homework

Item 20

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Taking into account all the individual aspects of HOMEWORK REVIEW (i.e., items 1-5), the appropriateness of not adhering to specific items (e.g., homework was completed unusually well; there was a crisis; risk to client safety), and any other special considerations from the session rated (e.g., interpersonal features of the specific therapeutic relationship; and the therapist's ability to adapt the process of homework administration based on the client conceptualization), please provide an overall rating for the therapist's competence in HOMEWORK REVIEW.

Rating

Item 21

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Taking into account all the individual aspects of HOMEWORK DESIGN (i.e., items 6-14), the appropriateness of not adhering to specific items (e.g., no need to practice a particular skill for homework as this had covered extensively in previous sessions; client was extending a mastered skill to a new situation rather than learning something new), and any other special considerations from the session rated (e.g., interpersonal features of the specific therapeutic relationship; and the therapist's ability to adapt the process of homework administration based on the client conceptualization), please provide an overall rating for the therapist's competence in HOMEWORK DESIGN.

Rating

Item 22

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Taking into account all the individual aspects of HOMEWORK ASSIGN (i.e., items 15-19), the appropriateness of not adhering to specific items (e.g., the session was near the end of therapy and the client was taking responsibility for the process and leading in-session discussion), and any other special considerations from the session rated (e.g., interpersonal features of the specific therapeutic relationship; and the therapist's ability to adapt the process of homework administration based on the client conceptualization), please provide an overall rating for the therapist's competence in HOMEWORK ASSIGN.

Rating

APPENDIX F
HAACS - FINAL VERSION

HAACS

Homework Adherence and Competence Scale

**Nikolaos Kazantzis
Paul Wedge
Keith S. Dobson**

Second Draft

HAACS

Homework Adherence and Competence Scale

Instructions:

This therapist adherence and competence rating scale consists of 19 items regarding therapists' integration of homework assignments in cognitive behavior therapy (CBT). Items 1-5 cover therapist behaviors in REVIEWING previously assigned homework. Items 6-14 cover therapist behaviors in DESIGNING new or revised homework. Items 15-19 cover therapist behaviors in ASSIGNING how the new or revised homework will be practically carried out. Please note that although the items are categorized into these three conceptually different groupings, they are often not so clearly delineated during a CBT session. Finally, each individual section (i.e., review, design and assign) concludes with an overall rating for that section.

Every individual item begins on a new page, and has two clearly identifiable questions; adherence (e.g., "DID the therapist ..." or "WAS a ...") and competence (i.e., "HOW WELL did the therapist ..."). The adherence question for each item is labeled with an 'a' (e.g., 1a, 2a, etc.), and the competence question for each item is labeled with a 'b' (e.g., 1b, 2b, etc.).

(a) Adherence

Please note that your rating for the *adherence* questions (i.e., the 'a' questions) is to indicate whether these aspects were carried out in the session to any extent. This is different from rating how well the therapist undertook each item (i.e., competence). For each adherence item, please consider the question carefully, and tick either 'yes' or 'no' to indicate whether the particular aspect was CARRIED OUT irrespective of how well it was done. Please select only one response option for any question.

(b) Competence

Please note that your rating for the *competence* questions (i.e., the 'b' questions) is to indicate HOW WELL the therapist undertook each item. This is different from rating whether these aspects were carried out by the therapist (i.e., adherence). Adherence is a necessary BUT NOT SUFFICIENT condition for competence. This means that if adherence was rated "no" for a therapist behavior, then the therapist competence cannot be rated higher than "0" for the same item. Conversely, any competence rating between 1 and 6 necessitates a "yes" adherence rating. These "rules" provide a double check that you are rating adherence and competence correctly. For each item, please consider the competence question carefully, and record the appropriate number in the rating box to indicate how well the therapist carried out each aspect.

Each competence question has seven descriptive response options. In the first instance, please use the descriptive response options to determine the rating for each item. Please be aware that these response options build in complexity from 0 to 6, with each increment adding more complex or additional requirements. To qualify for the higher rating, then all of the components of that descriptive response option must be met. If this is not the case then please revert to the next lowest option in which the criteria are fully met. However, if you are having difficulty deciding on a rating (e.g., the response options descriptions do not seem to easily fit the session being rated), then use the 7-point Likert scale ranging from 0 (*non-adherence/extremely poor*) to 6 (*excellent*).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

If several items seem to apply equally well, record the lowest number (e.g., if considering recording "3-4", record it as a "3"). Please provide a single rating for every item.

HOMWORK REVIEW

Items 1-5 cover the therapist behaviors involved in reviewing homework from the previous session, and typically occurs early in the session.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 1

1a DID the therapist discuss the completion of previously assigned homework to any extent? Yes ☐ No ☐

1b HOW WELL did the therapist discuss the completion of previously assigned homework? Competence Rating

- 0 The therapist DID NOT discuss previously assigned homework.
- 1 The therapist made a CURSORY ENQUIRY about previous homework completion, but DID NOT ENGAGE the client (i.e., no exploration of the client's responses).
- 2 The therapist ENQUIRED about previous homework completion, and made an attempt to elicit feedback from the client but this was NOT SUCCESSFUL (e.g., the therapist used closed questions, or did not allow sufficient time for a response).
- 3 The therapist ENQUIRED about previous homework, and elicited some GENERAL FEEDBACK from the client. For instance, the client gave a vague response such as "I completed most of it" and this response was taken at face value and was not explored further (e.g., "Can you tell me more about the parts you completed?" and then "Can you tell me about the parts you had difficulty with or did not complete?").
- 4 The therapist ENQUIRED about previous homework and IDENTIFIED EXACTLY what portion of the homework was completed and what was not completed. However, the discussion focused EITHER on the completed homework OR the non-completed homework.
- 5 The therapist IDENTIFIED and DISCUSSED BOTH completed AND non-completed homework. However, in discussing completed homework, the focus was MORE on the quantity of what was completed (i.e., the extent of completion), RATHER THAN the quality (i.e., degree of client learning or skill acquisition, such as mastery in completing a thought record effectively, or testing out beliefs in behavioral experiments).
- 6 BOTH the quantity (i.e., the extent of completion and non-completion) AND quality (i.e., degree of client learning or skill acquisition, such as mastery in completing a thought record effectively, or testing out beliefs in behavioral experiments) of homework completion was discussed. The therapist facilitated a highly effective discussion to elicit the CLIENT'S LEARNING from the homework task (e.g., using Socratic questioning).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 2

2a DID the therapist provide verbal reinforcement (i.e., praise) for any portion of the homework carried out? Yes ☐ No ☐

2b HOW WELL did the therapist provide appropriate verbal reinforcement (i.e., praise) for any portion of the homework carried out? Competence Rating

- 0 The therapist DID NOT provide verbal reinforcement for any portion of the homework carried out.
- 1 Verbal reinforcement was given that was VERY BRIEF AND LIMITED in relation to the portion of homework completed, OR excessive praise was given for low completion.
- 2 SOME verbal reinforcement was given but this was NOT CLEARLY LINKED to the portion of homework completed, OR excessive praise was given for low completion.
- 3 Appropriate verbal reinforcement was given for MOST portions of the homework completed.
- 4 Appropriate verbal reinforcement was given for ALL portions of the homework completed.
- 5 Appropriate praise AND encouragement was given for ALL portions of the homework completed. The therapist ALSO appeared clearly enthusiastic in acknowledging and validating the client's efforts.
- 6 Appropriate praise AND encouragement was given for ALL portions of the homework completed. The therapist ALSO appeared clearly enthusiastic in acknowledging and validating the client's efforts. Encouragement was given for the client EXTENDING/ GENERALIZING the homework task to extend skill acquisition/ apply task to more challenging problems.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 3

3a WAS a situational conceptualization (e.g., thoughts, behaviors, emotions, physiology) used in reviewing previously assigned homework? Yes ☐ No ☐

3b HOW WELL did the therapist use a situational conceptualization (e.g., thoughts, behaviors, emotions, physiology) to review previously assigned homework (i.e., identify the client's beliefs about having engaged in the homework to synthesize their learning)? Competence Rating

- 0 A situational conceptualization WAS NOT used in reviewing previously assigned homework.
- 1 An UNDEVELOPED situational conceptualization was arrived at (i.e., the therapist completely interpreted on behalf of the client).
- 2 A VAGUE, brief and incomplete situational conceptualization was arrived at (i.e., the therapist mostly interpreted for the client's experiences rather than eliciting information).
- 3 A PARTIALLY DEVELOPED situational conceptualization was arrived at (i.e., the therapist elicited some information and interpreted other information). NO automatic thoughts OR beliefs about the consequences, OR synthesis of learning were identified.
- 4 A situational conceptualization facilitated the IDENTIFICATION OF salient (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as the TRIGGERS for homework completion.
- 5 A situational conceptualization facilitated the IDENTIFICATION OF salient (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as the TRIGGERS for homework completion. The therapist ALSO elicited beliefs about the homework (i.e., difficulty, sense of pleasure, sense of mastery).
- 6 A situational conceptualization facilitated the IDENTIFICATION OF salient (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as the TRIGGERS for homework completion. The therapist ALSO elicited beliefs about the homework (i.e., difficulty, sense of pleasure, sense of mastery), AS WELL AS their synthesis of learning (i.e., relevance, match with therapy goals, benefits, perceived progress).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 4

4a WAS an individualized conceptualization used to make sense of any portion of non-completed homework (i.e., linked non-completion to the client's automatic thoughts, underlying assumptions and rules, or core beliefs)? Yes ☐ No ☐ n/a ☐

4b HOW WELL did the therapist use an individualized conceptualization to make sense of any portion of non-completed homework (i.e., linked non-completion to the client's automatic thoughts, underlying assumptions and rules, or core beliefs)? Competence Rating

- N/a There was NO NON-COMPLETED homework (i.e., all homework was completed).
- 0 The therapist DID NOT use an individualized conceptualization to make sense of any portion of non-completed homework.
 - 1 The therapist LABELED/ INTERPRETED the portion of non-completed homework RATHER THAN facilitating the client's own understanding through collaborative discussion.
 - 2 The therapist FOCUSED on one individualized conceptualization component (i.e., either core beliefs, or conditional rules and assumptions, or automatic thoughts). The therapist used this information to LABEL/ INTERPRET the portion of non-completed homework RATHER THAN facilitating the client's own understanding.
 - 3 The therapist made LIMITED use of an individualized conceptualization, including SOME but NOT ALL of the following aspects: core beliefs, conditional rules and assumptions, and automatic thoughts. The therapist used this information to reach a VAGUE understanding of homework non-completion.
 - 4 The therapist facilitated a discussion that made REASONABLE use of an individualized conceptualization, including SOME but NOT ALL aspects of: core beliefs, conditional rules and assumptions, and automatic thoughts. This led to a REASONABLE understanding of the client's beliefs about the homework task that contributed to non-completion.
 - 5 The therapist facilitated a discussion that made GOOD USE of an individualized conceptualization, including ALL ASPECTS of: core beliefs, conditional rules and assumptions, and automatic thoughts. This led to a CLEAR understanding of the client's beliefs about the homework task that contributed to non-completion.
 - 6 The therapist facilitated a discussion that made FULL USE of an individualized conceptualization, including ALL ASPECTS of: core beliefs, conditional rules and assumptions, and automatic thoughts IN several situations, which were LINKED to overall treatment goals. This led to a VERY CLEAR understanding of the client's beliefs about the homework task that contributed to non-completion, AS WELL AS the generalization of the task to other situations.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 5

5a DID the therapist attempt to problem solve practical obstacles to the homework? Yes ☐ No ☐

5b HOW WELL did the therapist attempt to problem solve practical obstacles to the homework? Competence Rating

- The therapist DID NOT attempt to problem solve practical obstacles.
- The therapist PROVIDED solutions of their own accord, WITHOUT any contribution from the client.
- The therapist PROVIDED solutions of their own accord, with only a CURSORY contribution sought from the client. (e.g., "Does that sound okay to you?").
- The therapist ATTEMPTED to problem solve practical obstacles with SOME collaboration (i.e., the therapist provided some solutions themselves and elicited some input from the client).
- The therapist FACILITATED a discussion that IDENTIFIED the actual practical obstacles. SOME potential solutions were generated and considered. The client arrived at a VAGUE plan to overcome the obstacles.
- The therapist FACILITATED a discussion that IDENTIFIED the actual practical obstacles. A RANGE of potential solutions were generated and considered. The client arrived at CLEAR behavioral strategies to overcome the practical obstacles.
- The therapist FACILITATED a discussion that IDENTIFIED the actual practical obstacles, AS WELL AS a consideration of other potential obstacles that may have occurred. A FULL RANGE of potential solutions were generated and considered. The client arrived at CLEAR behavioral strategies to overcome the practical obstacles, AS WELL AS behavioral strategies for considering changing circumstances (e.g., bringing an outside activity indoors, testing beliefs in several situations, applying interpersonal skills to a range of relationships/interactions).

OVERALL RATING: HOMEWORK REVIEW

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Please look over your ratings for items 1-5. Now provide one overall rating for HOMEWORK REVIEW. Please take into account:

- the individual ratings for items 1-5.
- the appropriateness of not adhering to specific items, e.g., homework was completed unusually well; there was a crisis or risk to client safety.
- any other special considerations from the session rated, e.g., interpersonal features of the specific therapeutic relationship; and the therapist's ability to adapt the PROCESS AND DISCUSSION of homework based on the client's individualized cognitive conceptualization (e.g., greater verbal encouragement for a client with avoidant interpersonal style, normalizing aspects of non-completion for a client exhibiting perfectionism, emphasizing complimentary nature to existing coping strategies for client with demanding interpersonal style).

Rating

Please describe any factors that have affected your overall rating for HOMEWORK REVIEW:

HOMEWORK DESIGN

Items 6-14 cover the therapist behaviors involved in collaboratively deciding what homework will be carried out between sessions, and typically occurs throughout the session

0-----1-----2-----3-----4-----5-----6
Non-adherence/ Poor Mediocre Fair Good Very Good Excellent
extremely poor

Item 6

6a WAS any new or revised homework discussed? Yes ☐ No ☐

6b HOW WELL did the therapist discuss new or revised homework? Competence Rating

- 0 The therapist did NOT discuss new or revised homework.
- 1 The therapist BRIEFLY discussed new or revised homework.
- 2 The therapist allowed SUFFICIENT TIME for a discussion of new or revised homework, BUT only at the END of the session.
- 3 The therapist allowed SUFFICIENT TIME for a discussion of new or revised homework, throughout the course of the session. However, the homework WAS NOT linked to in-session content or therapy goals.
- 4 The therapist allowed SUFFICIENT TIME for a discussion of new or revised homework throughout the course of the session. The homework WAS linked to EITHER in-session content OR therapy goals.
- 5 The therapist allowed SUFFICIENT TIME for a discussion of new or revised homework throughout the course of the session. The homework WAS linked to BOTH in-session content AND therapy goals.
- 6 The therapist allowed SUFFICIENT TIME for a discussion of new or revised homework throughout the course of the session. The homework WAS linked to BOTH in-session content AND therapy goals. The therapist was ALSO able to tailor the discussion of the homework to the client's interpersonal style. The discussion was ALSO EFFECTIVE even when confronted with interpersonal difficulties (e.g., client avoidance, perfectionism, demanding interpersonal style).

0-----1-----2-----3-----4-----5-----6
Non-adherence/ Poor Mediocre Fair Good Very Good Excellent
extremely poor

Item 7**Note:**

This item asks about the therapist's use of the components of the "guided discovery" process. The guided discovery process has four sequential components which are:

- i. Asking informational questions to uncover information outside the client's awareness,
- ii. Listening empathically and providing reflections,
- iii. Summarizing the information discovered,
- iv. Asking synthesizing or analytical questions which enable the client's own learning.

7a DID the therapist use any aspects of guided discovery to identify the client's coping strategies and beliefs related to the homework? Yes ☐ No ☐

7b HOW WELL did the therapist use guided discovery to identify the client's coping strategies and beliefs related to the homework? Competence Rating

- 0 The therapist DID NOT use any aspects of guided discovery to identify the client's coping strategies and beliefs related to the homework.
- 1 The therapist used INEFFECTIVE questioning (e.g., closed questions or broad questions, but these did not uncover new information) and provided INTERPRETIVE answers RATHER THAN guiding the client's own understanding about coping strategies and beliefs.
- 2 The therapist used SOME but NOT ALL components of the guided discovery process. HOWEVER they were used in a cursory, inappropriate, or ineffective manner (e.g., inaccurate reflections or summaries). The therapist used INTERPRETIVE answers RATHER THAN guiding the client's own learning, and was UNABLE to identify coping strategies and beliefs (e.g., "If you think X, then surely Y is?").
- 3 The therapist used ALL FOUR components of the guided discovery process, BUT was INEFFECTIVE in identifying coping strategies and beliefs.
- 4 The therapist used ALL FOUR components of the guided discovery process REASONABLY EFFECTIVELY. In using this process the therapist facilitated the identification of A FEW coping strategies and beliefs.
- 5 The therapist used ALL FOUR components of the guided discovery process EFFECTIVELY. In using this process the therapist facilitated the identification of A NUMBER OF coping strategies and beliefs.
- 6 The therapist APPEARED genuinely curious and inquisitive, and used ALL FOUR components of the guided discovery process VERY EFFECTIVELY. In using this process the therapist facilitated the identification of A NUMBER OF HIGHLY CREDIBLE coping strategies and beliefs.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 8

8a DID the therapist integrate a disorder-specific cognitive model with the individualized conceptualization in designing homework? Yes ☐ No ☐

8b HOW WELL did the therapist integrate a disorder-specific cognitive model with the individualized conceptualization in designing homework? Competence Rating

- 0 The therapist DID NOT discuss a disorder-specific cognitive model or individualized conceptualization in designing homework.
- 1 The therapist MENTIONED the disorder-specific cognitive model BUT did not elaborate on how it was relevant to the client's presentation.
- 2 The therapist integrated SOME but NOT ALL aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to ONE ASPECT of the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies).
- 3 The therapist integrated SOME but NOT ALL aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to MORE THAN ONE aspect the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies).
- 4 The therapist integrated MOST aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to MOST aspects the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies).
- 5 The therapist integrated ALL aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to ALL aspects of the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies).
- 6 The therapist integrated ALL aspects of a disorder-specific cognitive model (e.g., Beck's Cognitive Triad, Clark's Panic Model, etc) to ALL aspects of the client's individualized conceptualization (i.e., core beliefs, conditional rules and assumptions, automatic thoughts, and under and over developed behavioral strategies). The therapist was ALSO able to integrate all this information with the client's presenting problems, evidenced in tactful responses to client's interpersonal style (e.g., critical, competitive, suspicious, controlling, exaggerative).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 9

9a WERE homework tasks selected for completion before the next session? Yes ☐ No ☐

9b HOW WELL did the therapist collaboratively select homework tasks for completion before the next session? Competence Rating

- 0 Homework tasks were NOT selected during the session.
- 1 The therapist selected homework tasks WITHOUT any contribution of the client.
- 2 The therapist only sought a CURSORY contribution from the client in selecting homework tasks (e.g., "Does that sound okay to you?").
- 3 The therapist INVOLVED the client in the selection of homework tasks, BUT at times reverted to a DIRECTIVE rather than collaborative approach, especially in the final decision.
- 4 The therapist INVOLVED the client in the selection of homework tasks (E.G., facilitated a DISCUSSION rather than provided direct answers). A FEW possible homework tasks were discussed, AS WELL AS a FEW advantages and disadvantages of the possible homework tasks.
- 5 The therapist encouraged the client to view the process of selecting homework tasks as the therapist and client working together as a TEAM. The therapist also ACTIVELY INVOLVED the client in selecting homework tasks (e.g., facilitated a discussion rather than provided direct answers). SEVERAL possible homework tasks were discussed, AND the client's thoughts and feelings about the possible homework tasks were elicited and explored, AND SEVERAL advantages and disadvantages of the possible homework tasks were discussed.
- 6 The therapist encouraged the client to view the process of selecting homework tasks as the therapist and client working together as a TEAM. The therapist also ACTIVELY INVOLVED the client in selecting homework tasks (e.g., facilitated a discussion rather than provided direct answers). A FULL RANGE of possible homework tasks were discussed, AND the client's thoughts and feelings about the possible homework tasks were elicited and explored, AND A FULL RANGE of advantages and disadvantages of the possible homework tasks were discussed (i.e., based on prior experience, benefits experienced by others). The therapist and client ALSO decided on homework tasks that built upon existing client skills and strategies, AND the client was encouraged to take on more responsibility for selecting homework tasks.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 10

10a DID the therapist present any rationale for the homework? Yes ☐ No ☐

10b HOW WELL did the therapist present a rationale for the homework that aligned with the client's goals for treatment? Rating

- The therapist DID NOT present any rationale for the homework.
- The therapist presented a BRIEF rationale but FAILED to relate it to the client's treatment goals.
- The therapist presented a RATIONALE for the homework with SOME mention of the client's treatment goals, however this was presented WITHOUT any input (and understanding) from the client.
- The therapist assisted the client to understand how the homework was ALIGNED to the specific presenting problem in the current session.
- The therapist assisted the client to understand that the homework was broken into achievable CHUNKS that were manageable and within the client's control. The therapist ALSO assisted the client to understand how the homework was ALIGNED to EITHER the specific presenting problem in the current session, OR their overall treatment goals.
- The therapist assisted the client to understand that the homework was broken into achievable CHUNKS that were manageable and within the client's control. The therapist ALSO assisted the client to understand how the homework was ALIGNED to BOTH the specific presenting problem in the current session AS WELL AS their overall treatment goals.
- The therapist assisted the client to understand that the homework was broken into achievable CHUNKS that were manageable and within the client's control. The therapist ALSO assisted the client to understand how the homework was ALIGNED to BOTH the specific presenting problem in the current session AS WELL AS their overall treatment goals, AND obtained feedback from the client on the rationale. The therapist ALSO provided empirical evidence to support the rationale for the homework.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 11

11a DID the therapist ask about the client's ability and perceived difficulty of the homework? Yes ☐ No ☐

11b HOW WELL did the therapist ask about the client's ability and perceived difficulty of the homework? Rating

- The therapist DID NOT ask about the client's ability and perceived difficulty of the task.
- The therapist made a CURSORY enquiry about the client's ability and perceived difficulty of the task, but did not discuss it any further.
- The therapist ENQUIRED about the client's ability and perceived difficulty of the task, and made an INEFFECTIVE attempt to elicit feedback from the client (e.g., the therapist did not listen to the client's responses, asked closed questions, questions did not follow the client's responses).
- The therapist ENQUIRED about the client's ability and perceived difficulty of the task, and elicited a GENERAL STATEMENT from the client, for example, the client was vague and said "Sure, I can do it" and this response was taken at face value and NOT explored any further.
- The therapist ENQUIRED about the client's ability and perceived difficulty of the task, and through Socratic questioning identified a BROAD ISSUE (e.g., "That thought record looks too hard. There is so much to complete"). HOWEVER, the therapist then provided their own solutions to resolve the issues raised (e.g., "Okay, just complete the first three columns of the thought record").
- The therapist ENQUIRED about the client's ability and perceived difficulty of the task, and through Socratic questioning identified SPECIFIC ISSUES (e.g., in addition to feeling overwhelmed by the entire thought record, it transpired that the client had difficulty distinguishing emotions and thoughts on thought record). Through further EXPLORATION the therapist and client collaboratively RESOLVED the issue (e.g., the therapist and client worked on automatic thoughts in-session, and/or the homework was redesigned to focus on practicing the identification emotions as distinct from automatic thoughts).
- The therapist ENQUIRED about the client's ability and perceived difficulty of the task, and through Socratic questioning identified SPECIFIC ISSUES. Through further EXPLORATION the therapist and client collaboratively RESOLVED the issue. The therapist ALSO elicited ADDITIONAL CLIENT LEARNING from the discussion, for example, the client learnt that breaking items into smaller chunks was less overwhelming, and also identified an underlying rule (e.g., "I've failed if I can't work things out for myself").

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 12

12a	WAS ANY attempt made to facilitate in-session homework practice?	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>

12b	HOW WELL did the therapist facilitate in-session homework practice?	Rating	<input type="text"/>
-----	--	--------	----------------------

- 0 The therapist DID NOT provide the opportunity for in-session practice of the homework.
- 1 The therapist briefly DEMONSTRATED or EXPLAINED (i.e., modeled or instructed) the homework, that provided no opportunity for the clients to learn from their own practice.
- 2 The therapist PROVIDED only a BRIEF opportunity for in-session practice. The therapist tended to FOCUS on correcting the client's mistakes AND provided LIMITED positive reinforcement. The therapist DID NOT discuss any learning points from the practice.
- 3 The therapist PROVIDED SOME opportunity for in-session practice. The therapist provided SOME positive reinforcement (i.e., shaping successive approximations of skill), AND gave SOME constructive guidance when the client needed assistance. HOWEVER, the therapist used a DIRECTIVE rather than collaborative approach in discussing learning points from the practice.
- 4 The therapist PROVIDED SOME opportunity for in-session practice. The therapist provided SOME positive reinforcement (i.e., shaping successive approximations of skill), AND gave SOME constructive guidance when the client needed assistance. The therapist and client COLLABORATIVELY discussed learning points from the in-session practice.
- 5 The therapist PROVIDED a GOOD opportunity for in-session practice, using the METHOD/S most appropriate for the client and the specific task. The therapist provided POSITIVE reinforcement (i.e., shaping successive approximations of skill) AND gave CONSTRUCTIVE guidance when the client needed assistance. The therapist was ENCOURAGING when COLLABORATIVELY discussing learning points from the in-session practice.
- 6 The therapist PROVIDED CONSIDERABLE opportunity for in-session practice, using the METHOD/S most appropriate for the client and the specific task. The therapist provided ENTHUSIASTIC positive reinforcement (i.e., shaping successive approximations of skill), AND gave WARM, GENUINE, CONSTRUCTIVE guidance when the client needed assistance. The therapist was ENCOURAGING when COLLABORATIVELY discussing learning points from the in-session practice. The therapist ALSO asked the client for FEEDBACK on the experience, and asked the client to WRITE down the learning points.

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 13

13a	DID the therapist use guided imagery to begin experiential learning for the homework in-session?	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>

13b	HOW WELL did the therapist use guided imagery to begin experiential learning for the homework in-session?	Rating	<input type="text"/>
-----	--	--------	----------------------

- 0 The therapist DID NOT use guided imagery in homework design.
- 1 The therapist used guided imagery INEFFECTIVELY (i.e., affect was not generated, client had difficulty staying on track, etc). Feedback was NOT sought throughout the exercise, and at the completion, the therapist DID NOT facilitate any experiential learning from the imagery practice.
- 2 The therapist provided an OPPORTUNITY for guided imagery, but was UNABLE to use this to assist the client with some experiential learning of the homework task (i.e., client completed imagery but did not gain an experience of completing the task).
- 3 The therapist FACILITATED the client in using guided imagery, and this was REASONABLY EFFECTIVE in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified). HOWEVER, imagery was INEFFECTIVE in providing the client with some experiential learning of the homework task (i.e., client completed imagery but did not gain an experience of completing the task).
- 4 The therapist FACILITATED the client in using guided imagery, and this was REASONABLY EFFECTIVE in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified), AND the client gained SOME experiential learning of the homework task (i.e., experienced the outcome of having engaged in the homework task).
- 5 The therapist FACILITATED the client in using guided imagery, and this was EFFECTIVE in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified), AND the client gained SOME experiential learning of the homework task (i.e., experienced the outcome of having engaged in the homework task). The therapist ALSO focused on skill acquisition AND discussed with the client how the task could be extended to more complex skills (i.e., shaping).
- 6 The therapist FACILITATED the client in using guided imagery, and this was EFFECTIVE in stepping the client through a scenario where they may use the homework assignment (i.e., physiological, emotional, cognitive triggers identified), AND the client gained SOME experiential learning of the homework task (i.e., experienced the outcome of having engaged in the homework task). The therapist ALSO focused on skill acquisition AND discussed with the client how the task could be extended to more complex skills (i.e., shaping). In feedback, the therapist and client ALSO discussed the application of the task across different situations (i.e., generalization and maintenance).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 14

14a DID the therapist use a situational conceptualization to help identify the client's beliefs and triggers (i.e., emotional, behavioral, physiological) for carrying out the homework in specific situations?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

14b HOW WELL did the therapist use a situational conceptualization to help identify the client's beliefs and triggers (i.e., emotional, behavioral, physiological) for carrying out the homework in specific situations?

Rating

--

- The therapist DID NOT use a situational conceptualization to help identify the client's beliefs and situational triggers for carrying out the homework in specific situations.
- An UNDEVELOPED situational conceptualization was arrived at (i.e., the therapist completely interpreted on behalf of the client).
- A VAGUE, BRIEF AND INCOMPLETE situational conceptualization was arrived at (i.e., the therapist mostly interpreted for the client rather than eliciting information).
- A PARTIALLY DEVELOPED situational conceptualization was arrived at (i.e., the therapist elicited some information and interpreted other information). This PROVED INEFFECTIVE in identifying the client's beliefs and situational triggers.
- A PARTIALLY DEVELOPED situational conceptualization was arrived at (i.e., the therapist elicited some information and interpreted other information). Emotions, behaviors, and physiology WERE IDENTIFIED to the use of homework, BUT no cognitive triggers or beliefs were identified.
- A SITUATIONAL CONCEPTUALIZATION facilitated the client's identification of SALIENT (i.e., emotionally laden) automatic thoughts that served as triggers for homework completion. Emotions, behaviors, and physiology were also identified.
- A SITUATIONAL CONCEPTUALIZATION facilitated the client's identification of a SALIENT (i.e., emotionally laden) automatic thoughts, emotions, behaviors, and physiology that served as triggers for homework completion. The therapist ALSO discussed the triggers to the use of homework in several situations, AND elicited beliefs about the homework (i.e., difficulty, obstacles).

OVERALL RATING: HOMEWORK DESIGN

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Please look over your ratings for items 6-14. Now provide one overall rating for HOMEWORK DESIGN. Please take into account:

- the individual ratings for items 6-14.
- the appropriateness of not adhering to specific items, e.g., no need to practice a particular skill for homework as this had covered extensively in previous sessions; client was extending a mastered skill to a new situation rather than being asked to learn something new.
- and any other special considerations from the session rated, e.g., interpersonal features of the specific therapeutic relationship; and the therapist's ability to adapt the PROCESS AND DISCUSSION of homework based on the client's individualized cognitive conceptualization (e.g., increased emphasis on in-session practice for a client with dependent interpersonal style, discussion of rationale for a client with controlling interpersonal style).

Rating

--

Please describe any factors that have affected your overall rating for HOMEWORK DESIGN:

--

HOMEWORK ASSIGN

Items 15-19 cover the therapist behaviors involved in determining how the homework assignment/s will be practically carried out, and typically occurs near the end of the session.

0-----1-----2-----3-----4-----5-----6
Non-adherence/ Poor Mediocre Fair Good Very Good Excellent
extremely poor

Item 15

15a WAS there any attempt to summarize the rationale for the homework in relation to therapy goals? Yes ☐ No ☐

15b HOW WELL did the therapist ask the client to summarize the rationale for the homework in relation to therapy goals? Rating

- 0 The therapist DID NOT ask the client to summarize the rationale for the task in relation to therapy goals.
- 1 The therapist summarized the rationale for the task, with LITTLE OR NO INPUT from the client.
- 2 The therapist ATTEMPTED to involve the client in summarizing the rationale for the task in relation to therapy goals, but used a DIRECTIVE rather than collaborative approach.
- 3 The therapist INVOLVED the client in summarizing the rationale for the task in relation to GENERAL therapy goals.
- 4 The therapist INVOLVED the client in summarizing the rationale for the task in relation to MOST PERTINENT therapy goals. That is, the homework was discussed in terms of the SPECIFIC behavior changes that would be expected to result from progress towards this goal.
- 5 The therapist SKILLFULLY INVOLVED the client in summarizing the rationale for the task in relation to MOST PERTINENT therapy goals. That is, the homework was discussed in terms of the SPECIFIC behavior changes that would be expected to result from progress towards this goal, AND this process was LEAD by the client.
- 6 The therapist SKILLFULLY INVOLVED the client in summarizing the rationale for the task in relation to MOST PERTINENT therapy goals. That is, the homework was discussed in terms of the SPECIFIC behavior changes that would be expected to result from progress towards this goal, AND this process was LEAD by the client. FURTHERMORE, in discussion with the therapist, the client demonstrated a clear understanding of the homework and was able to place the current homework in context of current and overall goals for therapy. The therapist skill was evidenced by their adaptation of this discussion to the client's interpersonal style.

0-----1-----2-----3-----4-----5-----6
Non-adherence/ Poor Mediocre Fair Good Very Good Excellent
extremely poor

Item 16

16a WAS there any attempt to specify how the homework will be practically integrated into the client's life (i.e., specification of when, where, how often, how long)? Yes ☐ No ☐

16b HOW WELL did the therapist collaborate with the client to specify how the homework will be practically integrated into the client's life (i.e., specification of when, where, how often, how long)? Rating

- 0 The therapist DID NOT collaborate to specify how the task would be practically integrated into the client's life.
- 1 The therapist DIRECTED how the task could be practically integrated into the client's life, WITHOUT any contribution from the client.
- 2 The therapist reached a VAGUE outline of how the task could be practically integrated into the client's life, with SOME collaboration (i.e., the therapist provided some specifics themselves and elicited some input from the client).
- 3 The therapist FACILITATED a discussion which resulted in the client being able to state with SOME behavioral specificity how the task could be practically integrated into the client's life in ONE of the following areas: when, where, how often, and how long.
- 4 The therapist FACILITATED a discussion which resulted in the client being able to state with SOME behavioral specificity how the task could be practically integrated into the client's life in TWO-THREE of the following areas: when, where, how often, and how long.
- 5 The therapist FACILITATED a discussion which resulted in the client being able to state with a HIGH DEGREE of behavioral specificity how the task could be practically integrated into the client's life in ALL of the following areas: when, where, how often, and how long. IF the client was unable to be specific in any area, the therapist gently GUIDED the client to a specific resolution.
- 6 The therapist SKILLFULLY ELICITED a description of how the homework would be practically implemented from the client. A HIGH DEGREE of behavioral specificity was achieved in ALL the following areas: when, where, how often, and how long. IF the client was unable to be specific in any area, the therapist gently GUIDED the client to a specific resolution. The therapist ALSO anticipated potential difficulties in communication and resolved them (e.g., misinterpretation of the process in achieving specificity, misinterpretation of the meaning of specificity, such as using a thought record "when" automatic thoughts occur).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 17

17a WAS there any consideration of potential difficulties for completing the homework? Yes ☐ No ☐

17b HOW WELL did the therapist consider potential difficulties for completing the homework? Rating

- 0 The therapist DID NOT attempt to consider potential difficulties.
- 1 The therapist PROVIDED potential difficulties of their own accord, WITHOUT any contribution from the client.
- 2 The therapist GENERALLY PROVIDED potential difficulties of their own accord, with only a CURSORY CONTRIBUTION sought from the client. (e.g., "So that would be difficult, wouldn't it?").
- 3 The therapist attempted to consider potential difficulties with some collaboration (i.e., the therapist provided some potential difficulties themselves and elicited some input from the client).
- 4 The therapist FACILITATED a discussion that identified SOME potential difficulties, AND SOME potential solutions were also generated and considered. The client arrived at a VAGUE plan to overcome the potential difficulties.
- 5 The therapist FACILITATED a discussion that identified MOST potential difficulties, AND a RANGE of potential solutions were generated and considered. The client arrived at a CLEAR plan to overcome the potential difficulties that included SPECIFIC behaviors (e.g., "My days are really busy next week, so I will set the alarm clock 30 minutes earlier on Tuesday morning and read the booklet before starting the day's other activities").
- 6 The therapist FACILITATED a discussion that identified ALL the potential difficulties, and a FULL RANGE of potential solutions were generated and considered. The client arrived at a CLEAR plan to overcome the potential difficulties that included SPECIFIC behaviors, AND behavioral STRATEGIES for considering changing circumstances (e.g., if unable to complete a task in a single sitting, then breaking it into smaller chunks and completing it over 2-3 sittings).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 18

18a WAS there ANY attempt to explain the outcome from the homework as having a learning 'experiment' focus? Yes ☐ No ☐

18b HOW WELL did the therapist emphasize the homework as having a learning 'experiment' focus (e.g., a no-lose scenario, partial completion is helpful, seeing what works and what doesn't)? Rating

- 0 The therapist DID NOT emphasize the task as a learning 'experiment' focus.
- 1 In ATTEMPTING to explain a learning 'experiment' focus of the homework task, the therapist specified or intimated there was a 'CORRECT' actual outcome (i.e. could pass or fail).
- 2 The therapist did not focus on actual outcomes, but was VAGUE about the learning outcome (i.e., "it will be useful") but did not elaborate any further.
- 3 The therapist BRIEFLY explained the homework task as a learning experiment (i.e., to test out an idea or skill), rather than guided the client to their own learning.
- 4 The therapist FRAMED the homework task as a learning 'experiment'. MOST of the following points emerged from the discussion: there is no right or wrong (no failure or grading); it is a no-lose situation for the client; in any experiment the outcome is not known; there is a learning from every homework task no matter what the actual outcome; any information from the experiment is useful to further help with the treatment.
- 5 The therapist used guided discovery to uncover the CLIENT'S BELIEFS about the outcomes of the homework task, and then used Socratic questioning and hypothetical examples to facilitate the CLIENT to view the homework task as a learning experiment (i.e., gaining client's previous experiences of learning and applying them to the homework). MOST of the following points emerged from the discussion: there is no right or wrong (no failure or grading); it is a no-lose situation for the client; in any experiment the outcome is not known; there is a learning from every homework task no matter what the actual outcome; any information from the experiment is useful to further help with the treatment.
- 6 The therapist used guided discovery to uncover the CLIENT'S BELIEFS about the outcomes of the homework task, and then used Socratic questioning and hypothetical examples to facilitate the CLIENT to view the homework task as a learning experiment (i.e., gaining client's previous experiences of learning and applying them to the homework). MOST of the following points emerged from the discussion: there is no right or wrong (no failure or grading); it is a no-lose situation for the client; in any experiment the outcome is not known; there is a learning from every homework task no matter what the actual outcome; any information from the experiment is useful to further help with the treatment. The therapist ALSO discussed the BENEFITS (e.g., new skill acquisition, reduction in distressing thoughts, better treatment outcome) VERSUS the COSTS of performing the homework task (e.g., time, energy, short-term distress).

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Item 19

19a **WAS there ANY attempt to summarize the homework?**
 Yes ☐ No ☐
19b **HOW WELL did the therapist ask the client to summarize the homework and obtain an indication of homework-related readiness, importance, and/or confidence?**

Rating

- 0 There was NO summary of the homework task AND NO indication of readiness, importance, or confidence.
- 1 The therapist summarized the task, WITHOUT any contribution from the client, AND DID NOT obtain any indication of readiness, importance, or confidence.
- 2 The therapist ATTEMPTED to involve the client in summarizing the task AND obtained separate indications for readiness, importance, or confidence, with only a CURSORY contribution sought from the client. (e.g., "Does about 80% sound right to you?").
- 3 The therapist INVOLVED the client in summarizing the task and obtained a VAGUE indication of readiness, importance, or confidence (e.g., the client said "I'd give that a very high rating").
- 4 The therapist FACILITATED the client to SUMMARIZE the task AND provide an indication of readiness, importance, and confidence.
- 5 The therapist USED Socratic questioning, which enabled the client to SUMMARIZE the task AND provide SPECIFIC ratings for EACH OF readiness, importance, or confidence. IF the task summary was incomplete, the client was gently guided to its completion. IF the rating was low (i.e., <70%) the client was gently guided to identify what it would take to increase their rating.
- 6 The therapist USED Socratic questioning, which enabled the client to ACTIVELY SUMMARIZE the task AND provide SPECIFIC ratings for EACH OF readiness, importance, and confidence. IF the task summary was incomplete, the client was gently guided to its completion, OR the task was modified with decreased demands. IF the confidence rating was low (i.e., <70%) the client was gently guided to identify what it would take to increase their confidence level. The therapist ALSO explored overly confident ratings (e.g., an immediate or persistent statement of 100%) to identify possible social desirability responses.

OVERALL RATING: HOMEWORK ASSIGN

0	1	2	3	4	5	6
Non-adherence/ extremely poor	Poor	Mediocre	Fair	Good	Very Good	Excellent

Please look over your ratings for items 15-19. Now provide one overall rating for HOMEWORK ASSIGN. Please take into account:

- the individual ratings for items 15-19
- the appropriateness of not adhering to specific items (e.g., the session was near the end of therapy and the client was taking responsibility for the process, and leading in-session discussion)
- and any other special considerations from the session rated, e.g., interpersonal features of the specific therapeutic relationship; and the therapist's ability to adapt the PROCESS AND DISCUSSION of homework based on the client's individualized cognitive conceptualization (e.g., greater use of collaboration for a client with suspicious interpersonal style, greater discussion of specifics and confidence ratings for a client with unrelenting standards).

Rating

Please describe any factors that have affected your overall rating for HOMEWORK ASSIGN:

APPENDIX G
RATING DISTRIBUTION CHARTS

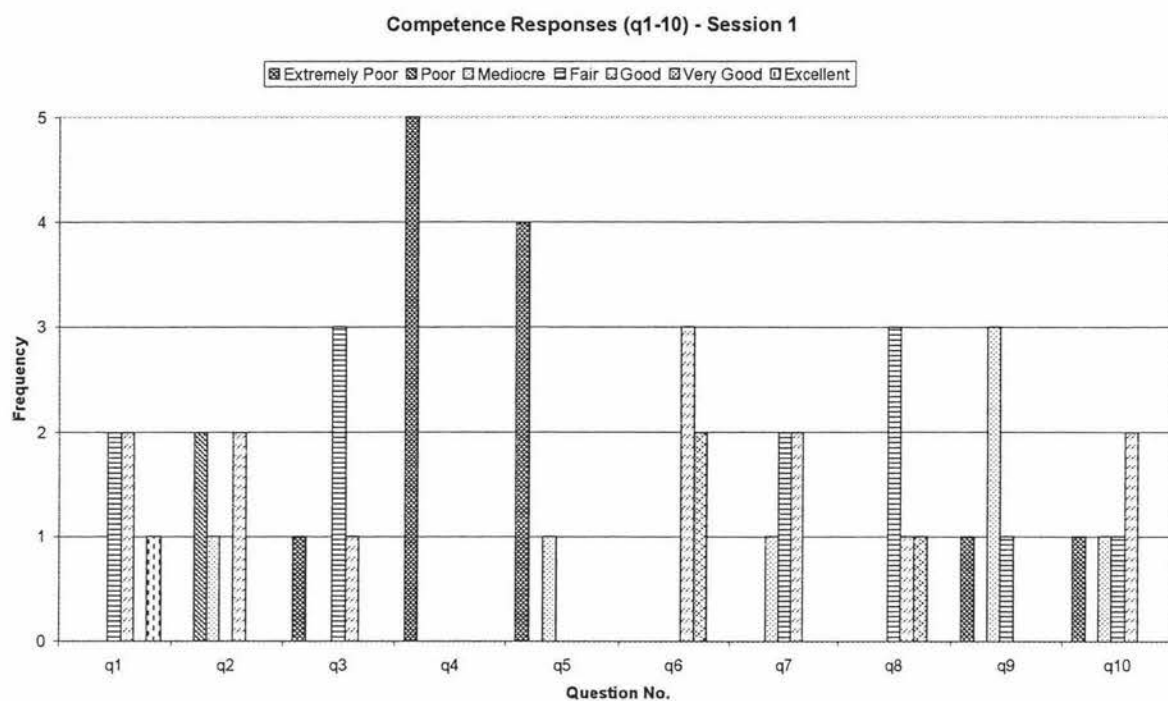


Figure 12. Competence responses (q1-q10) for pilot one, session one.

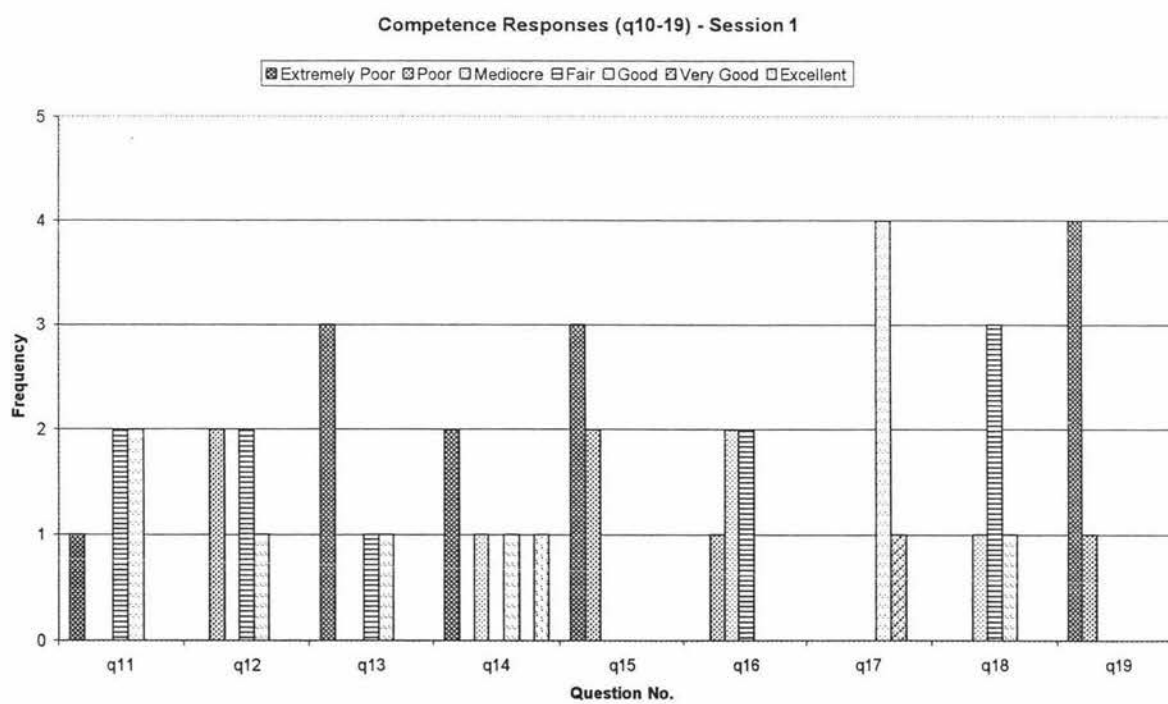


Figure 13. Competence responses (q11-q19) for pilot one, session one.

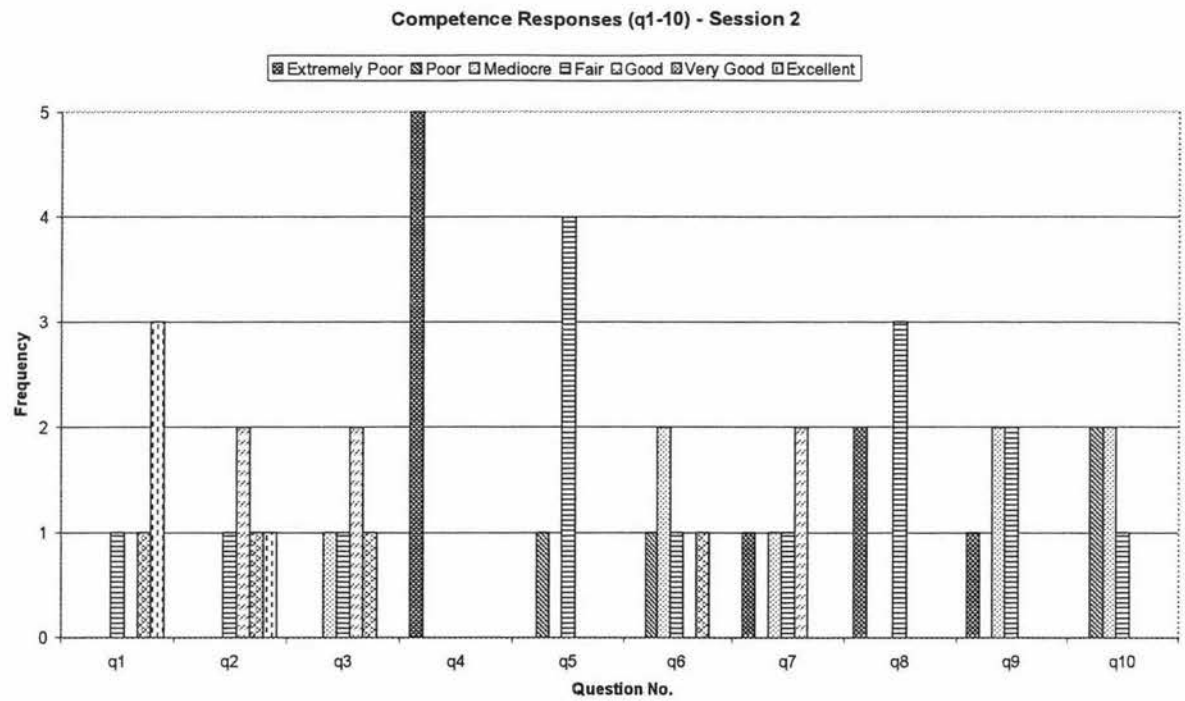


Figure 14. Competence responses (q1-q10) for pilot one, session two.

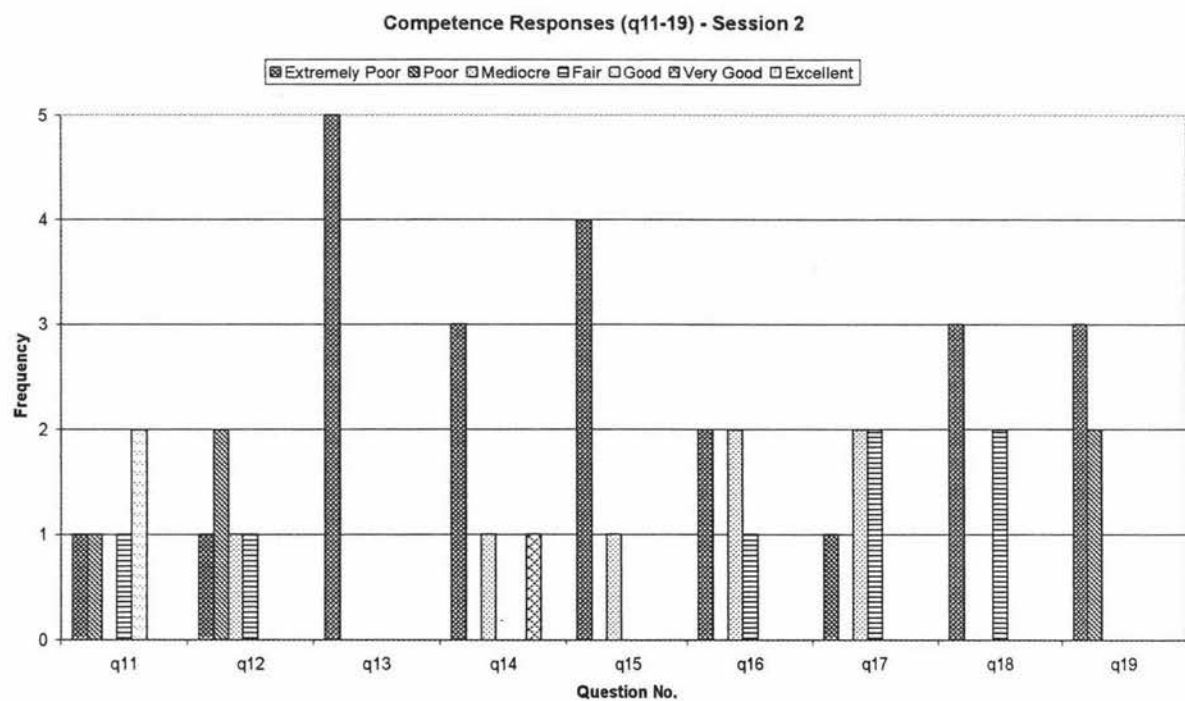


Figure 15. Competence responses (q11-q19) for pilot one, session two.

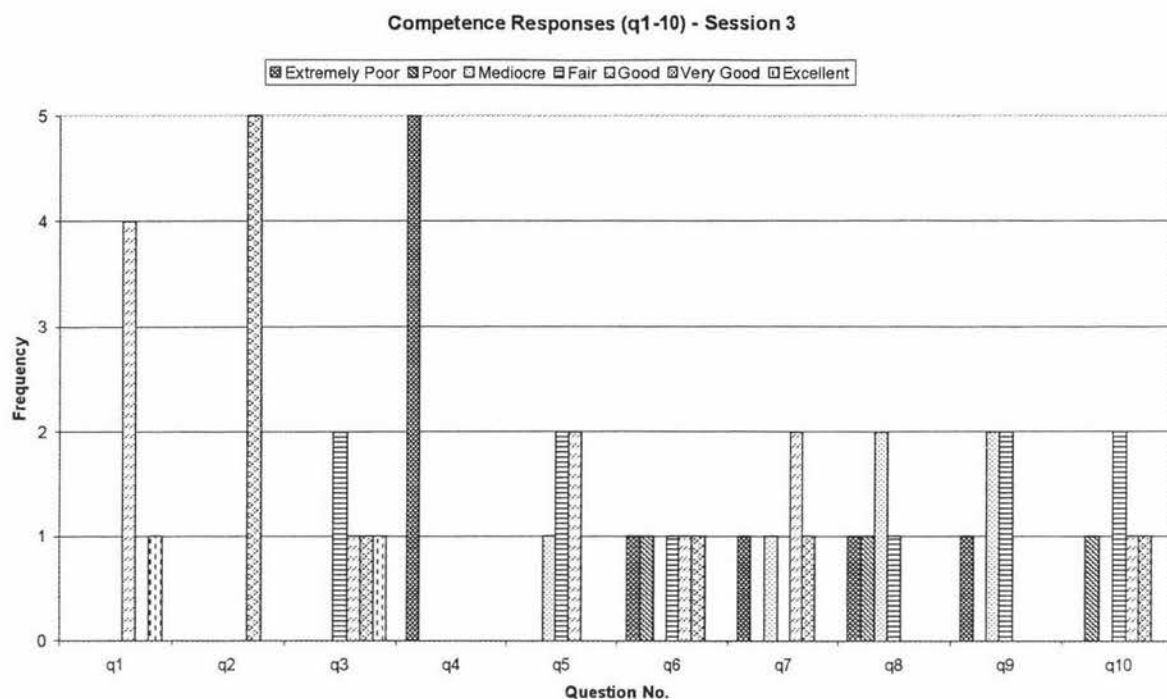


Figure 16. Competence responses (q1-q10) for pilot one, session three.

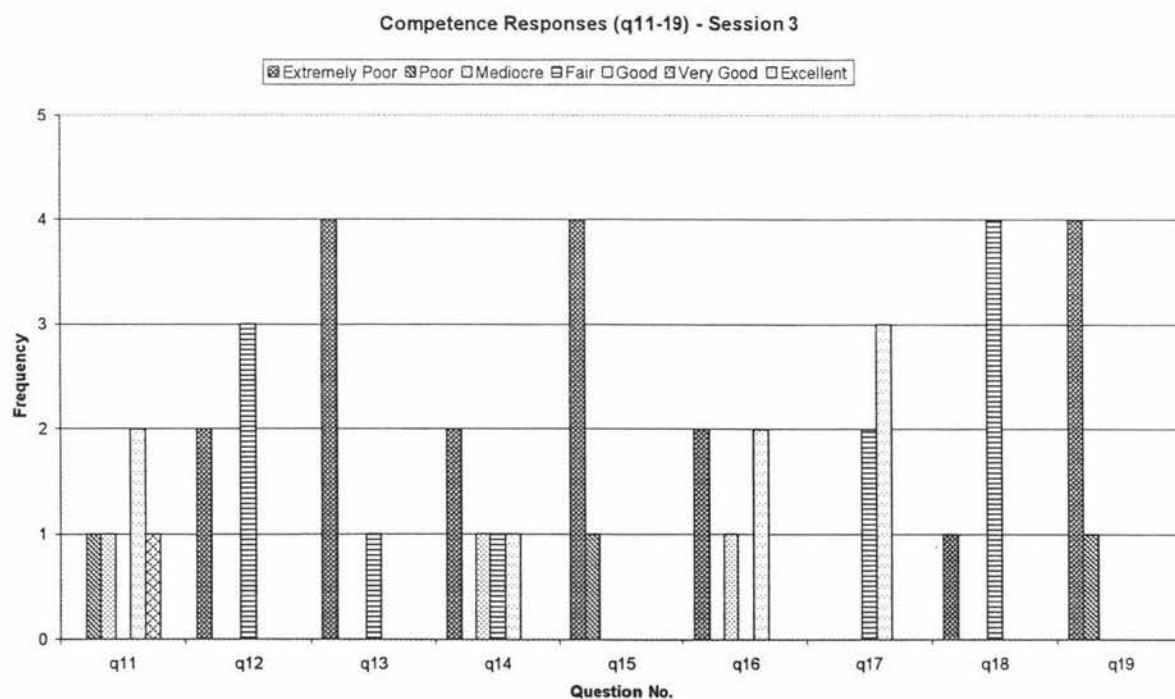


Figure 17. Competence responses (q11-q19) for pilot one, session three.

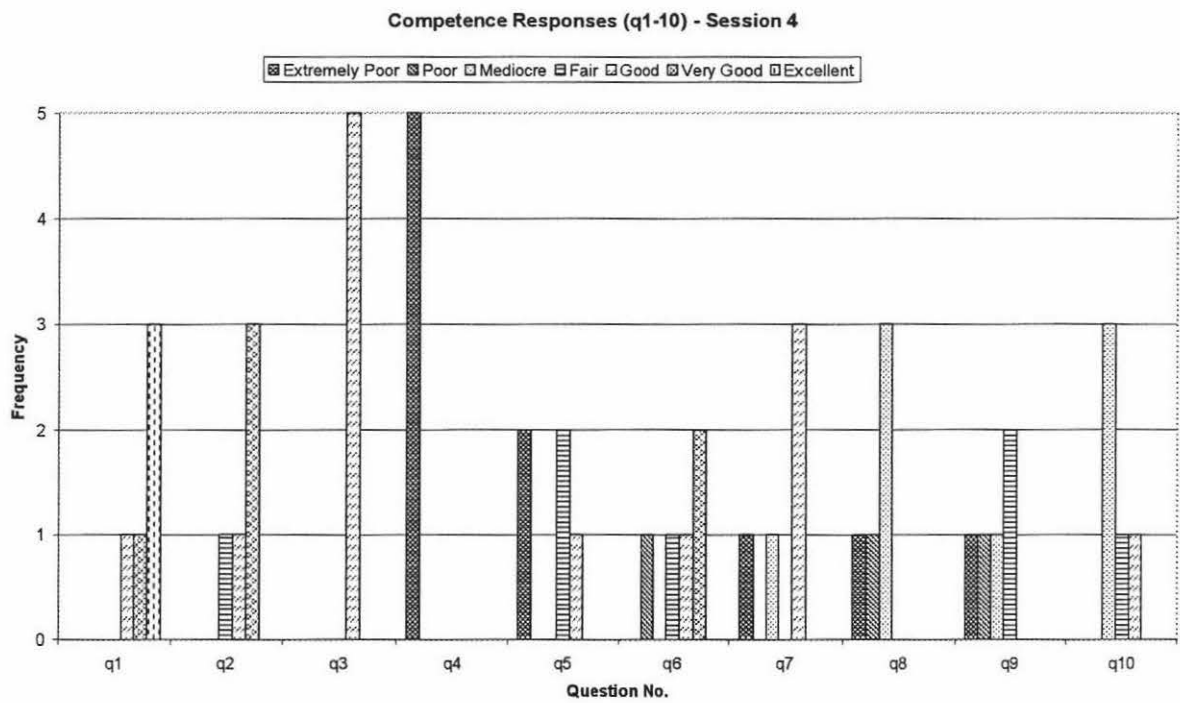


Figure 18. Competence responses (q1-q10) for pilot one, session four.

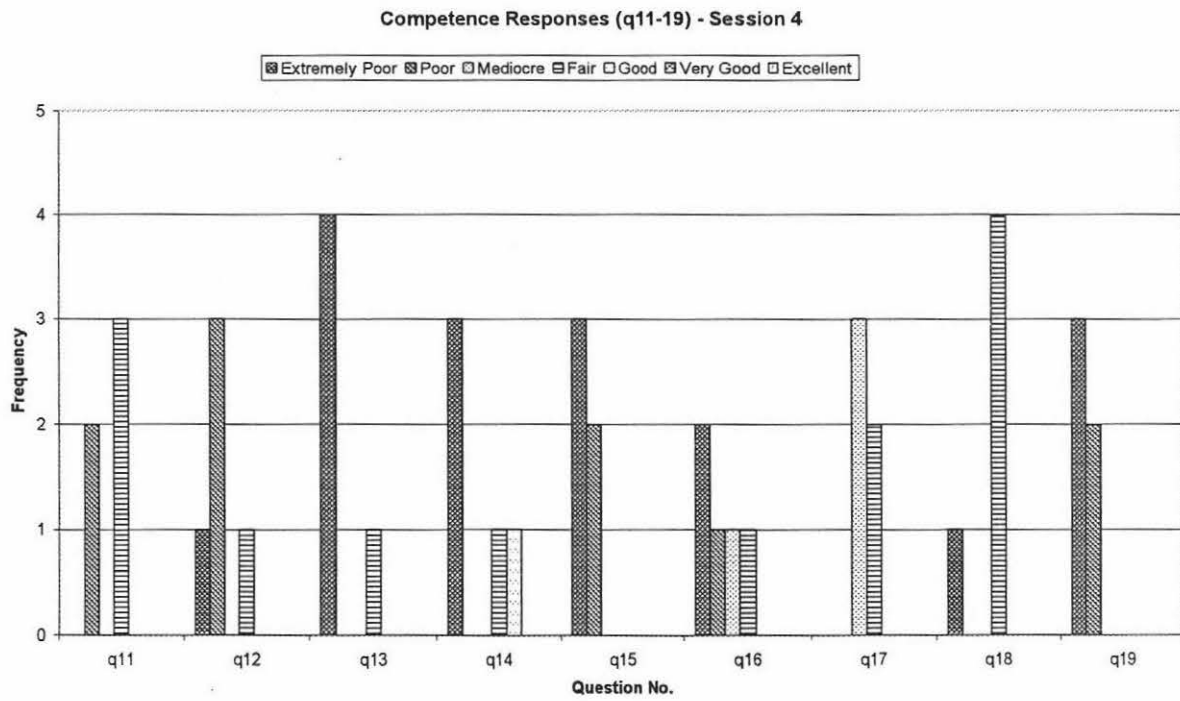


Figure 19. Competence responses (q11-q19) for pilot one, session four.

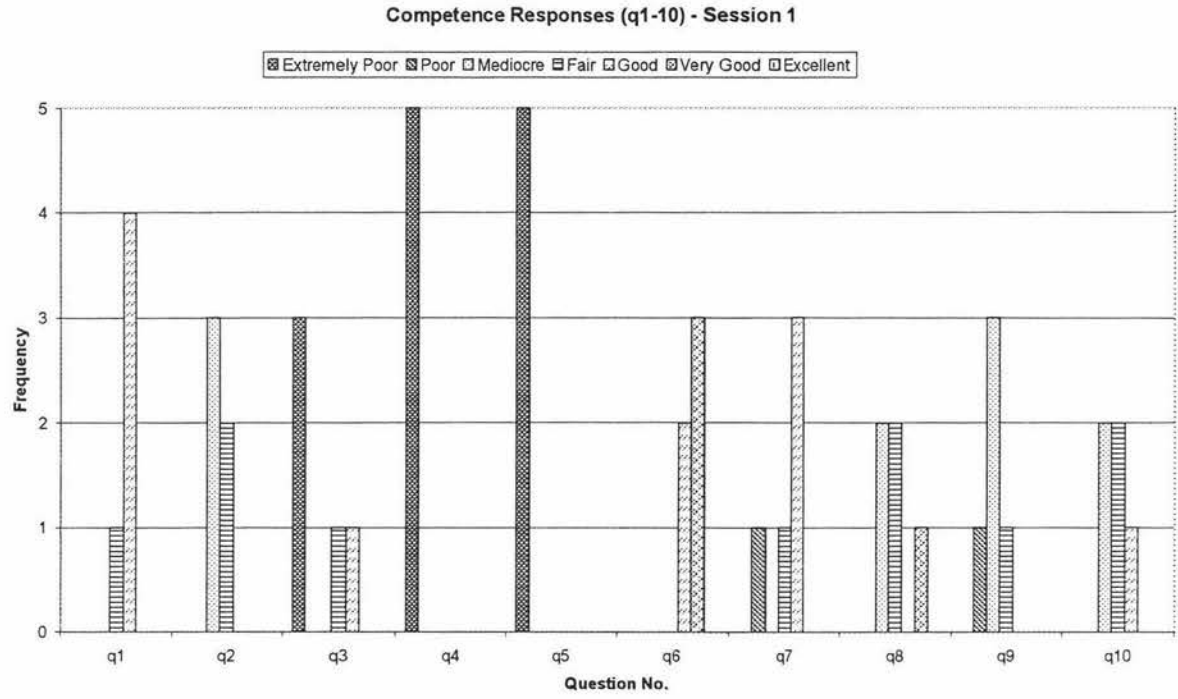


Figure 20. Competence responses (q1-q10) for pilot two, session one.

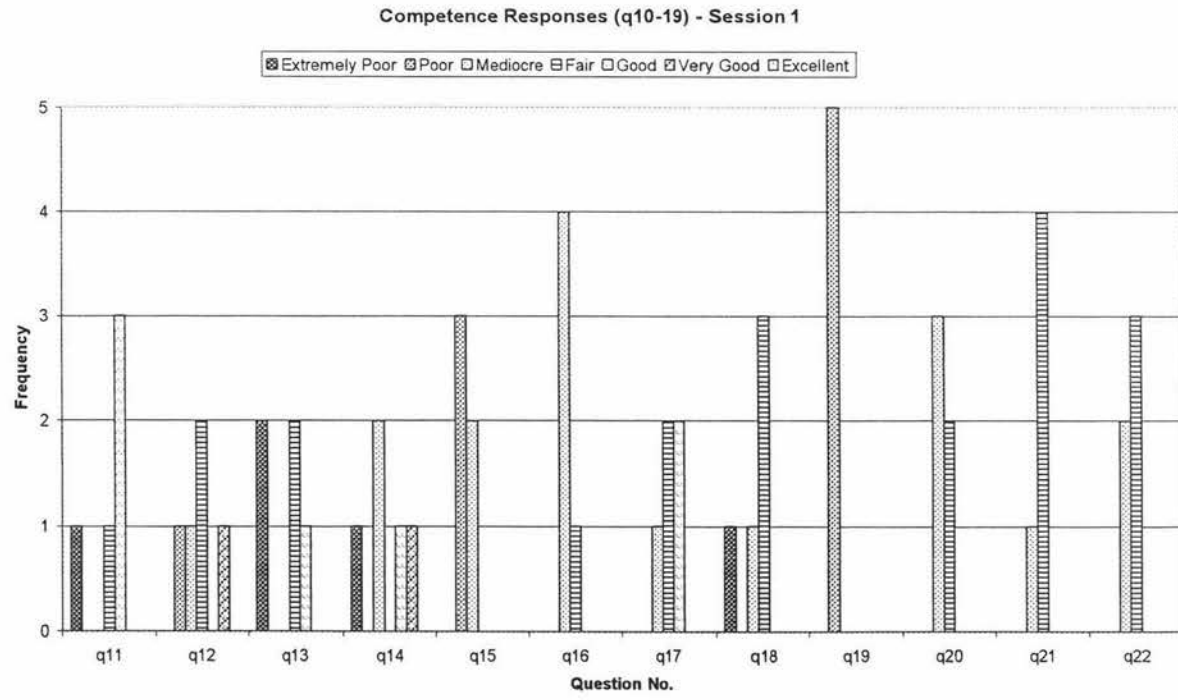


Figure 21. Competence responses (q11-q22) for pilot two, session one.

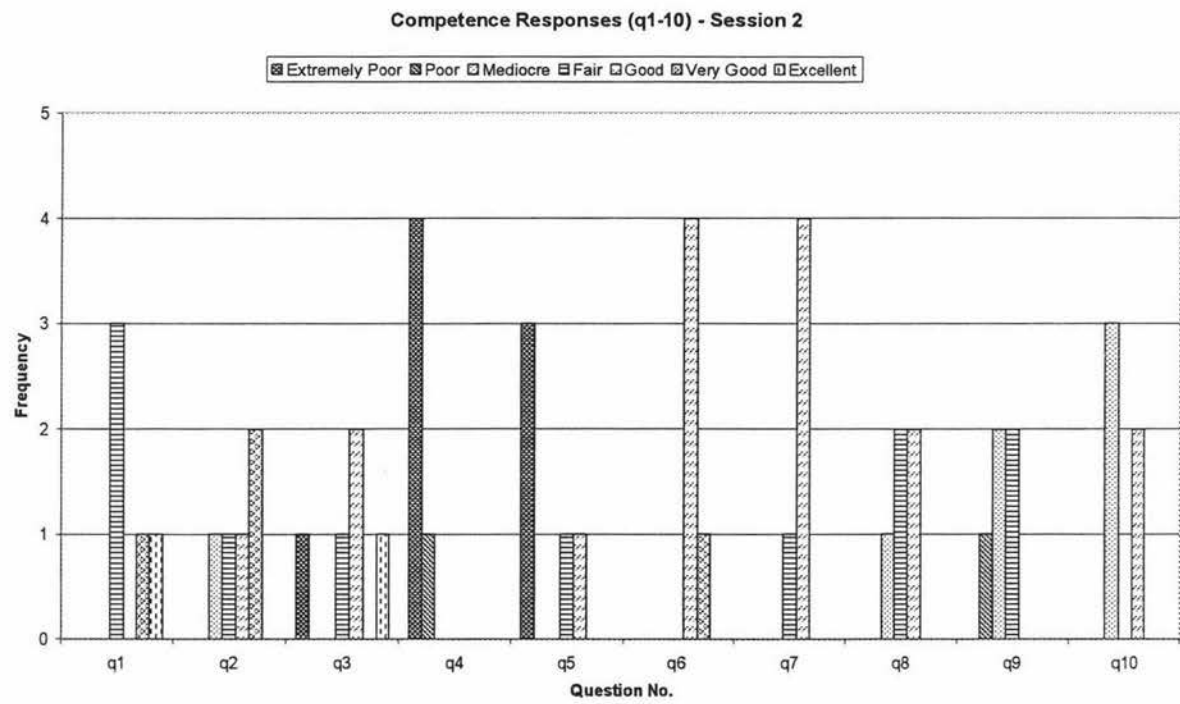


Figure 22. Competence responses (q1-q10) for pilot two, session two.

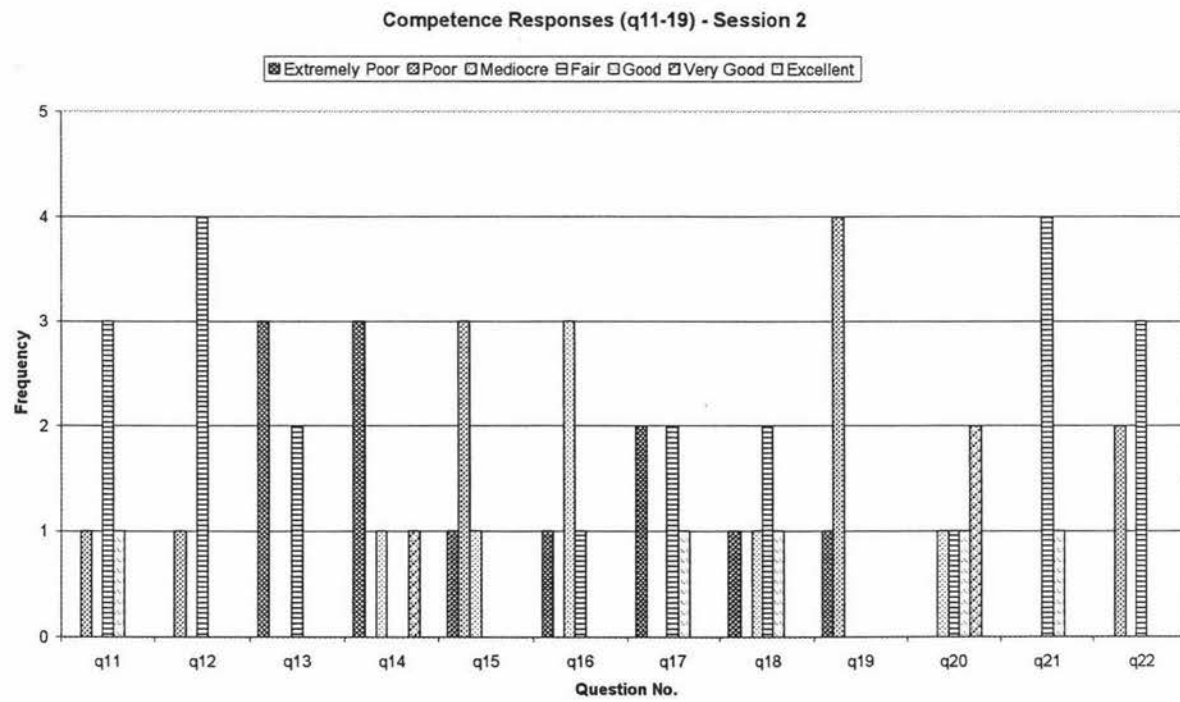


Figure 23. Competence responses (q11-q22) for pilot two, session two.

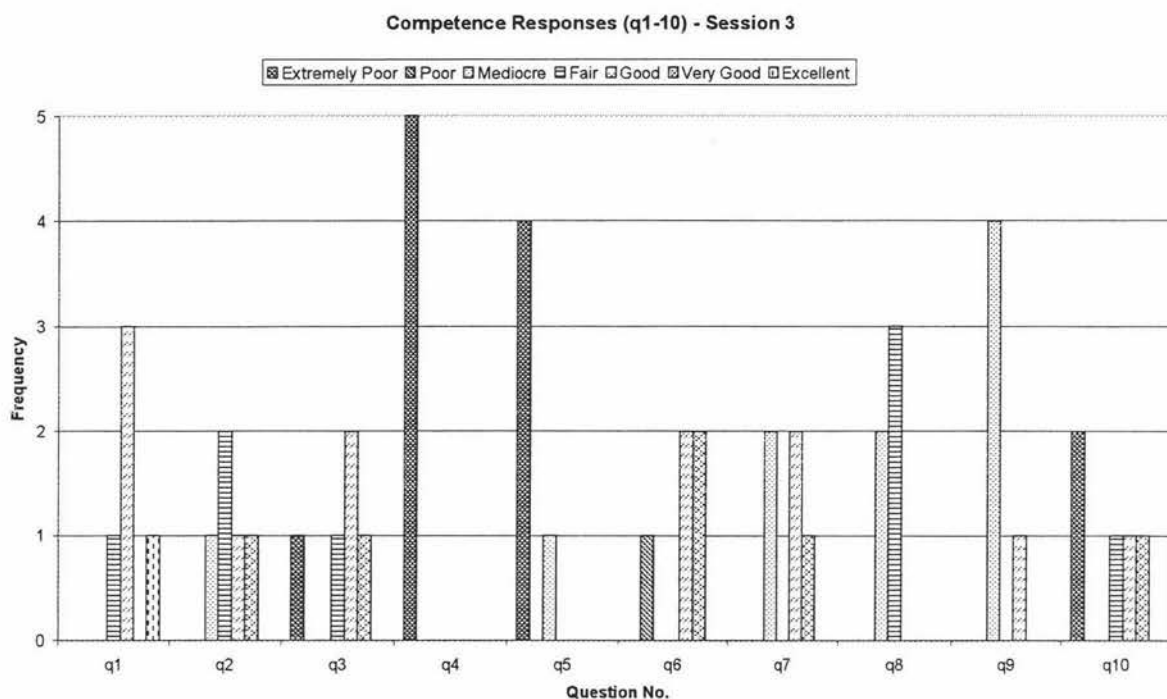


Figure 24. Competence responses (q1-q10) for pilot two, session three.

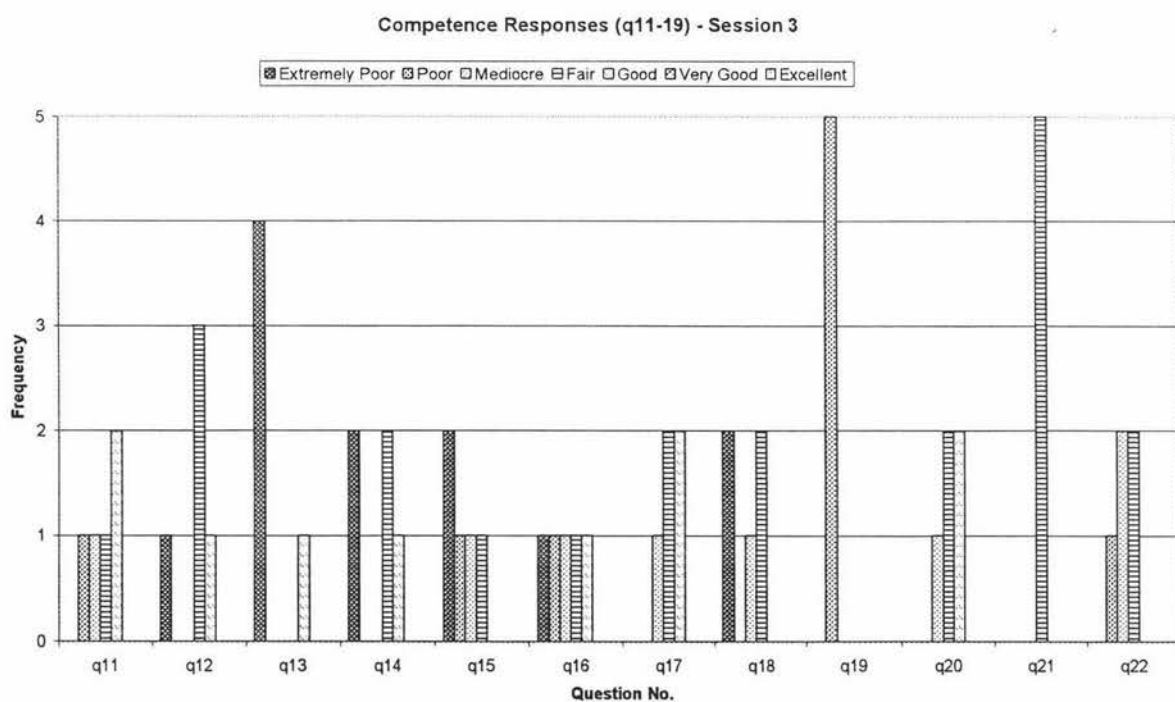


Figure 25. Competence responses (q10-q22) for pilot two, session three.

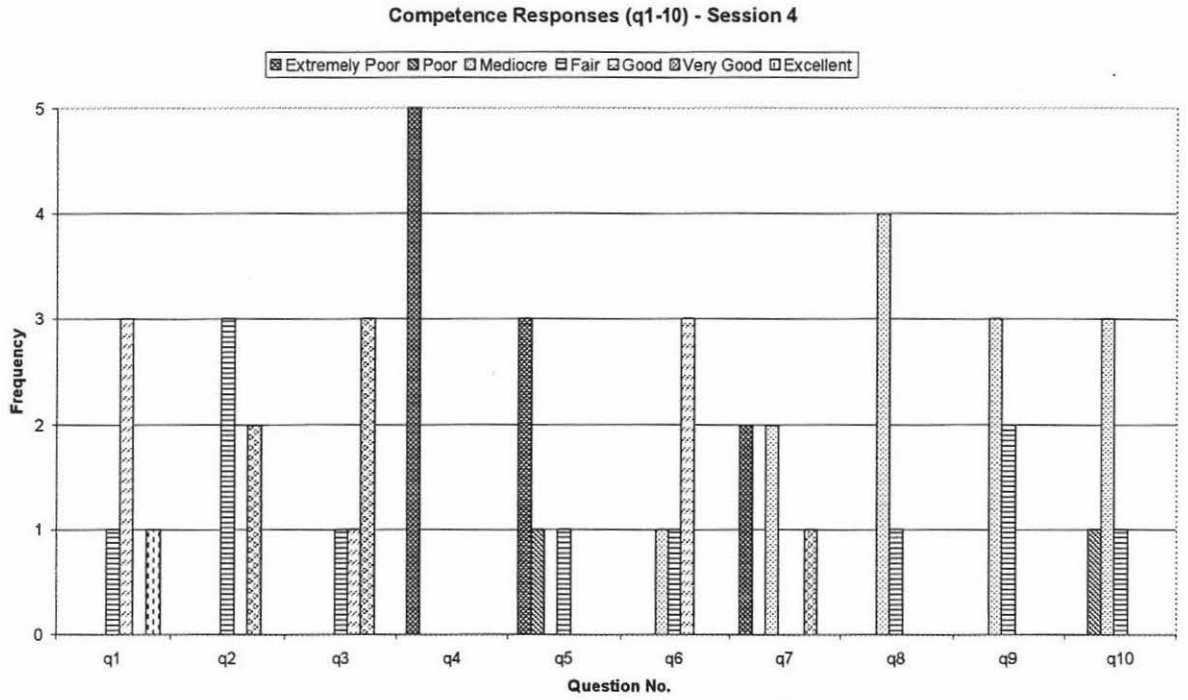


Figure 26. Competence responses (q1-q10) for pilot two, session four.

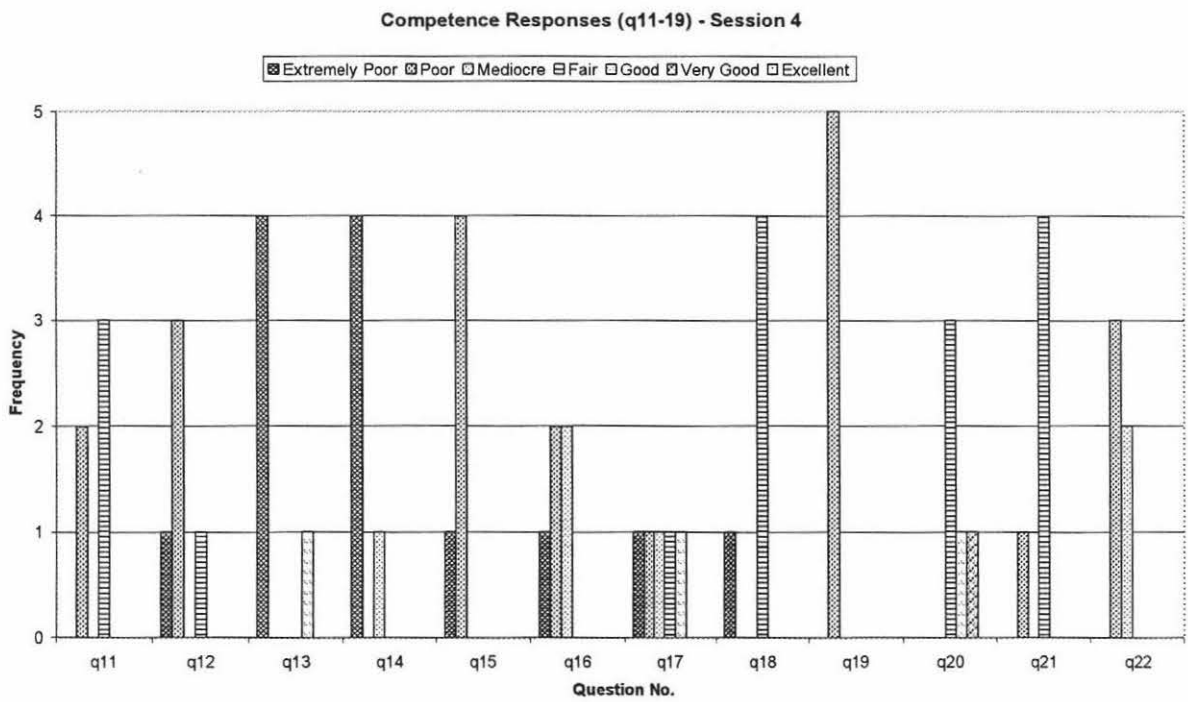


Figure 27. Competence responses (q11-q22) for pilot two, session four.