Assessing Quality in the Treatment of Obsessive-Compulsive Disorder: The Development of the Obsessive-Compulsive Disorder Cognitive Therapy Scale (OCD-CTS)

Elizabeth Forrester 2005

University of Surrey

A Portfolio of Study, Practice and Research

Submitted for the Doctorate of Psychology (PsychD) in Clinical Psychology Conversion Programme
Acknowledgments

I would like to thank all those who have contributed to the completion of my portfolio in many different ways.

I am particularly grateful to Professor Paul Salkovskis for his expertise and guidance as my Research Supervisor, and for leading me by the hand through the SPSS jungle.

The contributions of colleagues at the Centre for Anxiety Disorders and Trauma is also acknowledged, both for sharing ideas during the development of the Obsessive-Compulsive Disorder Cognitive Therapy Scale, and for agreeing to be 'scrutinised' in order to investigate its psychometric properties. I am indebted to Dr Victoria Bream who acted as an independent assessor in my research study, yet retained her enthusiasm for viewing videos of therapy sessions! Lesley Anderson has given so freely of her time to help me to edit and print the portfolio, and has created beautiful figures and graphs to accompany my work.

My thanks also go to academic staff (past and present) at The University of Surrey who have acted as Personal Tutor during the course of my studies, especially to Dr Lorraine Nanke who helped crystallise some of my ideas into a research project, but most of all to Dr Susan Thorpe for helping me to finally complete my portfolio.

The most important acknowledgements go to my partner, Brian, who has rejoiced with me when things have gone well, and been a shoulder to cry on and source of comfort when they have not….and for making enough cups of tea to fill a swimming pool in the last few days leading up to the deadline!

My darling son, Henry, has been so wonderful and patient, even when mummy was too busy to be a proper mummy.

And finally, I’d like to thank my parents for everything they’ve done to help me get this far. And even though my mum is no longer living, I know she is proud of my achievements.
Summary of Contents

This portfolio presents a combination of study, practice and research submitted for The Doctorate of Psychology (PsychD) in Clinical Psychology Conversion Programme.

The Professional Dossier includes an initial study plan outlining a plan of work for the duration of study. My Curriculum Vitae is elaborated by reflections on my professional development since first qualifying as a Clinical Psychologist and describes the milestones that have led the way. To demonstrate professional competence, a case study gives an account of applying a standard cognitive-behavioural treatment for obsessive-compulsive disorder in a new way.

The Academic Dossier is aimed to enhance my knowledge of a specialist area of clinical psychology. The first critical review of the literature about hoarding extends my current expertise and practice in obsessional problems, and paves the way to further developing the service in which I work. Whilst it was tempting to stay with my particular area of clinical interest, I recognised the value of taking a step back to review the literature in a different area. The choice of blood-injury-injection phobia was not as arbitrary as it may seem a clinician at the Centre for Anxiety Disorders and Trauma.

Finally, the Research Dossier brings to fruition the development of a new scale for measuring competence in the cognitive-behavioural treatment of obsessive-compulsive disorder, and describes an investigation of its psychometric properties. A copy of manual which accompanies the rating scale is included in the Appendix.

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University of Guildford

Psych D Clinical Psychology Conversion Course

Personal Study Plan

Name: Elizabeth Ann Forrester
Date of Registration: 23 April 1999
Registration Number: 3821269

1. Overall Aims and Objectives

Overall aim: To attain greater professional competence in order to enhance the contribution of clinical psychology to health care.

Overall objective: To translate the professional, clinical, and research skills that I have developed over the course of my career into a portfolio that will demonstrate a high level of competence in each of these areas.

2. Academic

2.1 Aims

i) To increase academic competence and knowledge in a specialist area of clinical psychology in order to enhance my contribution to the research and therapy offered by my research group.

ii) To use the wider knowledge acquired in order to guide further research interests
iii) To enhance my teaching engagements as a result of deepening my knowledge of a specialist topic

2.2 Objectives: To complete two critical academic reviews as follows:

1. Cognitive-behavioural approaches to the understanding and treatment of compulsive hoarding


2.3 Rationale: Working within a highly specialised anxiety research team, reviewing the literature on the above topics will significantly enhance and broaden my knowledge of related areas.

Hoarding is a problem occasionally encountered in the OCD referrals received at the Centre for Anxiety Disorders and Trauma. Sometimes this is symptomatic of the obsessional problem itself. However, it also seems to exist as a problem in its own right. Little attention has been paid to its understanding and treatment until recent times. The nature of the disorder means it cannot be adequately treated by the 'standard' treatment packages utilised which are based on the cognitive-behavioural and exposure and response prevention models, and the prognosis following treatment with such approaches is poor. The review will critically discuss current understanding and approaches to treatment of this disorder, and seeks to establish a cognitive-behavioural model that better explains its aetiology and
2.4 Plan

To carry out a literature search and read widely on these topics, with special reference to recent publications (ie. since 1994). Whenever possible, I aim to attend any relevant lectures or workshops on them. My proposed timescale is a maximum of three months for each academic component.

3. Professional

3.1 Aims

To demonstrate growth in professional experience and competence since qualification. To further enhance professional competence by critical reflection on practice.

3.2 Objectives

i) To compile a detailed CV which describes professional training and practice since qualification in 1991.

ii) To document continuing professional development for the period of
the PsychD conversion course.

iii) To describe current clinical and research duties. This will include a case study which demonstrates a standardised cognitive-behavioural approach to the treatment of obsessional ruminations, with a consideration of their effectiveness and difficulties they present.

3.3 Rationale

To provide an opportunity to reflect on clinical practice and assess the relationship between theory and treatment methods.

3.4 Plan

To describe a cognitive-behavioural intervention in a single-case format of a patient with obsessional ruminations. To identify and discuss advantages and drawbacks of treatment within a fixed research protocol. Demonstrate the link between theory and practice by reference to relevant literature.

4. Research

Title


Research Supervisor

Professor Paul M Salkovskis, Institute of Psychiatry, De Crespigny Park, London

4.1 Aims

To develop a scale for measuring therapist skill in Cognitive – Behavioural Therapy for Obsessive-Compulsive Disorder and evaluate its validity.
4.2 Background

Measures of competence in cognitive-behaviour therapy have been in existence from 1980, most notably those of Young and Beck (1980, 1988) and more recently by Blackburn, James, Milne, Baker, Standart, Garland, and Reichelt (2001). Whilst the Young and Beck measures were devised for assessing competency in the cognitive treatment of depression, it has been used as a disorder-wide measure of general cognitive-behaviour therapy (CBT) skill. Blackburn et al. have taken this shortcoming into account and have demonstrated reliability of their scale across a spectrum of psychological disorders. Whilst such measures may provide a useful means of assessing developing skills of therapists undergoing training in CBT, it may be argued that they are not sufficiently sensitive to the discrete skills and techniques which may be unique to the treatment of a particular disorder. In particular, it is argued by many researchers (eg. Startup, Jackson, and Pearce, 2002) that there is a need for measures of therapist skill and competence that is specific to individual disorders in order to further enhance the claims of several randomised control trials which offer evidence that CBT is the most effective treatment.

4.3 Design and methodology

4.3.1 The style and format of the OCD-CTS is based on the CTS-R (Blackburn et al., 2001). The content of the scale was arrived at by a series of discussions with a group of cognitive-behavioural therapists specialising in the treatment of OCD. Inter-rater reliability regarding the order of each anchor point was established.

4.3.2 Therapists were required to identify two sessions with each patient: one which they considered to be representative of CBT practice of the
highest level which adheres to the OCD treatment protocol, and one where they did not consider to have demonstrated such good quality CBT skills. A comparison group of good non-CBT treatment for OCD was selected from sessions of Exposure and Response Prevention conducted by the same therapist.

4.3.3 Sessions were rated by the researcher, with inter-rater reliability carried out by a second independent rater. Both raters were blind to the therapists’ subjective evaluation of the session.

4.4 Data collection plans

4.4.1 Therapists will be asked to identify sessions appropriate for the research project and supply videotapes for rating.

4.4.2 Ethical consent for the study is covered by Institute of Psychiatry Ethics Committee no. 296/01.

4.5 Help required in meeting aims and objectives

4.5.1 Co-operation of colleagues in providing videotapes of appropriate sessions.

4.5.2 Assistance with setting up an SPSS data base and interpreting results.
5. Portfolio outline

The portfolio will consist of the following components:

1. Personal study plan proposal
2. Academic reviews
3. Clinical dossier
4. Research dossier

Signed............................................................ Participant

Elizabeth Forrester

Signed............................................................ Course Director
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Reflections on my professional development

The remit for this part of my professional dossier gave much pause for thought. It begs the question, at which point could I truly say I had ‘qualified’. Certainly, completing my M.Sc in 1991 meant I had qualified to apply for posts as a Clinical Psychologist (and was legally entitled to use the title) but on reflection it was only the start of the long journey of ‘becoming’ the Clinical Psychologist I am today.

Early days

My first qualified post was in a Community Mental Health Team (CMHT) that was in the process of being set up. It seemed an exciting prospect for someone with the enthusiasm fired by my recent studies as the concept of the CMHT was still new and innovative, and there was the promise of being instrumental in the development of this service for the District Health Authority. The reality of this was quite different – at least in the early days of the post. On my first day, I was disappointed to find that there was no ‘team’. Whilst there was ample office accommodation for the ‘team’, there was no furniture. The reason for the lack of furniture appeared to be that the actual recruitment of a Clinical Psychologist seemed such an unlikely occurrence in a climate where the number of clinical posts far exceeded the number of qualified clinicians. However, seeing was believing and the Unit Manager was happy to provide both a chair and a desk now that the first member of the CMHT had taken up post!

Although a well-managed and moderately sized District Psychology Service, demand outstripped supply serving a socially deprived area that (at that time) held the dubious accolade of having the highest unemployment rate in the country. At the outset, the Adult Mental Health Service consisted of the Head of Adult Psychology and myself (with a couple of additional sessions supplied by the District Psychologist). The backlog of referral letters made a couple of very thick files. I recall looking through them and thinking, ‘this is it – I can’t take refuge in claiming trainee status any more’. But what excellent training that turned out to be. The breadth and depth of the nature of psychological difficulties I saw both challenged me and provided scope for me to practice and refine the therapeutic techniques I had developed during my training. It also gave me scope to experiment with different theoretical approaches and
methodologies. Although I didn’t always think so at the time, I was fortunate to have the guidance and support of a psychodynamic supervisor who encouraged me in my preferred theoretical orientation yet nurtured an openness to consider other views and approaches. It didn’t however, dampen my fervour for an empirically grounded approach and she supported my application to study for a post-graduate certificate in cognitive-behaviour therapy in Oxford.

**CBT in Oxford**
Commencing post-qualification training in January 1993 felt almost like a pilgrimage. In the preceding years I had avidly devoured anything to do with CBT, and now I was to be taught and supervised by many of those authors – Gillian Butler, David Clark, Melanie Fennell, and Paul Salkovskis, to name but a few. In the thick of a heavy clinical case load, it also provided the luxury of an entire day each week to be able to reflect on my current practice, and improve and refine it under the supervision of experienced and accomplished cognitive therapists. I learned so much in that year. Not just form a theoretical point of view, but also in terms of gaining a better understanding of my contribution to the clinical service, the way in which my personal style might affect the therapeutic relationship and the style and format of the kind of help I felt most comfortable in offering. And what I learned was not just from the ‘experts’, but also fellow ‘students’ who came from a range of mental health professions who offered a breadth of knowledge and experience to enhance the formal teaching. What we did have in common was a shared passion for CBT. On a personal level, a number of friendships developed whilst on the course which have continued to blossom in the intervening years. However, perhaps the most unexpected bonus from the course was that it opened up an avenue for my clinical skills that I had never anticipated. This will be described more fully below.

**Developing the CMHT**
Brimming with new ideas from my studies, I was keen to share my enthusiasm for CBT with colleagues in the Community Mental Health Team. My colleagues were mainly psychiatric nurses and social worker, although I had recently taken on line-management responsibility for a counsellor. Only recently qualified, the counsellor was keen to learn as much as possible. In particular, she often felt frustrated by the
completely non-directive approach that her training had espoused and was delighted to find that CBT could provide her with a number of verbal techniques to enhance her practice, and also that it was possible to take a more ‘practical’ approach by introducing behavioural experiments, or teaching skills such as relaxation. Looking back at my approach to therapy, I can see that despite the training I received in Oxford that a tendency to be didactic and prescriptive remained (given that I had spent three years as a Psychology Technician under the auspice of an extremely behavioural District Psychologist, this was hardly surprising!). I recall as an undergraduate, I interviewed Eugene Mullen, who was then a fairly recently qualified clinical psychologist, for one assignment. When asked which theoretical approach he favoured, he exclaimed that he still considered himself to be a ‘technician’ (Psychology Technician was the job title previously given to what we now call Psychology Assistant) because he was still applying ‘techniques’. Like Eugene, I also continued to apply ‘techniques’ for some time.

Some other colleagues in the CMHT also began to take a more active interest in CBT and how it might be used as an adjunct to the medical model that predominated. I provided some informal case supervision with a couple of psychiatric nurses who, like me, tended to work with Primary Care clients rather than those with psychosis and other enduring mental health problems. To supplement what I could offer, I also arranged a two-day workshop on CBT for anxiety disorders by Adrian Wells who was working as a research clinical psychologist in Oxford at the time, and had just returned from a year’s clinical work with Beck in Philadelphia.

My role in the CMHT was rapidly becoming established, and I was viewed as the lead therapist for the primary care services. The fashion then was to view primary care clients as ‘the worried well’, whose need for psychological services was not as great as those with ‘enduring mental health problems’. I was keen to fight for a comprehensive service on their behalf, and defended the criticism that they were an ‘easy’ group to treat. This view was quite misguided, and often the brief referral letters only presented the tip of the iceberg so what seemed on paper to be a ‘simple’ anxiety problem often masked deeper personality problems which needed to be addressed to have any lasting impact. Although during my clinical training I had read
about ‘personality disorders’, I soon had plenty of first hand experience of what it meant to work with clients who presented with the kinds of behaviours that are considered symptomatic of what are often referred to as Axis II problems. The anxiety of working for the first time with someone who self-harms and may at any time attempt suicide is hard to describe.

Thankfully I was able to maintain a balanced case load with a range of clients from the relatively straightforward to the complex. I also found respite through the vicarious ‘therapy’ I did through supervision with my counsellor colleague and also with trainee clinical psychologists on placement from the University of Birmingham.

Time passed quickly with the wealth of new experiences I enjoyed in my first qualified position. I was settled, and fairly confident that career progression could be achieved within the Psychology Department. As part of my professional development, I was attending training events and accumulating evidence for a portfolio in support of a National Vocational Qualification (NVQ) Level 4 in First Line Management as the District Psychologist hoped to groom me for a future role as Head of Adult Mental Health Services. However, this was to change almost overnight when I received a surprising telephone call from one of the 1993 cohort from the Oxford course. She worked in Oxford as a Research Clinical Psychologist, and having remembered a chance remark I had made, wondered if I might be interested in a research post that was newly available as a result of a Wellcome Research Programme Grant. After a brief conversation with Paul Salkovskis, who was looking for a trained cognitive therapist for a 3 year randomised control trial for the treatment of obsessive-compulsive disorder, I agreed to attend for an interview the following week and was offered the post on the spot.

**Moving to Oxford**

I was thrilled at the opportunity to work in a research department with such an excellent reputation, but had to keep my excitement under wraps at work until I was able to formally offer my resignation to the District Head – who was on holiday for a fortnight! She conceded that it was too good an offer to refuse, and felt it would be
futile to attempt to persuade me to stay. I commenced in my new post as Research Clinical Psychologist in September 1994.

This was the start of one of the most exciting and challenging episodes in my career. Although I had relatively little previous experience of working with obsessive-compulsive disorder (and even less success!), I was looking forward to developing the necessary skills to work with a psychological problem which had a reputation for its intractable nature and limited treatment success. Working exclusively with a particular client group meant there was ample scope to develop expertise.

The randomised control trial (RCT) compared two treatments for obsessional ruminations (i.e. participants met DSM-IV criteria for OCD but used predominantly covert neutralising strategies). Participants were randomly allocated to one of the treatments: CBT or applied relaxation. The waiting list control group also received one of the treatments at the end of the waiting period (which was matched to the 12 week duration of treatment).

In addition to direct clinical work, I was also heavily involved in planning the therapies and writing treatment manuals (e.g. Salkovskis, Forrester, & Richards, 1998). I also contributed to experimental work that was part of our research (e.g. Forrester, Salkovskis, & Wilson, 2002). The development of a number of OCD-relevant questionnaires was a significant achievement of the research group of which I was part, e.g. Responsibility Attitudes Scale and Responsibility Interpretations Questionnaire (Salkovskis, Wroe, Gledhill, Morrison, Forrester, Richards, Reynolds, & Thorpe, 2000), which have become widely used. As well as the work I was doing with adults, I was actively involved in a series of pilot studies applying our approach to the treatment of children with OCD (Williams, Salkovskis, Forrester, & Allsopp, 2002).

At the end of that grant, a further award from the Wellcome Trust enabled me to continue working with this client group with a new RCT. This time, we were comparing CBT for OCD with what had been considered to be the most effective treatment for OCD: exposure and response prevention (ERP). Whilst piloting for this
trial, a major upheaval in the University of Oxford Department of Psychiatry led to an unexpected change. The grant holder, Paul Salkovskis, had been offered a chair at the Institute of Psychiatry at King’s College, London, along with two other eminent Oxford colleagues, Anke Ehlers and David Clark. In addition, posts would be available to suitably qualified and experienced staff: I was strongly encouraged to apply.

Moving to London
It was with trepidation that I moved to London. Despite the familiarity of having several of my Oxford colleagues making the same move, and the relief of obtaining a permanent post (in contrast to the previous 5 years when I was reliant on a research grant to provide my salary), the prospect seemed daunting. As well as continuing with the RCT, with Professors Clark, Ehlers, and Salkovskis, the establishment of the Centre for Anxiety Disorders and Trauma was a priority. This was to be a centre of excellence for CBT and research.

Having relinquished my position as research clinical psychologist to become Consultant Clinical Psychologist at the Centre, further trial therapists were recruited to complete the RCT. I was heavily involved in their training, and introducing them to the protocols of the treatments and the way in which the trial was conducted. I also continued to see obsessive-compulsive patients who were receiving treatment as part of the trial, but also saw other patients referred to the Centre. I continue to specialise in the treatment of OCD, but many of the cases referred to us have multiple psychological problems. I try to maintain a smaller case load of other anxiety disorders, such as health anxiety, panic disorder, and specific phobias.

Developments in the treatment of OCD have continued at the Centre. An OCD ‘Special Care’ service caters for nationwide referrals. These patients have either been unable to find an appropriate OCD service locally, or (more typically) have exhausted local services yet continue to suffer from OCD. This can be extremely challenging – both professionally and emotionally – as our service is often ‘the end of the line’ for these people. However, many report significant improvements, and working with this client group provides many experiences to learn from and further develop effective
treatment. One of the most exciting developments pioneered by the Centre is an intensive treatment for OCD which offers a comparable number of therapist-contact hours to the regular treatment package as used in the RCT, but over a brief period (1-2 weeks). Funding has been secured to evaluate the effectiveness of this approach. In addition to the work I am directly involved in, the pilot work I did in Oxford led to my inclusion in the planning of a research trial of CBT for children and adolescents with OCD which is now underway as a joint venture between the Institute of Psychiatry and the University of Reading under the direction of Derek Bolton and Tim Williams.

As a result of my experience of working to treatment protocols, and of training other therapists in the OCD treatment 'package' we have developed, I have become increasingly interested in ways of monitoring treatment integrity through effective supervision and the use of structured evaluation.

**Dissemination: teaching and supervising**

A thread that is woven through my years of practice as a clinical psychologist is teaching and supervising. Sharing of skills and knowledge is integral to my profession, but especially one like clinical psychology, which is dynamic, and constantly changing. This seems to be particularly true of CBT as new empirical findings inform our practice. This is probably one of the reasons I was so drawn to this approach.

Teaching and supervision are viewed as an integral part of being a clinical psychologist. Indeed, initial training places an emphasis on developing these skills. The type and range of teaching and supervision has changed over time. In the early stages, I was called on to teach quite a broad range of topics which a clinical psychologist was considered to be equipped to speak upon. I often ran assertiveness courses for various health authority employees (both professional and non-professional groups), as well as teaching on clinically relevant topics. In recent years, I have focused on CBT for OCD, or anxiety disorders generally, speaking to groups of qualified mental health professionals at the Institute of Psychiatry, and on CBT training courses in Oxford, Manchester, and Glasgow. I have also been invited to speak to clinical trainees on Psych D courses at the University of Surrey for a number
of years, and to international psychology students as part of an Erasmus training event in Groningen, Netherlands in 1997.

Whilst working in Oxford, I regularly conducted undergraduate tutorials on Psychological Disorders. I found this a most refreshing experience, both because it gave me reason to read current thinking about disorders that I no longer saw in a clinical capacity, and the lively discussions that many of these tutees provided. It also allowed me a chance to instil in others the enthusiasm I have for my chosen profession — and if proof of that were needed, one of those undergraduates has recently joined the Centre in her first post as a qualified clinical psychologist!

Experience of supervision has also been very varied. I have been a supervisor of trainee clinical psychologists, non-psychologist therapists (such as counsellors and psychiatrists), and also a participant in peer supervision. My experience of personal supervision has been on both a one-to-one basis and also in groups. In earlier days, my supervision was mainly from a psychodynamically trained clinical psychologist. Although we discussed direct clinical issues, much attention was also given to interpersonal processes and my own feelings in the therapy setting. Since then, the supervision, which I have received, has paid little heed to this which is perhaps a deficiency. I do try to take a mental step back from my clinical work to consider the 'bigger picture': the broader social and interpersonal context of the therapeutic relationship can provide invaluable insights that can be used to facilitate therapeutic gains. Although time pressure often means there is not much time to do so, when supervising trainees I attempt to foster the importance of the therapist's experience of doing therapy. Currently, I have case supervision in a small group, which is disorder-specific — all therapists working with OCD in the Centre meet for supervision on a weekly basis. Despite being considered something of an authority on the treatment for OCD, I prefer to view the group as being akin to peer supervision where there is no 'expert' and everyone can make a contribution on an equal basis. I believe it is important to maintain a flexible and receptive mind and remain open to suggestions to incorporate into therapy, from both experienced and novice colleagues. Such openness is crucial if therapeutic processes are to evolve and improve, and in the spirit of CBT I believe in taking the stance our patients are urged to take: don't trust me, test me!
Thus a good therapist should try out suggestions so that if they subsequently eschew a strategy, there is sufficient empirical support to base that decision on.

Before coming to London, I participated in a monthly peer supervision group that was in addition to weekly individual supervision as part of the research trial. Peer supervision in this case provided time to reflect more broadly on my work. My supervision peers had all received training on the Oxford CBT course, but came from a variety of clinical settings that I felt encouraged me to draw upon a wider range of influences to inform my practice. Naturally, sometimes it seemed that I had little to contribute when the kinds of cases were outside my experience, but we would also openly discuss our feelings about supervision and its process. It was encouraging to hear that my colleagues felt similarly! It also helped me to understand that supervision is not just to do with an ‘expert’ issuing advice, but that good supervision is about facilitation – in a similar way that therapy should facilitate the client to work out new ways of looking at the world and approaching problems.

Whilst in Oxford, I was a supervisor on the Cognitive Therapy Diploma course. In addition to weekly case supervision with a range of anxiety disorders which supervisees were treating using their emerging CBT skills, the course required me to formally evaluate their performance in selected audio-taped sessions using Beck and Young’s Cognitive Therapy Scale at the beginning and end of each term. It was interesting to see the differing styles and approaches that could still be described as CBT, and to witness emerging proficiency in the approach. It also expanded my knowledge because my supervisees were professionals with a wealth of expertise in many different areas (and theoretical approaches).

These differing experiences have encouraged me to reflect on what I consider to be helpful in the supervision process, and I try to adopt a focused and collaborative approach to supervision. I consider this to be of particular importance when helping trainee clinical psychologists develop their therapeutic skills.
Opportunities for professional development

I have been most fortunate to have had the opportunity to engage in a wide range of professional development activities. Some of this has been in the form of pursuing formal qualifications (eg. Certificate in CBT, current Psych D), but much of it has been in the form of in-house seminars, workshops, and conferences.

Although the main focus of the workshops and presentations I choose to go to are OCD and OCD-related problems (such as hoarding, body-dysmorphic disorder, tic disorders, etc.) and other anxiety problems, I often choose some topics which have little obvious connection to my key areas of clinical activity as I believe they help to enliven my approach to learning. They can also often provide some interesting ideas that can be applied in a novel context.

Over the last three years, I have taken a more active interest in supervision issues and have attended a number of workshops by Joyce Scaife (University of Sheffield) and Mark Freeston and Peter Armstrong (Newcastle Cognitive and Behaviour Therapies Centre).

I have attended (and presented) at a number of international conferences, and am a member of an international working group for OCD which is convened by Gail Steketee (Boston University, USA) and Randy Frost (Smith College, Massachusetts). The international Obsessive Compulsive Cognitions Working Group (OCCWG) comprises psychologists, psychiatrists, and academics with a special interest in OCD and related disorders who are actively involved in research and treatment. As well as providing a forum for the exchange of ideas, the group is actively involved in research both as a whole group, and as sub-groups (see Publications).

The future

Although at the time of writing, completion of my Psych D portfolio in many ways seems like my ‘destination’, I know that it is in fact only a brief sojourn on a much longer journey. I do not have plans for any major changes, but growing interests have emerged from my Psych D studies that I hope to develop over the next few years and implement in my clinical work. The key element of this is to develop a treatment
package for hoarding that could be implemented at the Centre which currently does not accept people whose primary problem is hoarding. In parallel, I would also like to engage in further research. In particular, I am curious about the development of hoarding behaviours.

As a key component of my current job description is one of ‘quality control’ at the Centre, I hope to resume a more active role in this capacity. Since the OCD group has completed a randomised control trial during the course of my Psych D studies, the OCD-CTS that I devised for my research project could be put to good use by assessing treatment integrity on a random selection of videotaped therapy sessions of trial cases.
Case Study: a Brief Cognitive-Behavioural Intervention for Obsessional Ruminations

Introduction:
Obsessive-compulsive disorder is considered to be one of the more complex of the anxiety disorders and often resistant to therapy. Behaviour therapy (in the form of exposure and response prevention) has long been considered the treatment of choice, but has its limitations. Although effective to varying degrees with OCD where overt rituals (eg. Washing or checking) are the key problem, its success with obsessional ruminations is limited. Over recent years, cognitive theory has contributed to the clearer understanding of this frequently intractable disorder. In particular, it has proven effective in the treatment of obsessional ruminations (Salkovskis, Forrester & Richards, 1998), where covert neutralising strategies predominate.

A randomised treatment trial for obsessional ruminations in Oxford, funded by the Wellcome Trust and lead by Professor Paul Salkovskis, offered treatment in 15 sessions over a 12 week period, followed by up to 3 ‘booster’ sessions. Participants in the trial were randomly allocated to one of two treatment approaches: either cognitive-behaviour therapy or applied relaxation, or to a wait-list control group of 12 weeks following which they would receive one of the treatments. Outside the strict protocol of the research trial, some pilot work was carried out using the same cognitive-behavioural approach as the trial but as a brief, intensive intervention (over no more than 6 sessions plus up to 3 ‘booster’ sessions). The single case discussed below is an example of how a brief intervention for obsessional ruminations can be implemented. The intervention was not planned in advance as a single case, but the positive outcome of the intervention using a brief application of the cognitive model seemed an interesting case study. The systematic use of questionnaires as part of the treatment protocol meant that routine records provided adequate empirical support. Routine video recording of all therapy sessions also meant that case notes could be readily supplemented where further detail was required. Patients’ written consent was sought beforehand, in line with the requirements of Oxfordshire NHS Trust. The person was free to withdraw their consent at any time, without giving a reason.
Case outline and biographic data:
Gary was a 38 year old office supervisor, married with two children of primary school age. He was referred by his GP for treatment of his ‘severe perfectionistic tendencies’ that manifested themselves in a drive to complete all tasks he takes to perfection, and to repeatedly look for mistakes and imperfections. This applied to anything from work-related activities to decorating his home, having a haircut, or buying new clothes.

At initial assessment, it was quite clear that his constant preoccupation with even the most minor of flaws caused Gary considerable distress, caused disruption to his domestic life, and were a source of friction in the marital relationship. At this stage, Gary considered the impairment in his working environment to be manageable and continued to work. He took no medication.

Although physical checking constituted a significant part of his problem, the major neutralising strategies he employed were covert. His neutralising strategies are listed and described below:

Overt neutralising strategies:
- Repeated checking eg. Work tasks, DIY projects, hair, new clothing
- Extensive avoidance of situations, which may provoke OCD symptoms eg. moving to a brand new house in an attempt to decrease preoccupation with perfection of any household repairs and decoration

Covert neutralising strategies:
- Mental ritual eg. repeating a phrase in his head in response to intrusive thoughts and urges (“If it’s good enough for Cherie, it’s good enough for me”)
- Mental arguing, worrying and attempts to problem solve
- Attempts to suppress thoughts and urges
- Deliberate engagement in other activities as an attempt to distract himself
- Seeking reassurance about levels of perfection eg. from his wife, or hairdresser
- Transferring responsibility eg. asking hairdresser to check the regularity of his haircut
On occasions, Gary would try to resist responding to his obsessions in the ways described, but this would result in feelings of extreme anxiety.

There appear to be no clear time of onset of Gary's OCD concerns, but from his account he had always had obsessional tendencies. He recalls as a young teenager being preoccupied with his hair, and also how (at age 17) he sold his brand new motorbike after just 3 weeks when he discovered a paint chip on the fuel tank. There appear to have been other emotional difficulties around this time that he summarised as a fear of large groups of people and enclosed spaces, the nadir of this period culminating in an attempted overdose. To my knowledge, he received no counselling at this time.

The referral was precipitated by increased severity of the symptoms over the preceding 12 month period, and Gary had on occasions felt so low and tearful that he had taken to his bed. At the time of my initial screening, I felt he was coping moderately well although he clearly fulfilled a diagnosis of OCD. Ordinarily, Gary would have been offered treatment as part of our research trial but as he had initially been referred from outside the catchment area for Oxfordshire NHS Trust, and was imminently moving more than 100 miles away, it would have been impractical for him to attend on the regular basis required by trial protocol (twice weekly initially, followed by weekly appointments over a 12 week period). Instead, Gary was offered up to 6 sessions of brief, intensive therapy commencing after a 4 month wait (few treatment slots for non-trial patients were available). In the interim period, Gary's condition worsened significantly and he had been signed off work for some weeks prior to the start of treatment. He was prescribed Citalopram (20 mg) by his GP.

**Diagnostic criteria:**

Assessment was completed using a structured clinical interview. At the time of referral and the start of treatment, Gary met DSM-IV criteria for obsessive-compulsive disorder. Although in general the intrusive thoughts with which he was troubled were ego-dystonic, there seemed to be concurrent personality factors, which may have accounted for his perfectionism (although insufficient to meet full criteria for obsessive-compulsive personality). At the start of treatment, he also met criteria
for a major depressive episode, although when initially screened his mood was fairly elevated and stable. Further screening questions for the presence of other psychological disorders suggested the possibility of social phobia and agoraphobia, although at a sub-clinical level. It is difficult to ascertain whether these would exist as difficulties in their own right, or whether they were sequelae of the main OCD problem.

**Rating Scales and Standardised Measures:**
In addition to the structured clinical interview, Gary completed a range of standardised self-assessment measures at various points before, during, and after treatment. These were as follows:

- Beck Anxiety Inventory (BAI) (Beck, Epstein, Brown, & Steer, 1988)
- Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961)
- Obsessive-Compulsive Inventory (OCI) (Foa, Kozak, Salkovskis, Coles & Amir, 1998)
- Responsibility Attitudes Scale (RAS) (Salkovskis, Wroe, Gledhill, Morrison, Forrester, Richards, Reynolds, & Thorpe, 2000)
- Responsibility Interpretations Questionnaire (RIQ) (Salkovskis, Wroe, Gledhill, Morrison, Forrester, Richards, Reynolds, & Thorpe, 2000)

**A Summary of the Cognitive Approach to OCD:**
The basic tenet of cognitive-behavioural therapy (CBT) is that the way we think affects how we feel ie. it is not the situation *per se* that causes us to feel depressed, anxious, etc., but the way in which we *appraise* the event. Examination of clinical and research data suggests that cognitive-behavioural theory may provide the best supported and most comprehensive current account of obsessional problems (Salkovskis, Forrester, Richards, & Morrison, 1998). According to this theory, obsessional problems arise from the particular meanings that obsessional patients attach to the occurrence of intrusive thoughts, urges, or impulses. More specifically, those with a tendency to develop OCD do so because they interpret the occurrence of
such thoughts, urges, or impulses as a sign that they are responsible for any harm which they perceive may occur were they to simply ignore what they consider as 'signs'. Such responsibility appraisals thus generate the drive for obsessionals to attempt to 'neutralise' intrusions, and seek to prevent the harm they fear by carrying out rituals. The concept of responsibility in the context of the cognitive theory of OCD has a specific definition:

... 'The belief that one has power which is pivotal to bring about or prevent subjectively crucial negative outcomes. These outcomes are perceived as essential to prevent. They may be actual, that is, having consequences in the real world, and/or at a moral level'.

(Salkovskis, Rachman, Ladouceur, Freeston, Taylor, Kyrios, & Sica, 1996)

As a result of making such responsibility appraisals, it is asserted that, as in the cognitive theory of other anxiety disorders, particular innocuous situations become the focus of concern as they are imbued with these ideas of danger or threat. The emotional, behavioural, and attentional consequences are tempered by these appraisals.

A particular strength of the cognitive theory of OCD is that it provides a comprehensive model to explain the maintenance of the disorder. This is a key feature of therapy in general, but perhaps even more so in the treatment of OCD as the chronicity one often encounters amongst OCD sufferers, and the tendency of the focus of their obsessional concerns to change over time (from checking, to fears about contamination, to rumination over unwanted thoughts about causing harm) tends to increase the complexity of the problems, and frequently make it more difficult to make sense of them.
Overview of Treatment:
The cognitive-behavioural treatment of OCD consists of a number of stages to facilitate the main aim of therapy which is to allow the obsessional patient to identify their present beliefs about the problem (a key example in Gary's case being, 'Unless I ensure things are perfect, I have failed and let everyone down') and to help them to consider a less threatening alternative (e.g. I am worried about the possibility of doing things badly and that others might think badly of me and so I try to cope using counter-productive strategies). The 'alternative model' is an important aspect of the approach as disconfirmation of the 'threat' belief is often difficult (take as an example the fear that 'I may burn in hell for all eternity unless I cancel out blasphemous thoughts by repeatedly getting up from the chair' which does not lend itself readily to a behavioural experiment!).

The stages of therapy described below are not necessary sequential, although some components of therapy occur naturally at a particular point. For example, conceptualisation (also known as formulation) would occur at the commencement of treatment when a shared understanding and collaborative construction of a non-threatening alternative account of the person's obsessional experience and preoccupations is agreed upon. This includes a preliminary identification of underlying beliefs that can be elaborated on as therapy progresses.

A major goal of therapy is to help the person understand that the intrusive thoughts they are experiencing are not an abnormal phenomenon, but have been reported by at least 90% of non-clinical populations (e.g. Rachman & De Silva, 1987: Salkovskis & Harrison, 1984). Normalising the occurrence of particular intrusive thoughts would include helping the person to understand that it is not the occurrence of the thoughts per se that is the problem, but the meaning attached to the occurrence of those thoughts.

Discussion techniques for challenging appraisals and the basic assumptions upon which appraisals are based are a core component of therapy. However, discussion techniques are not used in isolation: CBT is not intended to be 'persuasion therapy'. The therapist adopts the stance, 'Don't trust me, but test me'. Thus, behavioural
experiments are integrated into the cognitive therapy framework. Because a detailed alternative explanation has been built up, testable ideas that can act to strengthen the alternative view and weaken the other are readily identifiable. For example, the effect of neutralising can be tested to see whether this reduces or prolongs preoccupation.

Behavioural experiments fulfil a variety of functions: identifying further beliefs where ritualising is rife, to illustrate the counter-productive nature of such safety-seeking strategies, testing out new beliefs.

As with cognitive-behavioural therapy generally, the overall style is based on guided discovery. The style is not prescriptive, and may appear less systematic than CBT for other anxiety disorders such as panic as the presentation of OCD tends to be more idiosyncratic and thus a more flexible application of the relevant techniques is required, although these are integrated into a clearly defined theoretical overview of the disorder.

**Session 1: Duration 2 hours**

The first session concentrated on conceptualisation. Using a recent experience, Gary and I worked together to identify: (i) factors that seemed to keep the problem going, and (ii) underlying elevated responsibility appraisals. We then charted a feedback model that seemed to provide an acceptable explanation of what was happening in Gary’s case (see Fig. 1). It shows some possible origins for the development of heightened responsibility appraisal through early experiences and pre-existing assumptions and more general beliefs. However, the key focus for the therapeutic intervention is on the way in which behaviours (such as neutralising actions), attentional bias, and mood create a cycle, which maintains the meaning, attached to the occurrence of the intrusive thoughts, urges and doubts.

It was also important to explore the perceived cost of accepting something that was less than perfect, or that he had not done to the best of his ability. Although the reasons may seem obvious, it is important to be mindful that as a therapist, we should not make assumptions about what the reasons may be. They are often idiosyncratic,
and on occasions can prove surprising (as occurred in a later session). A 'double-bind' was identified when Gary was questioned about a further example of an occasion when he had been much troubled by obsessional worries after purchasing some new trainers on which he noticed a minor flaw (a small lump of glue between the sole and upper) which led him to feel most anxious. When asked what, to him, would be the problem about keeping the trainers, Gary said, 'I'd be accepting something that isn't perfect or good enough'. Using the 'downward arrow' method, he was asked, 'What would be so bad about that?' to which he responded, 'I've failed (because I haven't complained)'. Thus it becomes clear that Gary is operating under a particular rule that leads him into numerous difficulties: Unless I complain about minor things, I've failed. The reverse side of this rule also leads him to be fastidious in his scrutiny of things: I've failed unless I find something wrong with things.

He was in tears during the session, declaring that he had let everyone down, including himself, because of his OCD and that he only 'kept going' for the sake of his wife and children. The urge to cut and scar himself as a punishment for his perceived failure was strong.

A further key belief identified was: 'If it's not worth doing properly (ie. perfectly) it's not worth doing at all'. This was added to the conceptualisation, as it helped to further explain Gary's difficulties. We did not directly address this particular belief during this session, but it would inform interventions in later sessions

**Medication:** Citalopram 20 mg

**Homework:** Gary was asked to listen to the audiotape of the session, and make notes of the key points. He was also requested to draw his own copy of the conceptualisation, to ascertain his understanding of the model.
Figure 1: Formulation

Early experiences:
• Obsessional tendencies as a child
• In teens, obsessed with his hair

Critical incidents:
(What started OCD off)
• Responsibilities at work
• Moving to a brand new home

Assumptions, general beliefs:
• If it’s not worth doing properly, it’s not worth doing at all
• If I accept something that isn’t perfect, I’ve failed
• I’m not mentally strong

Intrusive thoughts, urges, doubts:
• This isn’t perfect
• (Urge to check)
• I’m not mentally strong

Neutralising actions:
• Rituals e.g. “If it’s good enough for C, it’s good enough for G
• Mental arguing
• Checking e.g. haircut, house
• Reassurance
• Transfer responsibility

Attentional bias:
• Looking for trouble

Meaning attached to intrusions
(misinterpretation of the significance of intrusions)
• If I accept something that isn’t perfect, I’ve failed & let everyone down
• This is a sign I’m not mentally strong
• If I get really anxious / upset / down, I won’t be able to get out of this state ever
• I’m in danger of losing my mind

Counterproductive:
• Impossible criteria (flawless, perfect)
• Thought suppression
• Avoidance e.g. new house

Mood change:
• Anxiety
• Depression + +
• [Anger]?
Session 2: Duration 2 hours

Gary’s wife had telephoned to cancel the appointment arranged for the previous day. He had been feeling quite anxious about attending, but also quite excited. Possibly the combination of the two emotions can be explained by this perfectionist tendencies and worries that although therapy may help him overcome his OCD, he may not be able to ‘do it’ to the best of his abilities (activating failure beliefs which make him anxious and depressed).

He made an interesting observation in that pre-morbidly he would have become cross about things, but these days he just gets anxious. He finds anxiety puzzling and worrying: ‘I can’t concentrate – this is new to me because I’m used to being able to juggle a hundred different things’. He describes how he used to be able to get out of a particular mood quickly ‘by positive thinking and believing I’m strong enough’. He makes some clear appraisals which help explain both some of his obsessional preoccupations and also the accompanying depression as the meaning he attaches to his current emotional state as ‘this is a sign that I’m not mentally strong’ which he rated as 50% belief in the session, but 0% (ie. he did not believe it at all) the previous day when feeling very anxious and low. In retrospect it would have been more sensible to rate the actual belief, as that was one of the meanings (ie. negative misinterpretations) Gary attached to the occurrence of intrusions. As discussed previously, it is important to challenge such misinterpretations as they are at the hub of the maintenance cycle.

Homework: In addition to listening to the audiotape of the session, Gary was also asked to read two chapters from “Feeling Good” (Burn, 1980) (Ch. 5 – How to change the way you feel; Ch. 6 – Ten ways to untwist your thinking). These chapters provided additional reading to support the work done during the session, which links thoughts and feelings. In particular, it emphasises the way in which people can develop thinking ‘biases’ which leads that they can have a tendency to persistently (mis)interpret situations in the same way. This is one of the key messages for the initial stages of treatment.
Sessions 3: Duration 1 hour

Gary had put off reading ‘Feeling Good’ and listening to the audiotape of the previous session ‘until I had a big window of time’. We discussed this in the context of the formulation we had (eg. ideas about doing things to the best of his ability, etc.) and how this compounds the problem and makes it difficult for him to start tasks. However, despite not having listened to the session, he summarised some key learning points in a useful way:

1) How the formulation described the OCD cycle and made links between thoughts, mood, and behaviour.

2) Recognising that the way in which he had been dealing with intrusive thoughts had been self-defeating and that it is more effective to allow thoughts to wash over him. Interestingly, he felt that the formulation gave him ‘permission’ to do so. This reflects the findings of some studies of responsibility and OCD (eg. Salkovskis, Shafran, Rachman, & Freeston, 1999), as it appeared that responsibility had been transferred to the therapist who had implicitly given permission not to act when intrusions occurred.

3) That he needed to change his impossible criteria and learn to accept things that are less than perfect.

Gary gave an example of how he had applied some of the alternative strategies we had covered the previous week and challenged his drive for perfection. Having put off a visit to the barber’s for some time (to avoid activating obsessional worries), he finally went to have it cut. Despite strong urges to check the cut as he normally would, he resisted. However, he eventually gave in to the compulsion and decided to return to the barber for a further cut as he felt it did not meet his criteria for a perfect haircut. He described how he suddenly recalled an ‘all or nothing’ thinking error which we had identified as pervasive in Gary. He considered this for a moment, and decided that if he viewed the quality of his hair cut on a continuum from 0 to 100 (where 100 represents an immaculate cut which could not be bettered), this one would rate at about 90 and thus is ‘okay’. Having made this reappraisal, Gary was delighted that he returned home without having it cut.
Whilst challenging ideas about perfection is encouraged, the therapist must be mindful that these therapeutic strategies may be adopted as a further neutralising strategy by the obsessional patient. For example, instead of restricting it to a one-off or occasional means of reaching a more balanced view, the obsessional person is at risk of adopting it as a routine neutralising strategy. On this occasion, I was satisfied that Gary had used the strategy appropriately to successfully bring about new learning.

*Homework:* To build on his success following his haircut, we negotiated a homework task to further challenge his underlying beliefs that the absence of perfection would have catastrophic consequence. Between sessions, Gary was to deliberately leave a few whiskers when he shaves.

**Session 4: Duration 1 hour 45 mins**

Reviewing last session’s homework, Gary reported that he had had some fun with the shaving experiment. On the whole, he was feeling better and considered that he had ‘got his head around the OCD’. He noted that although he initially experienced considerable anxiety upon first completing his shave and was very mindful of ‘imperfections’, no-one else appeared to notice and he eventually even forgot about it himself.

Although there had been no extreme incidents since our last meeting, and having successfully allowed intrusive thoughts to wash over him, the prospect of a busy weekend planned with his family activates a bout of anxiety and depression. Feeling that he couldn’t cope with the looming demands, Gary cancelled all plans for the weekend (to the disappointment of his wife and children) and withdrew to bed. Whilst explaining this to me, Gary became extremely tearful. Careful questioning identified that he believed that he was a bad parent because of his OCD. A ‘pie chart’ was used to explore this further and challenge his belief (see Fig. 2).
Figure 2: What makes a good parent?

- Don’t take out other upsets on the kids
- Spend time with kids
- Do “quality” / worthwhile things together
- Set a good example
- Provide rules and guidelines
- Love
- Treat children with respect
- Allow their personality to develop
- Do nice things for them
- Provide a stable home
- Provide financial support
The process began by turning the statement around to ‘what makes a good parent?’. Commencing with the notion that he was a ‘bad’ parent because he had ‘taken out his upsets’ on his children, this also was reversed (ie. a good parent doesn’t take out upsets on the children). Gary was then encouraged make further suggestions of the qualities that make up a ‘good parent’ (the therapist often needs to assist in the process, although the key ideas should be provided by the patient). The next step is to apportion the ‘pie’ with each of the qualities identified, taking heed to begin with the last item on the list in order to avoid the biased view which might assign ‘not taking out upsets’ to the bulk of the ‘pie’. The aim is not to prove that the initial appraisal is wrong, but to demonstrate that it is not the only criterion for being a good parent and to engender a more balanced view.

An unexpected disclosure emerged from the pie-chart exercise when Gary confessed how difficult he found playing with his children. The reason for this was his fear of his hair becoming messed up by rough-and-tumble games. It was important to examine this further, as his concerns about ruffled hair clearly pervaded other aspects of day-to-day functioning. To this end, a two-way costs/benefits analysis was done. Many therapists use a basic ‘pros and cons’ (one-way analysis), but much can be gained by switching the question around. We looked at the advantages and disadvantages of ruffling his hair, and then at the corollary, ie. the advantages and disadvantages of not ruffling his hair (see Fig. 3).

Figure 3: Two way costs-benefits analysis

<table>
<thead>
<tr>
<th>Advantages of ruffling hair</th>
<th>Disadvantages of ruffling hair</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care less about it</td>
<td>• Feel unattractive / decrease confidence</td>
</tr>
<tr>
<td>• Challenge OCD</td>
<td>• People won’t want to bother with me</td>
</tr>
<tr>
<td>• Reduce worries about hair</td>
<td>• I’d be a less interesting person</td>
</tr>
<tr>
<td></td>
<td>• Increase my anxiety</td>
</tr>
<tr>
<td></td>
<td>• Less likely to want to do things</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advantages of NOT ruffling hair</th>
<th>Disadvantages of NOT ruffling hair</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Stay confident</td>
<td>• Tense and uptight about hair getting messed up</td>
</tr>
<tr>
<td>• Look as nice as I can</td>
<td>• Can’t scratch my head</td>
</tr>
<tr>
<td>• People will find me more interesting</td>
<td>• Can’t do what I want (e.g. try clothes on in shops)</td>
</tr>
<tr>
<td></td>
<td>• Maintains worries about hair</td>
</tr>
<tr>
<td></td>
<td>• Feeds OCD</td>
</tr>
<tr>
<td></td>
<td>• Time consuming</td>
</tr>
<tr>
<td></td>
<td>• Reduces my spontaneity</td>
</tr>
</tbody>
</table>

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This strategy is used in part as a Socratic means of facilitating the patient to devise an appropriate behavioural experiment. The high point of the session was when Gary identified that the way forward for him was to ruffle his hair. The following transcript from the session demonstrates the procedure.

P: The intrusive thoughts I’ve been getting have been decreasing...until yesterday, when I had my haircut.

T: What happened yesterday?

P: Well, I went and had my hair cut and...I came out, and no, I didn’t check it...then I got home and just let my thoughts...well, I didn’t just let them wash over me as I’d done until I got home...then I got the mirror and started checking at the back...and I went to my wife and said, ‘I think this bit’s longer’, and she said, ‘No, no, I’m not reassuring you’...

T: Good!

P: ...then I went and checked again, and said ‘No!’, so I went for a walk – and it [the urge to check] stopped...mmm...then I washed my hair ‘cos it had just been cut and I was going out in the evening...and I checked a little bit, but not quite as much, and then this morning as well, but not so much...So it has been decreasing, but I feel...and I know that we’ve been through it...that you just feel ...even though you know it’s the same at the back...but I’ve got this bizarre feeling like I’ve got this big lump of hair here (shows with his hands) that sticks right out like this and I know it isn’t! This is generally each time I have my hair cut...it always causes me the most distress ...and I know I shouldn’t look because eventually I’ll find something wrong with it... So that is something I have to work on.

But if there’s one exercise you might want me to do that I’d categorically say ‘no’ to, it would be something to do with my hair. Like, if I was going out for the evening, and I’d do it like it is now and then ruffle it up...well, I just couldn’t do it...aagh (he groans)...once it’s grown and it’s no longer just cut, well, I’d be a lot better with it because I can comb it the wrong way and put my T-shirt on over the top...

T: Have you combed it the ‘wrong’ way today? (an exercise we’d previously done)

P: No...’cos I just couldn’t do it (now holding his hands to his face and looking anxious)

T: ...Hmmm...What do you think would be the most useful thing for you to do right now?...
P: *(sighs and puts hands to face)*...ha, ha...ruffle my hair... but I, er...*(sighs and shuffles in seat)*

T: What would be so bad about ruffling?

P: It wouldn’t be perfect anymore and I... would lose confidence...I’d feel I was ugly...erm...that’s always been the worst thing. When it’s first cut, I won’t even let my kids put their arms around me ‘cos I don’t want them touching it... or put my head on the back of the chair... I know it’s wrong.

T: It’s interesting that all these thoughts you’re having that people will think you’re ugly, that you would lose confidence and you wouldn’t be able to live with it... you had those kind of thoughts about *shaving*...

P: ...but not quite as bad.

T: ...but you still had those thoughts. And what *did* you find with shaving?

P: *(he shakes his head and objects)* It wouldn’t be the same with my hair...I...*(sighs)*

T: How could we find out? *(Patient laughs)*...it sounds like you’re making a prediction?

P: ...I...I...I...I’ll have to try and do it, won’t I?

T: What have you got to lose by ruffling it up?

P: ...What have I got to lose?...hhhh...*(rubs face and chuckles)*... like I said, I feel like I wouldn’t be so confident...and...er...

T: Why don’t we look at the pros and cons of ruffling it up *(2-way costs-benefit analysis is drawn up on white board)* (See Fig. 3)

Whilst doing this exercise, he recalled an earlier memory from the age of 12-13 years. He explains that he was always fiddling with his hair, making sure it was okay. His mum was always telling him, “Leave your hair alone!” In the midst of recounting this, he suddenly asked anxiously:

P: ...You’re not going to ask me to cut a chunk out of it, are you?...

T: I’m not going to ask you to do anything!
P: Oh!...Okay! (Looking relieved)...‘cos I probably would, actually...‘cos it’s the worst thing. Looking at the chart (referring to the Cost-benefits analysis we are working on), I’ve been getting a lot better and this brings it all back again...I...I...I wanted to go back to the hairdressers this afternoon and have the back shaved shorter again, but I’m not going to.

(We continue with the analysis on the board)

T: Let’s turn it round the other way, and look at the advantages and disadvantages of not ruffling hair.

P: ...I’ll stay confident...I’ll be looking as nice as I can possibly look...Whilst that’s vanity, I don’t consider myself good looking in any shape or form and I could never understand what anybody sees in me...em...so it isn’t a vanity thing, it’s a CONFIDENCE thing... people will find me a little bit more interesting...That’s it. Those are the 3 main things. (He pauses for a while, thinking) If I were to get up and put old clothes on...I could just ruffle my hair and take the kids to school and it wouldn’t bother me, but once I start that...that...‘grooming process’, you might call that...like, I brush my teeth, have a shave, wash my hair...it’s got to be perfect otherwise I just can’t....(he doesn’t complete the sentence and there is a silent pause)

T: Gary, from looking at the advantages and disadvantages, what do you think would make most sense to do now?

P: What, this minute?

T: Mm Hmm...

P: (laughs) ...err...err...(laughs again)...I only had it cut yesterday! (Laughter changes to agitation) To...scratch it!

T: ...Mm Hmm (and therapist messes her won hair up. Patient laughs). I’m prepared to leave my hair like this for the rest of the day.

P: ...Oh...grief!...I want to, I really want to...but the day after I’ve had it cut!...

T: That sounds like it could be the best time to do it?...what if for all these years you’ve been catastrophising about the confidence bit, worrying about people finding you less interesting, or not wanting to bother with you?

P: ...Yeah...I’d be a lot more relaxed, I’d have more time on my hands...I’d feel a lot more confident because if I had a sweater on and it was too hot, at least I could take it off without worrying about ruffling my hair...(he wipes his hands on his jeans)...I’m sweating...(looks very anxious and then ruffles his hair). Okay!...now, I...I...I...

T: How do you feel right now?
P: ...I ...silly! I...er...at a party, everyone was putting silly hats on and I really wanted to put on a silly hat but I didn’t want my hair to move, and I didn’t enjoy it as much...err...I just spent so long doing it this morning.

T: (Smiling) If you’re seeking reassurance, I’m not going to give it!

P: No, I’m not!...It doesn’t actually feel that bad now (he messes it again). It doesn’t feel so bad – I can drive home with the window open now...You’re not laughing at me, are you?

T: No, I’m not laughing at you...I understand exactly how difficult it is for you. (Patient becomes tearful and buries his face in his hands) I think you’ve been very brave to do it...I can see your tears: is that from anxiety? ...or....?

P: Yeah...Relief! I started to get anxious, but it actually changed to relief...You’d like me to do it again, right?

T: Well, deep down, what do you think would be helpful?

P: Well, I’ve got it written down (looks at his list of therapy goals from a previous session)... number 7...let people touch it, lean back on chairs, etc...but not ruffle it like that (he laughs). I wouldn’t even let my kids come near it...it stops me playing with them on the floor...but once it’s ruffled and it’s ruined...

T: It sounds like it’ll give you the opportunity for some great quality time playing with the lids...’Hey! Let’s play hairdressers!’

P: (laughs nervously, sighs)...yeah...Didn’t it stress you out when you ruffled your hair?

T: I can feel it...it feels a bit strange. You may have noticed that I scratched my head a few times because it tickled me...

P: (interrupts) You’re so brave!

T: I feel a bit foolish, ‘cos I’m convinced it’s sticking out in a silly way but...

P: (interrupts again) It’s not though...it looks fine.

T: (interjects) I don’t want your reassurance – I don’t need it! (we laugh)...and probably for a while I’ll be aware of it feeling strange.

P: ...(Looking worried and stroking his hair) ...You don’t...it doesn’t look daft...I don’t look ugly or anything? You don’t think any less of me because I’ve done it? ...Oh, it sounds so stupid!

T: How helpful do you think it would be for me to reassure you?
P: Oh, I don’t…Don’t! Don’t! I don’t want you to say a word…you can’t reassure me. I don’t want it (still touching his hair). I’m not trying to flatten it down, I’m actually trying to make it stand up…make it look worse.

T: …and here’s a way to make it stand up even more (demonstrated on own hair)

P: (laughs and rubs head) There you are!… I can’t believe what I’ve done.

T: And how do you feel?…(patient rubs hand on his lap)...Still very uptight about it?

P: (Lightly) No…actually…the anxiety has subsided quite considerably…It’s almost like the ‘game’ thing again… going ‘ner-ner’ (thumbs his nose) to the OCD!

Use of the ‘downward arrow’ technique in this instance revealed underlying schemata that are hypothesised as the bases of seemingly ‘fixed’ and inflexible beliefs and assumptions (Burns, 1980). The key assumption was ‘unless I look my best, others will find me less interesting’ (ie. it means I’m boring). The underlying belief is therefore ‘I am boring’. From this arises Gary’s hypothesised rule, ‘I must always be perfectly groomed’ which makes sense if the assumption were accurate.

The session ends with the Gary summarising what he had learned, and collaboratively agreeing suitable ‘homework’ tasks that have evolved from the session.

*Homework:* His success in the session encouraged Gary to make suggestions for ‘homework’ that would capitalise on his gains. He proposed that he would use a comb instead of a brush on his hair (the rationale being that it was a deviation from his usual grooming ritual), and put his T-shirt on after combing his hair, and then go out without checking in the mirror. He also intended to tackle other aspects of his exacting standards regarding his appearance by wearing odd socks and buckling his belt back-to-front.

**Session 5: Duration 1 hour**

Gary had generally continued improvement, and was usually consistent in approaching any obsessional worries using the alternative explanations generated
during therapy. As a direct consequence of the previous session, Gary was thrilled to be able to say that for the first time ever he had been able to play rough-and-tumble games with his children, and even to allow his daughter to play ‘hairdressers’ with him. This change was particularly important in light of his conviction that he was a bad parent, and he felt that his new-found playfulness was reaping some excellent rewards by improving his interactions with his children. The changes he had instigated also appeared to be successful in altering underlying responsibility appraisals. Because Gary seemed for the most part to have adopted new ways of looking at his difficulties, it seemed timely to review this objectively.

Review of Measures: In the 12 session treatment trial for obsessional ruminations upon which this brief intervention is base, patients would routinely complete self-report measures at regular intervals. They may also be utilised at other times at the discretion of the therapist, for example when a shift in beliefs seems to have occurred. Since Gary’s attitude and behaviour seemed indicative of such a shift, it was considered timely to repeat the measures in this session rather than at the end of session 6 (the end of the active treatment phase).

The results are summarised in Table 1 below.

Table 1: Questionnaire scores from pre- to post-treatment

<table>
<thead>
<tr>
<th>Assessment point</th>
<th>Months</th>
<th>BAI</th>
<th>BDI</th>
<th>RIQ Freq</th>
<th>RIQ Belief</th>
<th>OCI Freq</th>
<th>OCI Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre</td>
<td>0</td>
<td>2</td>
<td>9</td>
<td>29</td>
<td>650</td>
<td>50</td>
<td>52</td>
</tr>
<tr>
<td>Session 1</td>
<td>4</td>
<td>26</td>
<td>29.5</td>
<td>44</td>
<td>980</td>
<td>54</td>
<td>54</td>
</tr>
<tr>
<td>Session 5</td>
<td>6</td>
<td>11</td>
<td>9</td>
<td>24</td>
<td>350</td>
<td>41</td>
<td>27</td>
</tr>
<tr>
<td>Review</td>
<td>16</td>
<td>4</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>34</td>
<td>7</td>
</tr>
</tbody>
</table>
Beck Anxiety Inventory (BAI) and Beck Depression Inventory (BDI)

A considerable decrease in anxiety and depression ratings can be seen between Session 1 and Session 5. At session 1, scores on both scales were at a clinically relevant level (although it is interesting to note that at the Pre-treatment assessment point Gary scores on the BAI were minimal, and at a high normal level for the BDI). By session 5, scores had reduced to what would be considered a slightly elevated normal level, and at review were within the normal range.

Obsessive-Compulsive Inventory (OCI)

From the start of therapy, scores on the OCI show a decrease in scores on both frequency of OCD relevant concerns and distress created by those concerns when they do occur. As we might expect using a cognitive-behavioural approach, frequency of thoughts had not decreased as much as the associated distress (frequency decreased from 54 to 41; distress from 54 to 27). This is because the key message with the cognitive approach to the understanding of obsessional concerns is that it is not the occurrence of the thoughts per se that causes anxiety or distress, but the meaning attached to the occurrence of such thoughts. For example, Gary was more able to just allow the thoughts to come and go without acting on them (ie. neutralising them) because his appraisal had changed to, “There I go again” – a less threatening view which meant he found them far less distressing. A side-effect of this is that the thoughts naturally decrease in frequency as the person is less aware of thoughts that are not appraised as a threat.

From the OCI, it was possible to identify other residual difficulties. He still scored moderately highly on checking (scores on the checking subscale had reduced from 9 to 6, but distress associated with checking had increased from 1 to 4), and despite his success in dismissing intrusive thoughts, he still considered control over thoughts to be a problem.

Responsibility Interpretations Questionnaire (RIQ)

It was encouraging to see that there had been substantial decrease in scores. Consistent with the cognitive model of OCD, although frequency scores were still moderately high (24), Gary’s belief in the meaning of these ideas had decreased greatly (from 980
in Session 1 to 350 in Session 5). Reviewing his responses from a clinical perspective, Gary still held strong beliefs in certain thoughts: that he shouldn’t be having thoughts of this nature and ideas about control of thoughts and the need to resist them. Unless addressed, beliefs of this kind are likely to cause a relapse.

It was agreed that the agenda for this session should include exploring these persistent ideas, and how they might be tackled.

*Homework:* In the manner usually adopted in the later stages of CBT for OCD, Gary was given responsibility for designing his own behavioural experiments to challenge specific beliefs. The rationale for this is that therapist-assigned tasks may be interpreted as holding less personal responsibility for the patient (even though this may not be an explicit appraisal) as they may consider themselves to be ‘just following instructions’, or that the therapist wouldn’t expect them to do something that wasn’t safe/ sensible, etc.

**Session 6: Duration 1 hour**

Gary arrived for our appointment in excellent spirits, having enjoyed a most productive fortnight operating under an alternative set of beliefs. For example, that “just good enough” is sufficient for most things and there was no need to pay heed to the most minute details (we had previously discussed how his previous preoccupation with minor details resulted in losing sight of the ‘big picture’, ie. what he hoped to achieve). He recounted that he had painted the interior of his garage – imperfectly – and had much fun in the process, leaving hairs stuck in the paint, etc. this had been a really liberating experience for him and he had actually enjoyed the activity. In the past, Gary would have become extremely tense and upset. The most important learning point for Gary was illustrated by his conclusion that the job was “still done to a far better standard than most people would do”. We used this as excellent evidence to refute the fear that if he relinquished his perfectionistic tendencies that his standards would deteriorate completely and that the results would be completely unacceptable.
Given his improvements, Gary's GP wished to reduce his Citalopram to 10 mg. We agreed that this would be a good time to do so as we still had a further review session that we planned to schedule about a month hence.

**Booster I: Duration 1 hour**

Gary continued to feel 'brilliant'. Quite often, obsessional patients become reluctant to 'rock the boat' when they have made enough gains to improve their quality of life for fear of triggering a set-back. However, Gary continued to embrace the cognitive model of OCD whole-heartedly. To build on his success with painting his garage, he deliberately scratched the wall with a screwdriver and omitted to 'cut in' when painting around the lights. To his surprise – and amusement – he forgot all about it. This was used to reinforce an important learning point that neutralising behaviours in their many guises create a feedback model that prolongs preoccupation.

In addition, Gary had identified some other compulsions and counting behaviours that he then chose to stop, recognising them as further manifestations of his old obsessional beliefs. Despite an initial surge in anxiety levels when he reduced the Citalopram to 10 mg, he managed to resist the increased urge to carry out compulsive behaviours. A further marker of his success was that he was planning a graded return to work.

**Homework:** No further homework is assigned, although Gary is advised to continue to challenge obsessional beliefs through his behaviours in the manner he has learned in therapy.

**Follow-up:**

In the manner of the full 12 session treatment trial we were completing, patients were reviewed at various points following the end of treatment. Gary's progress was reviewed for the final time 12 months after the start of treatment (16 months from initial assessment). He was delighted to have not only maintained improvements noted at Booster I but had continued to build on them. He no longer felt depressed or
anxious (BAI score=4; BDI score=6). Troublesome intrusions had become infrequent, and on the occasions they did occur Gary was able to dismiss them without having to act on them in any way (reflected in RIQ scores where Frequency = 3 and Belief = 0). Gary’s scores are summarised in Table 1 on p. 45, and illustrated in the graph in Figure 4 (see over). Furthermore, he had successfully returned to work, and was enjoying family life. A time-line provides an overview of the spacing of treatment sessions and significant events (Figure 5).

Discussion:

This case demonstrates that a therapeutic intervention for obsessional ruminations intended for delivery over 12 weekly sessions of one-hour duration can be successfully implemented as a briefer intervention. The initial aim was to offer fewer sessions of longer duration (ie’ 6 x 2 hours) so that a comparable treatment was offered. However, Gary’s progress suggested that all of the sessions did not need to be of the same 2 hour duration. It is interesting to consider the possible reasons for this. It seems unreasonable to conclude that Gary’s OCD was not severe: compared to participants in the concurrent treatment trial there would be no difference and he would have been offered treatment in the trial had geographical distance not been an issue. Indeed, the severity of Gary’s OCD was sufficient to require sickness absence from work and was so distressing for him that he felt suicidal prior to commencing therapy.

A more likely possibility is that it was the structure of therapy that gave an additional advantage to the CBT approach. As the therapist, it seemed that more momentum could be established in therapy at the outset. The initial two-hour session enabled us to arrive at a detailed formulation that was understood by the patient. When attempting to formulate within the constraints of a one-hour session, it can seem that the patient has not had sufficient time to assimilate what they have learned, and indeed the therapist may be tempted to adopt a rather didactic approach if the patient is reluctant to take an active role in the process. Because Gary and I managed to agree a formulation, it provided a well-defined shared understanding of what maintained the problem. From this, Gary was able to form hypotheses about the most effective way of
Figure 4 – Graph showing changes in questionnaire scores over time

<table>
<thead>
<tr>
<th>Event</th>
<th>Questionnaire scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial assessment</td>
<td>9</td>
</tr>
<tr>
<td>Re-assessment / #1</td>
<td>17</td>
</tr>
<tr>
<td>#5</td>
<td>29.5</td>
</tr>
<tr>
<td>Review</td>
<td></td>
</tr>
</tbody>
</table>

- **Beck Depression Inventory**
- **Obs. Compulsive Inventory (Distress)**

Moved house (2nd time in 6 mths)
GP signs off sick (↑ depression, ↑ OCD)

Session 6
Medication: Citizopran 10mg
Commence graded return to work
Medication: None
Full time return to work
Medication: None
Full time work
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>05.01.00</td>
<td>INITIAL ASSESSMENT</td>
</tr>
<tr>
<td></td>
<td>Medication: none</td>
</tr>
<tr>
<td>01.04.00</td>
<td>Major house move</td>
</tr>
<tr>
<td>04.04.00</td>
<td>GP signs off sick -↑Depression -↑OCD</td>
</tr>
<tr>
<td>08.05.00</td>
<td>RE-ASSESSMENT &amp; Session 1</td>
</tr>
<tr>
<td></td>
<td>Medication: Citalopram 20 mg</td>
</tr>
<tr>
<td>06.07.00</td>
<td>Session 5</td>
</tr>
<tr>
<td>20.07.00</td>
<td>Session 6</td>
</tr>
<tr>
<td></td>
<td>Medication: Citalopram reduced to 10mg</td>
</tr>
<tr>
<td></td>
<td>Work: Graded return to work.</td>
</tr>
<tr>
<td></td>
<td>Part-time for 1 month</td>
</tr>
<tr>
<td>22.08.00</td>
<td>Booster I</td>
</tr>
<tr>
<td></td>
<td>Medication: none</td>
</tr>
<tr>
<td>20.09.00</td>
<td>Work: Full-time return</td>
</tr>
<tr>
<td></td>
<td>end of 09.00</td>
</tr>
<tr>
<td>01.01.01</td>
<td>Follow-up</td>
</tr>
<tr>
<td></td>
<td>Work: Full-time</td>
</tr>
<tr>
<td></td>
<td>Medication: none</td>
</tr>
<tr>
<td>22.05.01</td>
<td>16 months</td>
</tr>
</tbody>
</table>

**Fig5:** Time Line Illustrating Treatment Sessions and Significant Events
breaking the vicious circles identified and recognise that what had previously seemed to be the solution to his problem (neutralising) was in fact maintaining his difficulties (if not aggravating the problem further).

Because we were in effect doubling up some of the sessions, both in terms of actual therapeutic contact time and content, it also helped eliminate some of the diversions that often eat into therapeutic time. It can be difficult to successfully handle diversions that the patient introduces, such as being given detailed accounts of trivial or irrelevant events (such as the weather, traffic jams, etc.).

Perhaps more importantly, longer sessions enabled us to work through specific problems in a rigorous and systematic way, and carry this through to its conclusion. For example, in session 4 Gary and I had ample time to explore his beliefs about having perfect hair. We managed to successfully identify the underlying meaning that explained why Gary would find the prospect of having a hair out of place to be so catastrophic, and then to plan and execute a behavioural experiment during the session which would encourage him to further experiment on his own between sessions. It is very important that therapists model some of the tasks to enable patients to have success with behavioural experiments, but can quite often be deferred (or omitted altogether) when it seems that time in an individual session is at a premium. This is likely to have a detrimental effect on progress. The inclusion of modelling clearly had a major impact on Gary who was happy to follow my lead and mess up his own hair after I had done so.

Another reason why this brief treatment may be successful is that it instils a positive attitude towards therapy. Since the therapist is offering a fixed number of sessions, the implication is that they will have improved by the end of that time. An interesting study by Clark, Salkovskis, Hackmann, Wells, & Gelder (1995) has demonstrated this with panic disorder and found that there was no significant difference between participants receiving 8 compared to 12 sessions (both interventions were offered over a 12 week period).
The success of this case instigated a series of brief interventions, and a plan to further develop a brief intervention for OCD. Currently, a systematic pilot is underway to evaluate the outcome of a brief intensive therapy which is completed over a one week period, with a maximum of 12 hours direct therapist contact. Early indications are that this method of delivery can have a major impact on obsessive-compulsive symptoms, despite the fact that the recipients of this approach have chronic difficulties and have often exhausted local treatment resources and have been referred from all over the United Kingdom to our specialist OCD service.
References:


Cognitive- behavioural approaches to the understanding of Hoarding: a critical review of the literature

The cognitive-behavioural approach to the understanding and treatment of obsessive-compulsive disorder (OCD) is now well established, and based on empirical research (eg. Salkovskis, 1985, Rachman, 1993). As a disorder, it can probably be regarded as having a range of idiosyncratic constellations of symptoms ranging from fears of contamination to persistent intrusive thoughts of perverse sexual behaviours. The associated behaviours (compulsions) include many variations from keeping scrupulously clean to being unable to discard garbage. Although typically included within a diagnosis of OCD, hoarding does not make an easy bed fellow as there seem to be numerous differences both in terms of the presentation of hoarding as a condition, the emotional response of hoarders to their difficulties, factors involved in both development and maintenance, and requirements of therapy. A major obstacle is already encountered in that a diagnosis of hoarding is not derived from any standardised diagnostic interview (Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) does not classify separately), but is often the result of the clinician’s subjective opinion.

A working definition for the purpose of this literature review is that the primary problem is the acquisition of, and failure to discard, possessions which seem useless or of limited value (eg. Frost & Gross, 1993), resulting in unmanageable amounts of clutter. CBT assumes that cognitive factors account for the motivation of behaviours such as the inability to throw away worthless items. This motivation is highly relevant to therapy. It may be that the person fears that they may inadvertently contaminate others by carelessly discarding their rubbish (a behavioural concomitant of beliefs about spreading disease, for example). For others, there may be no such fear but they experience a strong drive to acquire or amass a variety of possessions. Whilst this is quite acceptable in our Western, consumer-driven society, for some hoarding becomes a problem of clinical significance: their homes become increasingly cluttered, their acquisitions attain unmanageable proportions, and the resulting chaos may become a health hazard.
Although typically included within a diagnosis of OCD, hoarding does not make an easy bed fellow as there seem to be numerous differences both in terms of the presentation of hoarding as a condition, the emotional response of hoarders to their difficulties, factors involved in both development and maintenance, and requirements of therapy. Literature on the topic is relatively scarce, in particular from a cognitive-behavioural standpoint.

A number of possible reasons for the scarcity of literature on hoarding have been proposed. Ball, Baer & Otto (1996) suggest that OCD patients are underrepresented in clinical trials because they are more likely to either refuse, discontinue, or fail in therapy. Based on the author’s clinical experience over almost a decade on a treatment trial for OCD, empirical research is also made difficult because of the relatively low numbers of hoarders seeking help.

What does the literature tell us about hoarding?

So far, researchers appear to be looking for factors which would differentiate hoarding from non-hoarding OCD. As a consequence, a number of deficits pertaining to cognitive functions have been considered as potential underlying factors in hoarding. The notion of memory deficits holds a common-sense appeal, in particular as they have been a popular area of OCD research (Amir & Kozak, 2002, provide a summary). Studies demonstrate that hoarders report less confidence in their memory (Constans, Foa, Franklin & Matthews, 1995). Frost & Hartl (1996) intimate that hoarders may thus keep their possessions visible to avoid forgetting about them. However, low confidence in memory is not exclusive to hoarders but has also been demonstrated in non-hoarding OCD (Cougle, Salkovskis, & Thorpe, submitted). From the point of view of cognitive-behavioural therapy, poor confidence in memory would be an ideal focus for cognitive restructuring and lends itself readily to both behavioural experiments and introducing the concept of ‘Two conflicting theories’ approach which features in the work of Salkovskis and his colleagues (eg. Salkovskis, Forrester, Richards, & Morrison, 1998). This is a strategy used in the treatment of OCD, but could easily be adapted for hoarders ie. “There are two possibilities: the first is that you really do have a poor memory. The second is that you are worried that your
memory is poor. At the moment, you are behaving as if your memory really is poor, eg. Keeping everything visible to avoid forgetting about them. We can test out which of those theories is most accurate...”. A behavioural experiment may then be set up. The scope of this review does not allow for a detailed description of the technique.

Frost and colleagues identify an interesting feature of compulsive hoarders, proposing that their almost universal lack of organisation may be the result of difficulties in decision making (Frost & Gross, 1993; Frost & Shows, 1993), and tentatively conjecture that this leads to difficulty assigning items to a category, although this has not so far been empirically validated but is based on clinical observations. Like Reed (1985) for OCD, Steketee, Frost, Wincze, Greene, & Douglass (2000) describe “under inclusive categorisation in which each saved possession is considered unique (its own category)”. The cause of this is not made clear. Is it the result of a cognitive impairment ie. a ‘deficit’, or is there an explanation that can be accounted for by a CBT model of hoarding? Steketee et al. have suggested that attentional focus may be a problem, and have noted that hoarders appear to be easily distracted from the task of organising and discarding. A cognitive-behavioural explanation for this might point to the role of mood and a tendency to attend to mood state as a potential distracter (eg. Focusing on feelings of anxiety rather than external or objective stimuli). Support for such a view can be found in the work of Richards (2000) and Wahl, Salkovskis, & Cotter (submitted) whose studies indicate that obsessionals rely more on subjective internal criteria (‘feels right’) as their cue for terminating an action (such as deciding when they have washed their hands sufficiently, checked adequately, etc) than a non-clinical control group. It may therefore be the case that hoarders also use some idiosyncratic subjective logic when attempting to organise items according to categories because they are using ‘feeling’ rather than objective criteria to decide whether they have made a correct decision. As a result, they may appear distractible as they attend to transient internal cues in order to ‘feel certain’. This observation could be framed more systematically as a hypothesis or theory for hoarding.

From their observations, Frost and Hartl (1996) had put forward some interesting points about apparent deficits in categorisation and organisation based on some of the earlier ideas put forward by Reed (1985), which could provide a basis for developing
an interesting cognitive-behavioural model of hoarding. They suggest that obsessionals have more complex concepts than non-obsessionals which require more information for making decisions (Frost, Lahart, Dugas, & Sher, 1988; Persons & Foa, 1984; Reed, 1969 a, b). They discuss the way in which each of the hoarder’s possessions:

..."is seen as totally unique (in its own category) and thus no other possession can substitute for it. Such a view greatly increases the value of each possession, and makes discarding it more difficult." (p.345)

They offer this as a partial explanation for the clutter and disarray that typifies the hoarder’s home: if an item cannot easily be categorised with similar objects, organisation of possessions becomes extremely difficult as, for example, not two items of clothing, tools, utensils, mail, etc. would have an obvious place in which they could be kept together. There would appear further difficulties in that items can achieve a special status with the hoarder that further complicates categorisation. Frost and Hartl provide an interesting scenario to illustrate how seemingly similar objects can attain a unique status:

"...The clutterer begins to read a book and, after reading for a while is interrupted or must do something else. The book is not returned to the bookshelf because it is not like all the other books (it is actively being read) and is placed on the floor. The person may not come back to that book right away, but instead looks something up in another book. This book is now also unique and cannot be returned to the bookshelf, nor placed with the other book on the floor. Instead, this book is placed on the couch. Next, a cookbook is scanned and placed on the counter. This pattern is repeated until there are books everywhere. Their position in the room has meaning and an idiosyncratic sort of organisation exists, but the ultimate result is chaos and clutter. In fact, the lack of a coherent organisational scheme may be a major variable in determining the level of impairment for the compulsive hoarder". (p. 345)
This raises a number of issues from the point of a developing cognitive-behavioural explanation which Frost fails to address, preferring to emphasise the role of 'cognitive impairment' in hoarding. From a therapy standpoint, the most obvious cognitive-behavioural aspects would seem to be the role of dysfunctional assumptions in the decision making process, and the underlying beliefs which fuel them, eg. ‘If I read this book, then...’, ‘if this book is returned to the bookshelf, then...’ (ensuing ideas pertaining to self, others, the world, the future). None of the authors so far have identified the kinds of beliefs that may fuel such assumptions, in the way that the notion of responsibility appraisals have proven a useful way in which to conceptualise the way in which obsessional patients present (an example of these are, “Even if harm is a very unlikely possibility, I should always try to prevent it at any cost”, or, “If I can’t be certain I am blameless, I feel I am to be blame” (Salkovskis, Wroe, Gledhill, Morrison, Forrester, Richards, Reynolds, & Thorpe, 2000).

The role of beliefs and emotion in hoarding

A cognitive-behavioural explanation for some of these alleged ‘deficits’ has been put forward by Frost, Kim, Morris, Bloss, Murray-Close, & Steketee (1998) and sounds highly feasible. Lack of confidence in memory, they propose, may stem from a belief that they must remember everything perfectly. This kind of belief has been encountered in various forms in obsessionals, and is unlikely to be specific to hoarders. In particular, compulsive checkers would typically subscribe to this kind of belief. Frost et al. have identified additional beliefs that may be specific to hoarders. For example, the inability to discard items may also result from beliefs about loss of opportunity or loss of important information that may ensue from indiscriminate ‘throwing away’. It seems quite plausible that the implicit belief is that nothing should be wasted. This fits quite well with the main postulate of the cognitive-behavioural model of OCD that emphasises the role of responsibility (eg. Salkovskis, Rachman, Ladouceur & Freeston, 1992) as hoarders do seem to believe that they have a responsibility to ensure that anything is used to its maximum potential. An interesting question arises from this about the boundary between normality and pathology. For example, should ‘green’ lifestyle advocates be viewed in the same vein, and if not, how would they be distinguished from hoarders? This question will be addressed later.
Frost and Hartl (1996) refer to Rachman (1993) and Salkovskis (1985) and concede that hoarders may experience an exaggerated sense of responsibility for harm. They suggest that there are two types: the harm associated with not having needed the possession, and harm (damage) to the possession should it be discarded. However, they go on to say that the exact nature of the negative consequences for hoarders is less clear than for checkers or cleaners (p.344).

A further, seemingly compatible, belief identified by Frost et al. is the notion that possessions represent comfort and/or safety. Whilst in general this has commonsense appeal, it does little to explain the fact that many hoarders collect or keep meaningless items, or items that most people would consider rubbish, or the inability to even dispose of bodily waste (although this opens up a further debate which will not be addressed here about whether hoarding should be considered a primary diagnosis for such individuals).

It has been found that hoarders (both clinical and non-clinical) demonstrate elevated perfectionistic attitudes, especially with regard to mistakes and doubts about actions. Frost and Gross (1993) claim that hoarders view their errors as evidence of their incompetence and lack of worth, but again this has not been incorporated into a systematic CBT model, and exists merely as an observation. This does not seem to be specific to hoarders, but clinical observations indicate its prevalence in non-hoarding OCD. Low self-esteem has been shown to be a salient feature in depression (eg. Fennell, 1997) and may feature in the general clinical population.

Taking all of these kinds of beliefs into account, it is not difficult to imagine that hoarders may develop a strong emotional attachment to their possessions:

1) by keeping things, they believe they would be able to compensate for their ‘poor’ memory by referring back to documents they have kept, or that they would forget important aspects of their past should they be without their possessions;
2) loss of opportunity can be avoided (eg. They would have ‘just the right thing’ for a task at a later date) or the inconvenience and distress of losing important information that they might urgently require some day;

3) the person may convince themselves that they are responsible and caring individuals because they are minimising waste by retaining objects that may possibly come in useful at some future date;

4) the belief that unless they have the familiarity of their many possessions around them they would suffer discomfort, or that to be surrounded by their belongings provides a sense of safety;

5) beliefs about responsibility for harm – either to themselves (‘I would become so upset if I threw this away, and it would be my fault’) or even to the item itself (‘It would be wrong of me to throw this away in case it is damaged in some way’);

6) perfectionistic attitudes (eg. They have yet to read and fully understand the many newspaper articles they have amassed);

7) errors of judgment can be avoided which would lead them to feel incompetent and worthless if they had inadvertently thrown away something they later required;

Based on the available literature and the range of beliefs itemised above, it is not difficult to visualise the possibility of a rudimentary conceptualisation for use in therapy. Frost and Gross proffer the explanation that:

"meaningless items such as store receipts or scraps of paper with unknown phone numbers come to represent important past events in the person’s life and help define their identity" (from Steketee et al, 2000).

This is also borne out by Frost, Hartl, Christian, and Williams (1995) who report that hoarders only feel safe and comfortable when surrounded by their possessions. Other writers highlight the sense of emotional loss that occurs when attempting to discard possessions (Greenberg, 1987; Warren & Ostrom, 1988). This may offer at least a partial explanation why some hoarders appear happy to live in what the average
person would consider abject squalor. No qualitative phenomenological studies have sought to find out how hoarders explain their behaviours.

So far, beliefs and emotion have only been considered in the context of the hoarder making errors of judgment, making mistakes, maintaining a sense of comfort, and other perfectionist-type traits. The cognitive approach also involves examining thoughts and beliefs about the nature of emotion, and in particular, erroneous beliefs about the potency of anxiety. This is well documented in the cognitive approach to the treatment of panic disorder (eg. Clark, 1986) and is frequently relevant to the treatment of OCD where the meaning attached to the occurrence of intrusive thoughts or urges may be that if such intrusions are ignored, anxiety may increase so dramatically that the patient will lose control and some dreadful fate befall them (a variety of possibilities are frequently cited, such as going mad, act out the dreaded deed, etc.). The literature so far fails to consider the implications of this for hoarding, although some authors provide some interesting case material which may benefit from such an analysis. The effect of such appraisals and resulting emotions on behaviour provides the final part of the link in a cognitive-behavioural explanation of hoarding.

**Linking cognitions and emotions with behaviour**

Now that the range of cognitions have been identified, it is important to consider the way in which they link with behavioural concomitants. Before doing so, it is necessary to take into account the range of hoarding behaviours encountered with the disorder. Frost, Steketee, & Grisham (2002) clarify hoarding symptoms into three well-defined categories:

1) difficulty discarding  
2) clutter  
3) acquisition

Hoarding behaviours may fall into one or more of these categories, with distinct (but not necessarily exclusive) associated beliefs. The hoarder who has difficulties discarding may hold beliefs about the importance of utilising everything to its
maximum potential, in a similar manner to the person who acquires more and more items (‘rescuing’ them from skips and rubbish dumps), resulting in clutter. The hoarder living amidst clutter may believe that they can only feel secure with familiar objects around them, or that if they lose sight of particular items they may ‘forget’ them (thus they may avoid tidying their home). Clutter may also result from difficulties with organising possessions as described on p. 56 above.

Avoidance behaviours are an established central feature of all anxiety disorders. It has also been identified as a major behaviour in hoarders in that they avoid organising and discarding their possessions. The question that observation begs is what is it that hoarders are avoiding? Frost and Hartl (1996) postulate that saving possessions allows the hoarder to avoid or postpone making a decision and therefore they can avoid making a mistake (which Frost & Gross, 1993, suggest is a major concern for hoarders). The examples of avoidance behaviours which they give include saving (and its concomitant in that a mistake is avoided lest they erroneously throw something away), and postponing tidying things away. They also highlight that avoidance can also pertain to affect and the “emotional upset associated with discarding cherished possessions” (p.348). Although not referred to in the current literature, it may also be considered that hoarders avoid triggering intense emotion because they hold erroneous threatening and/or catastrophic beliefs about emotions as discussed previously. Steketee et al (2000) propose that hoarders avoid organising and discarding their possessions in order to avert the need for decision making and eliciting fears related to having a ‘faulty’ memory, as well as the obvious avoidance of emotional upset. Whilst this on the surface would seem to provide an explanation, in itself it is inadequate because if it was only a matter of not evoking concerns about deficits in memory or decision-making abilities, why are hoarders unable to allow others to make decisions on their behalf (transferring responsibility) in the way that the compulsive checker is happy to allow their spouse to lock the front door without a further doubt that it will have been securely locked?

Frost and Hartl (1996) include an eloquent account that illustrates the way in which cognitions and emotions may be linked with behaviour. They describe how a woman putting an unread book into a ‘to sell’ box as part of a therapeutic assignment. She
became immensely tearful, the emotion being associated with the thought, "I want to die". The authors reported that within 2 minutes, her SUDS (Subjective Units of Distress) rating had dropped to zero. More interestingly, the woman was surprised at the rapid change in her affect (both the increase and the decrease) and how intense her feelings of loss had been for an item that she now recognised as of little worth to her. Frost and Hartl conclude that:

"perhaps what is most onerous is not the discarding of a possession, but the decision to discard it. Once a decision is made to discard something, the emotional reaction may be gone". (p. 348)

There would appear to be scope for challenging these kinds of beliefs in the treatment of hoarders, eg. "If I throw this away, I will become so distressed/ anxious/ depressed that I won't be able to cope, and I will feel like this for ever". This is, of course, a clumsy over-simplification but the idiosyncratic variants may well benefit from attention in therapy in the way Salkovskis asserts that responsibility appraisals must be tackled in obsessive-compulsive disorder. Unless these appraisals are addressed it is understandable that avoidance is likely to remain a prominent feature: if it were true that one would feel so distressed/ anxious/ depressed for ever, avoiding such an outcome makes perfect sense.

But it is not only threat appraisals such as these that affect behaviour. The way in which hoarders may focus on particular aspects whilst ignoring others is also influential. We have seen how several writers think that hoarders have unusual perspectives which interfere with decision-making processes. Again, Frost and Hartl (1996) provide an account of the process when a hoarder is deciding whether or not to discard a possession:

"...they spend most of their time thinking about being without [it] (the cost of discarding) and little time thinking about the cost of saving it, or the benefit of not having it." (p.344)
Their explanation of this is that these kinds of thoughts put the hoarder in touch with the feeling of being without the item and needing it (i.e. The effect of thoughts on emotions). Thus, retaining the item prevents the feeling of deprivation or loss. It can be argued that there are similarities in this regard with non-hoarding obsessionals who take a similarly skewed view in decision-making. If we take the example of doubting, obsessionals appear to take a different approach to non-clinical subjects as they appear to be trying to have a clear recall of, say, not locking the door, or of the old lady they didn't run over (e.g. Salkovskis, Forrester, & Richards, 1998). Some authors may view such cognitive 'biases' as a deficit, but from the perspective of a cognitive-behavioural theory it may be viewed as an aspect of the hoarder which is amenable to change through therapy.

Implications for treatment

A cognitive-behavioural explanation of any disorder should provide guidelines for therapy: what are the key cognitions/behaviours/moods that need to change in order to combat the presenting difficulties. Does what we have read so far about hoarding have any such implications or give us tips about the direction therapy should take?

Much of the literature focuses on attempting to identify cognitive deficits. A major problem with this kind of approach is that it is at odds with the principles of cognitive-behavioural therapy (which, put very simply, is based on the premise that what we think affects both how we feel and how we behave), and also offers a rather pessimistic view of whether it is possible for the hoarder to change since the notion of a 'deficit' would imply to many that it is something that is 'missing'. At best, if such deficits were viewed as skills deficits it would suggest that skills (such as decision-making or organisation) could be taught. A criticism of this view is that hoarders do not appear to exhibit such deficits universally i.e. They do not necessarily have problems making decisions in a work environment, they may demonstrate high levels of competence in other areas of their lives, or even arrange their clutter in a perfectly neat and systematic manner with their collections of scrap timber, elastic bands, and used carrier bags sorted according to size, colour, etc.
When considering a treatment approach, the anticipated outcome must be made specific and should be quantifiable in some way. However, for any improvements to be maintained, it can be argued that it is insufficient to merely change behaviours but to also change beliefs which give rise to such behaviours.

**Cognitive-behavioural treatment for hoarding**

Cognitive-behavioural therapy (CBT) has been one of the major advances in psychological therapy during the twentieth century, and its credibility and popularity continues to grow with the increasing emphasis on evidence-based practice in mental health. As with OCD, hoarding has widely been viewed as resistant to treatment. Black, Monahan, Gable, Blum, Clancy, and Baker (1998) claim that hoarding symptoms are the strongest predictor of non-response to medication or behaviour therapy (67% of non-responders compared with 18% of responders). However, the number of participants in the study is rather low (n=38), so results should be interpreted with caution. The number of participants is even lower in a study by Winsberg, Cassic, and Koran (1999) who note limited improvement in 20 OCD patients for whom hoarding is one symptom (6% improvement in a pharmaceutical trial). A combined treatment consisting of both a drug and CBT resulted in a slightly better response, but the outcome figures are not specific to hoarding symptoms and therefore shed little light on the effect of CBT on hoarding per se and appear to reflect the effects of medication generally found in OCD. Perhaps the major criticism of these outcome studies is that the treatments reviewed were not specifically designed for hoarding but have been modified from standard treatments for OCD which do not target directly the salient components of hoarding.

Literature on CBT for hoarding is limited in the main to case reports. For example, Shafran and Tallis (1996) describe ‘moderate success’ with CBT over a 3-year period for one case. Hartl and Frost (1999) carried out a multiple baseline experimental case study. The main focus of therapy was on decision-making, exposure and response prevention, and restructuring of hoarding cognitions. They report a significant decrease in clutter achieved over 18 months. However, Steketee, Frost, Wincze,
Greene, and Douglass (2000) describe a small pilot study (n=7) based on the hoarding model by Frost & Hartl (1996) which views hoarding behaviour as a:

"multifaceted problem that stems from information processing deficits, emotional attachment problems, behavioural avoidance, and erroneous beliefs about the nature of possessions". (p.343)

The outcome measure used was a modified version of the Yale-Brown Obsessive-Compulsive Scale (YBOCS) (Goodman, Price, Rasmussen, Mazure, Fleischmann, Hill, Heninger, & Charney, 1989). Whilst widely used as a measure of severity of OCD symptoms, it is not especially sensitive to hoarding symptoms and it is likely that for those patients for whom hoarding is the primary concern, they may score lowly on aspects such as time taken or even distress. It is true to say that at the time of the study, the YBOCS may represent the best available measure for hoarding.

Steketee, Frost, et al. (2000) describe ‘cognitive and behavioural interventions derived from Frost & Hartl’s (1996) theoretical model of hoarding (p.259). They outline the foci of their intervention as:

1) Education about hoarding  
2) Decision making practice  
3) Skills training in organising  
4) Behavioural exposure  
5) Cognitive restructuring

Much of the treatment programme is based on skills training and behavioural strategies, and the authors note that the majority of patients found it easier to begin with categorising and organising before discarding. Although a cognitive component is clearly included in the programme (we are told that clients were taught to identify erroneous beliefs associated with acquiring and saving, and that ‘cognitive challenge strategies were introduced and practiced’ both in the group and in vivo), the way in which the various components were integrated is unclear.
It is consistent with the cognitive model of OCD that ‘an established rule of treatment was that clients, not therapists, determined what to discard and how to dispose of sorted items’ (p.264) in that the importance of the client assuming full responsibility is well established as a key feature in the cognitive-behavioural treatment based upon it (eg. Salkovskis, Forrester, & Richards, 1998), and reflects the central tenet of the theoretical model. However, it would appear that a valid criticism of Steketee et al.’s programme is that homework tasks were assigned as behavioural exposure, rather than devised by the clients themselves as ‘behavioural experiments’ designed to test out specific beliefs. If responsibility plays a major role in hoarding as well as OCD, there are a number of ways in which this may be an obstacle in therapy. For example, a difficulty frequently encountered in the treatment of obsessional problems is reassurance seeking by the client. This can be obtained in quite subtle ways, such as the presence of the therapist (this has also been linked to transferring responsibility by Shafran, 1997), and is not unlikely to occur in situations where the client has been ‘instructed’ by the therapist to carry out a particular task (eg. “My therapist wouldn’t ask me to do it if it wasn’t okay”, “It wouldn’t be my fault if it turns out wrong”, etc.).

Overall, the concept of responsibility receives scant attention in Steketee et al.’s treatment approach, or the discussion of its outcome. The authors reported that several clients had difficulty completing homework tasks independently between sessions, but they speculated that “difficulties with information processing and organisation and possible attention deficit problems may have played a role in this” (p.267). It may be more plausible that responsibility appraisals would lead to difficulties completing homework tasks (which is consistent with those difficulties encountered in the cognitive-behavioural treatment of OCD), and such appraisals can be considered relevant to any real or imagined deficits that the client may have (eg. ‘I can’t be certain that I won’t need this in the future’ and ‘If I throw this away, and then need it later it will be my fault’). The sample size is also very small (n=7) so caution should be employed in extrapolating from their results. Six out of seven clients are reported to have made ‘significant improvements’ after 15 group therapy sessions over a 20-week period, according to their responses on the Hoarding YBOCS (the group adapted the Yale-Brown Obsessive Compulsive Scale (Goodman et al., 1989)). As with OCD outcome studies generally, it is important to be clear what ‘improvement’ means in
real terms. The authors themselves are circumspect about the outcome of their treatment programme, and intimate that the group "appears unusual in the absence of other OCD symptoms apart from hoarding" (eg. Winsberg, Cassic, & Koran, 1999) and felt that additional OCD symptoms may have complicated the intervention strategies which they had employed.

Although Steketee et al. would undoubtedly assert that their treatment has evolved from a cognitive-behavioural analysis of hoarding, there is minimal evidence of this in their results. A plausible reason for this may be the absence of an appropriate measure which is sensitive to changes in hoarding-related cognitions and beliefs. The outcome of the majority of studies so far has relied on measures for developed for OCD or more general psychopathology, although Frost & Gross (1993) developed a 22-item Hoarding Scale which was subsequently revised by the first author to include two further items (Frost, 1998). However, in a recent paper by Frost, Gross, & Grisham (in press) they acknowledge that the original Hoarding Scale does not reflect the most important symptoms as the items had been generated early on in hoarding research and were unknown at the time of its development.

Recent developments have introduced two measures of hoarding which should prove to be more accurate monitors of change during treatment. The Savings Cognitions Inventory (SCI-R) (Steketee, Frost, & Kyrios, in press) has excellent face validity. It includes a variety of cognitions that one might expect in hoarders, such as beliefs about the nature of possessions (eg. That items may be almost personified, "it's like losing a friend"), the belief that memories would be erased or lost, the relationship between the person and the possession (eg. "it's part of me"), etc. whilst the SCI-R has been empirically validated for group comparisons amongst hoarders (n=95), non-hoarding obsessionals (n=21), and community controls (n=40), the numbers per group are unbalanced with almost 80% more hoarders than obsessionals, and 60% more obsessionals than controls. Given the comparative ease of recruiting non-hoarding obsessionals and controls, this reflects poorly on the study overall and more powerful results would have been yielded had balanced comparison groups been used. As a revised version of the Hoarding Scale used in previous research (eg. Frost & Gross, 1993; Frost, Hartl, Christian & Williams, 1995) it is indeed an improvement in that it
is more sensitive to cognitive appraisals and provides more clinically useful data. Undoubtedly, it would reflect subtle changes that occur during therapy (ie. Shifts in beliefs).

The Savings Inventory Revised (SIR) (Frost, Steketee, & Grisham, 2002) appears similarly sensitive to subtle changes, but also provides a broader measure as it separates symptoms of hoarding from the beliefs associated with it. It also aims to measure distress and impairment (ie. Emotional and behavioural concomitants associated with clinically significant pathology. An additional benefit of the revised scale is that it is likely to discriminate between clinical and non-clinical levels of hoarding. One of the key strengths of this measure is that it does not refer to specific types of possessions, which would automatically exclude significant sub-groups for whom a particular item poses no problem (eg. Someone who hoards paper, junk mail, etc. may have no difficulty discarding empty containers and packaging). This kind of specificity is frequently problematic in constructing measures of psychopathology. In non-hoarding OCD, for example, artificially low scores may be obtained on some scales which focus predominantly on overt rituals rather than covert behaviours typical in obsessional ruminations.

The development of these measures is, at the time of writing, the most up-to-date addition to the cognitive-behavioural understanding and treatment of hoarding. It is anticipated that these concepts will shortly be crystallised into a comprehensive treatment approach.

**Summary and Conclusion**

So what does the literature reviewed provide in the quest for a cognitive-behavioural model of compulsive hoarding? Many interesting ideas about hoarding have been documented. These are summarised below.

At the outset, the lack of a universal definition of hoarding was identified and that it was generally classified under the broad category of OCD. Although this can be considered a problem in its own right, a further quandary occurs. The lack of a
standardised diagnostic interview in psychiatric practice has been an almost universal confound in the studies reviewed where group comparisons have been made. The definitions of hoarding used for comparison groups are often loose, and are likely to be inconsistent between studies. As a result, interpretation of outcomes from the various studies should be done with caution.

The notion of deficits has been quite pervasive in the research although there is scant evidence in support of cognitive deficits. Actual memory deficits have not been identified, but it is possible that confidence in memory may be a salient factor. This possibility and other factors (such as lack of organisational skills) have yet to be empirically validated. An explanation based on deficits also requires further questions to be answered. For example, does it mean that such deficits are acquired or have they always been present? Further investigations should therefore look at the ‘career’ of hoarders and the route by which they have attained their current predicament. Limited clinical observations suggest that hoarders may have been able to function ‘normally’ and that it is a problem that developed for reasons not yet clear. Qualitative research may help discover possible pathways to hoarding of clinically significant proportions.

Frost & Hartl (1996) proposed a cognitive-behavioural model of hoarding in which they hypothesised that there were four general types of ‘deficits’:

1) Information processing
2) Emotional attachment
3) Beliefs about possessions
4) Behavioural avoidance.

Arguably, 2, 3, and 4 can hardly be described as ‘deficits’ although they may sensibly fit into a CBT model. As discussed above, there is also insufficient evidence to support the idea that ‘information processing’ deficits occur in hoarders, but that such ‘deficits’ may be more adequately explained as a cognitive (thinking) bias eg. Focusing on negative aspects of discarding an item rather than positive ones (see p. 10 in Frost & Hartl, for example). To apply the term ‘cognitive’ in the context of Frost
and Hartl's hypotheses is thus quite different to its application in a cognitive-behavioural sense.

A more fruitful thread that can be traced throughout the articles is that hoarding behaviours have been closely scrutinised and as a result components of hoarding have been broken down into discretely definable behaviours (nb. 'behaviours' in this sense refer to both overt (physically observable behaviours) and covert (mental events) activities. The benefit of this is that many of the authors have coined new terms for some of these components which enable clearer definitions of the stages of hoarding (eg. In an unpublished manuscript by Frost & Hartl (1995) they use the term 'churning' to describe a behaviour they had frequently observed in their patients. Churning is used to describe how, when attempting to organise possessions, the hoarder's inability to decide how an item should be categorised would lead them to use a temporary measure ("I'll just put it here for now") until they felt able to make the decision. As we have seen, theoretical explanations for this are various and may be based on having 'sufficient information' or that it 'felt right'.

These early theories of hoarding have given more credence to the importance of dysfunctional beliefs in hoarding. Until recently, many of the characteristics outlined by the different authors had a cognitive-behavioural 'flavour' to them but failed to offer a comprehensive phenomenological account. The recent work of Frost and Steketee with various colleagues has exciting possibilities for achieving such an account. As well as defining clarify hoarding symptoms as three distinct categories (difficulty discarding, clutter, and acquisition), they have also identified salient beliefs that help explain such behaviours (Steketee, Frost, & Kyrios, in press). Their work has clearly provided an excellent foundation for a comprehensive cognitive-behavioural theory of hoarding and they have been pioneers in the development of a comprehensive treatment approach. Although there is growing evidence for the effectiveness of their approach, a major weakness is that it fails to integrate smoothly the modification of cognitive change strategies with its more skilful application of behavioural change techniques.
Having considered the literature, this review reaches three main conclusions. Firstly, the lack of a universally accepted definition of hoarding is problematic since it leads to difficulties in extrapolating from the research literature. The definitions of hoarding used for comparison groups are often loose, and are likely to be inconsistent between studies. There appears to be sufficient evidence to suggest that hoarding should be designated as a separate diagnostic category to OCD, which would thus require its own standardised diagnostic interview in psychiatric practice. This would enable greater comparability of future research.

The second conclusion is that there is currently insufficient evidence to assert that cognitive deficits are the cause of hoarding behaviours. Further investigation is required, and this could be enhanced once a well-defined diagnostic classification is established.

The third conclusion is that derived from the emerging treatment approaches. Although many of the characteristics outlined by the different authors do have a cognitive-behavioural 'flavour' to them, no-one has as such put forward a definitive model that is as well developed as that for obsessive-compulsive disorder. Whilst the foundations of a cognitive-behavioural theory of hoarding are developing through research and there is an emerging protocol for treatment, a comprehensive conceptualisation has yet to be derived to adequately explain the aetiology and maintenance of the hoarding problem and link theory with clinical practice. Without this, any intervention is likely to lack cohesion. Thus it can be argued that what is now required is a visual formulation to provide an overall 'map' which draws together beliefs, appraisals, emotions, and behaviours and illustrates the way in which they interact to maintain the problem (ie. vicious circles) and suggest possible pathways by which an individual may develop a hoarding problem. An effective intervention plan would readily be derived from such a model.
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Introduction and background

Phobia is defined as a marked and persistent fear that is considered by the individual to be excessive (by adults and adolescents). Exposure to the phobic stimulus causes an immediate increase in anxiety, the situation may be endured with distress but avoidance is a prominent feature of the disorder. Avoidance, anxious anticipation, or marked distress which has a significant effect on the person's life in terms of social, domestic, or occupational/academic functioning is a further defining feature (American Psychiatric Association (APA), 1994). Blood-injection-injury phobia (BII) is classified as a sub-type of specific phobias typified by fear induced by seeing blood or an injury, having an injection or receiving some other invasive medical procedure. It is considered to have a strong familial association. One of the key defining features of BII is that, in contrast to other specific phobias, it is often accompanied by fainting in the presence of the phobic stimulus (seeing blood, the prospect of having an injection, or receiving some other invasive medical procedure) (eg. Öst, 1992; Thyer, Himle, & Curtis, 1985). Approximately 75% of BII phobics faint when confronted by blood, injury, or an invasive medical procedure (eg. Connolly, Hallam, & Marks, 1976). In other phobias there is activation of the sympathetic nervous system that leads to increased heart rate (tachycardia) and blood pressure (the 'fight or flight' response). Conversely, blood-injection-injury phobia is frequently accompanied by a parasympathetic response resulting in a reduction in heart-rate (bradycardia) and blood-pressure (hypotension) (eg. Merckelbach & De Jong, 1997) resulting in what is referred to as 'emotional fainting' or vasovagal syncope (eg. Lewis, 1932).

Whilst DSM-IV (APA, 1994) considers blood and injury phobics as belonging to the same diagnostic category as injection phobics, Öst, 1992 found that they were not a homogeneous group and that significantly more blood phobics had an injection phobia (69%) compared to only 31% of injection phobics having a blood and injury phobia. Although it is reported that blood-injection-injury phobia is relatively common in a normal adult population (Agras, Sylvester, & Oliveau, 1969), in adolescents
(Kleinknecht, 1987), and also in children (Lapouse & Monk, 1959), it is argued that there have been no accurate epidemiological studies of the condition since reports on incidence tend to focus solely on the occurrence of fainting in the presence of blood, without taking into account the feelings of intense fear that are crucial to the diagnosis of a phobia (Page, 1994). Fainting amongst blood donors is a commonly observed phenomenon, yet only a minority of these people would meet criteria for BII phobia (since avoidance of the phobic stimuli is one of the key criterion for such a diagnosis, it is unlikely that many BII phobics are likely to be regular blood donors). Despite his reservations about reports of the incidence of BII phobia, Page offers an estimate of the frequency of fainting in the presence of blood and injury of between 5 and 15% amongst the general population. He goes on to argue that the actual incidence of BII phobia is therefore likely to be lower, since not all of those who have fainted in the presence of blood will be phobic. This would be consistent with the figures put forward by Agras, Sylvester, & Oliveau (1985) who suggest that there is roughly a 3% incidence amongst the general population.

Many authors consider fainting in the presence of blood and related stimuli to have evolutionary origins because it appears to be related to death-feigning in animals in response to a life-threatening situation (eg. Marks, 1988), and is also considered to be beneficial in the event of injury since slowing blood circulation reduces blood loss (Thyer, Himle, & Curtis, 1985; Barlow, 1988). As such it is argued that it is not a unique psychopathological syndrome, but the remnants of a basic reflex that is a relic of our evolutionary past (Merckelbach & De Jong, 1997; Thyer, Himle, & Curtis, 1985). It is certainly true that marked facial pallor accompanies the rapid decrease in blood-pressure, as blood flow is directed away from the extremities of the body. Recovery is often slow, with heart rate and blood-pressure remaining low even after consciousness is regained.

It has been suggested that there tends to be a strong family history of BII, and this has often been put forward as evidence in support of these evolutionary arguments. However, findings have often been contradictory. Whilst Öst (1992) claims that 61% of BII phobics had a close relative with the same phobia, only 27% of the sample investigated by Thyer, Himle, & Curtis (1985) reported incidence of BII in their
families. Behaviourists would argue that a more probable explanation for the occurrence of familial patterns of phobias is that it is a learned response occurring through vicarious observations (eg. Rachman, 1990: Mineka, Davidson, Cook, & Keir, 1984).

Whilst fainting in the presence of blood or injury may seem no more than an inconvenience to many, for the BII phobic there can be more serious implications (Hamilton, 1995). Since a phobia is partially defined by avoidance of the feared stimuli (or the stimuli can only be endured with marked distress), the person may avoid necessary medical or dental treatment, visiting hospitals, etc. However, wider ramifications have also been reported (eg. Öst & Hellstrom, 1997) where their fears have influenced their career and education, causing them to be fearful in a range of situations for fear that they will encounter distressing stimuli, and even avoiding pregnancy since medical procedures are likely to be involved. Yet a significant proportion of BII phobics claimed that, although distressing, their problem did not have adverse effects on other aspects of their life.

**Treatment of Blood-injury-injection Phobia**

The most influential figure in the development of treatment for BII phobia is Öst (eg. Öst, Lindahl, Sterner, & Jerremalm, 1984; Öst & Sterner, 1987; Öst, Fellenius, & Sterner, 1991; Hellstrom, Fellenius, & Öst, 1996). Hellstrom, Fellenius, and Öst (1996) assert that applied tension is the treatment of choice for BII phobia. The aim of this approach is to teach the phobic patient an effective means of increasing their blood pressure and to help them identify early signs of an impending drop in blood-pressure so that they can apply this technique to prevent fainting. In applied tension, the muscles of the arms, legs, and torso are tensed but not relaxed. This is the opposite of applied relaxation, a technique popularly used in the treatment of anxiety and panic (eg. Öst, Sterner, & Fellenius, 1989; Öst, Westling, & Hellstrom, 1993). Öst emphasises the importance of a detailed rationale that explains the diphasic pattern of symptoms and reasons for feeling faint should be explained and how treatment involves training in a coping skill that can be applied quickly and easily to prevent fainting (Öst & Hellstrom, 1997). Once training in applied tension is underway, the
patient is taught to recognise early signs indicating a reduction in blood-pressure, at which point they are then instructed to practice the applied tension techniques previously learned. Graded exposure is then carried out to enable the person to become skilled at identifying early signs of falling blood pressure and act to prevent it. Initially, patients may be shown slides of injuries and medical procedures, etc., and at a later session watching a blood donor in the process of giving blood, followed by the phobic patient themselves donating blood. Each stage of the exposure hierarchy involves practicing applied tension as a coping skill. In Hellstrom, Fellenius, & Öst’s (1996) study, exposure culminates in the final session by the phobic patient observing an operation in vivo.

The approach described above has been proven successful in a number of treatment trials (eg. Öst, Fellenius, & Sterner, 1991; Öst, Sterner, & Fellenius, 1989), including in a single session format (Öst, Hellstrom, & Kaver (1992). Significant improvements were found by the end of treatment, and were reported to have been maintained at 12 month follow-up. Whilst the results of these studies are suggestive of compelling evidence for this treatment approach, certain factors may influence confidence in the approach including the characteristics of the participants used in their studies, and whether the treatment approach includes adequate mechanisms for change to ensure improvement is maintained in the longer term.

For whom is applied relaxation a suitable treatment?

Participants in treatment studies of applied relaxation conducted by Öst and his colleagues all met diagnostic criteria for specific phobia (blood-injury-injection subtype) according to DSM-IV (APA, 1994) (or its antecedent, DSM-III-R, APA, 1987). However, psychiatric comorbidity was a key exclusion criterion. It is also of note that in one of those studies it is explicitly reported that participants’ average scores on the Beck Depression Inventory (Beck, 1967 sic.) and Beck Anxiety Inventory (Beck, Epstein, Brown, & Steer, 1988) fell within a non-clinical range (Hellstrom, Fellenius, & Öst, 1996). Thus it may be pondered whether their sample is truly representative of blood-injury-injection phobics.
A population-based study of the psychological and response characteristics of dentally anxious individuals (Locker, Liddell, & Shapiro, 1999) found that, rather than being a single homogeneous group, they could be assigned to four distinct diagnostic categories according to their responses to self-report measures of general anxiety and fearfulness and dental fears using published scales (e.g., Spielberger Trait Anxiety Inventory, Spielberger, Gorsuch, & Luchene, 1983; Dental Fear Survey, Kleinknecht, Klepac, & Alexander, 1973). Dentally anxious individuals in Group I did not differ significantly from a non-clinical population with respect to general levels of anxiety and fearfulness, but reported more fear of pain, blood, and injury with an aversion to dental procedures. Group II participants appeared to have multiple phobias although they were not generally anxious. They also had significant blood and injury fears, and are described as showing "the most marked physiological response to dental care" (p.35), although Locker et al. do not indicate whether this group had a tendency to faint during dental procedures. The remaining groups showed an increasing tendency to multiple fears and general anxiety, with Group IV presenting the most complex of their diagnostic categories with responses indicating symptoms they considered to be indicative of a significant psychiatric disorder. The findings of this study suggest that blood-injury-illness phobics could be similarly classified. If this is so, it would appear that the participants in treatment studies by Öst and colleagues are most likely to fit into Groups I or II, since there seems to be no psychiatric comorbidity of note. In addition, in Hellstrom et al.'s study, a number of participants were recruited through newspaper advertisements. This suggests that they were either highly motivated to overcome their fears, or that the incapacity caused by their phobia was not of sufficient intensity to cause disruptions in normal functioning, or to have come to the notice of their physician (as other participants had). For these reasons, the samples in these studies may not be representative of typical blood-injury-injection phobics.

The diagnostic categories identified by Locker et al. have intuitive appeal in terms of how one might consider blood-injury-injection phobics. The literature also lends support to the criticism that Öst's samples have not been typical of phobics presenting in clinical settings. In her description of cognitive-behavioural approaches to the treatment of phobias, Butler (1989) proposes that personality disorder is a complicating factor in treatment. Anxiety disorders are particularly common in
individuals with dependent personality disorders (Beck, Freeman, & Associates, 1990). Dependent personality disorders are typified by a pervasive pattern of dependent and submissive behaviour, beginning by early adulthood and present in a variety of contexts. People diagnosed with dependent personality are described as being particularly prone to separation anxiety since they exhibit heightened dependency on others, and that “Panic attacks may occur as they anticipate and dread new responsibilities that they do not believe they can handle” (p.286, Beck, Freeman & Associates, 1990). These observations suggest that treatment of a phobia cannot be considered adequate unless it also addresses these personality issues.

Beck also describes somatic complaints in dependent personality disorder, and cites Hill (1970) in a study of passive-dependent women with somatic complaints leading to much attention from family and professionals. Based on clinical experience, there seems sufficient reason to accept these suggestions. These factors fit with Butler’s advice for the therapist to ascertain whether there are reasons why the person might prefer to live with their phobia since greater independence may be perceived as threatening. It has been argued that phobias: “elicit care and protection, as well as enabling avoidance of responsibilities, providing secondary gains are fully consonant with the individuals’ basic dependent orientation” (Millon, 1981). When quizzed about the Axis I and II status of individuals treated with applied tension, Öst maintained that there was no comorbidity of note (Öst, 2004).

According to Reich, Noyes, & Troughton (1987), dependent personality disorder is the most frequent Axis II diagnosis in phobic avoidance. In a review of factors for the development of avoidance in panic disorder, Clum and Knowles (1991) suggest that there is evidence to suggest that avoidant panic patients have more dependent personality traits than those without (eg. Brehony & Geller, 1981; cited in Clum & Knowles, 1991). Since exposure to feared stimuli is an essential part of applied relaxation treatment for BII, there is support for Butler’s (1989) view that personality disorders (such as avoidant or dependent) is a likely complication in the treatment of phobias in general and one that is unlikely to be addressed by the procedures prescribed by Öst and colleagues.
What other factors should be taken into account to provide a comprehensive treatment for blood-injury-injection phobia?

For the effective cognitive-behavioural treatment of phobias, Butler (1989) stresses the importance at looking at maintaining factors rather than obtaining a detailed history of its development. Avoidance is usually the main maintaining factor, but that cognitive factors are also important eg. Thoughts about the dangerousness of the stimulus. Since avoidance is a key issue, real-life exposure is important. Considering the cognitive aspects of treatment for phobias in general (rather than BII), Butler suggests that there are 3 main cognitive biases in the maintenance of phobias that should be identified and modified in therapy:

1. **Biases which affect the past**, eg. Remembering events that have been particularly significant or associated with strong emotions, and how it is relatively easy to recall past events associated with that mood. She advises that the therapist should attempt to restore perspective by helping person remember positive aspects of the situation (eg. “Although I felt anxious and thought I was about to faint, I didn’t actually pass out and the injection was over very quickly. It was such a lovely day, I went for a walk in the hospital grounds”).

2. **Biases affecting the present**, eg. Being hypervigilant. In most anxiety disorders, hypervigilance is counterproductive and maintains symptoms. It is often helped by relaxation training or distraction.

3. **Misinterpretation**, eg. anxious people have a tendency to interpret events in a threatening way.

Although this approach to the cognitive-behavioural treatment of phobias may seem quite dated, it is still based on collaborative empiricism as proposed by Beck (eg. Beck, 1976; Beck, 1993). Despite Öst and Hellstrom’s reference to the applied tensions treatment protocol (Öst & Hellstrom, 1997) as a “good cognitive-behavioural treatment” (p.76), it lacks any attempt at identifying or modifying cognitions that might be relevant to the development and maintenance of blood-injury-injection phobia. Their published studies in general omit to discuss in much detail the types of cognitions BII phobics report. Although they have not used a rating scale specifically
for BII, responses from self-report measures they have used would help identify fearful cognitions. This presents a major weakness in their treatment approach since there is much evidence to support the view that cognitive factors play an important role in specific phobias (e.g., Thorpe & Salkovksis, 1995; Thorpe & Salkovskis, 1998), and it has been long identified that some phobic patients continue to remain anxious or avoidant following purely behavioural interventions. Kent (1985) emphasised this very point in his study of cognitive processes in dental anxiety, and concluded that dental anxiety is resistant to extinction because it is maintained and intensified through the interaction of anticipation of negative experiences at the dentist that leads to an increase in anxiety. Because they are anxious, they are more likely to recall past unpleasant dental experiences that means they are less likely to return for dental treatment. The vicious circle is completed as their avoidance of essential dental care causes them to anticipate further negative experiences (e.g., painful, more invasive interventions). There are many similarities here with the cognitive biases described by Butler (1989) above. Whilst Öst, Fellenius, & Sterner (1991) do not directly address cognitive factors during treatment, they conclude that the rationale given for treatment (that the phobic patient will be trained in an effective strategy for increasing blood-pressure which can be swiftly applied to prevent fainting) is not necessarily the mechanism for change. They observed that following successful treatment, self-confidence improved and they exhibited a more positive mind-set.

Other studies have placed a greater emphasis on cognitive factors in the treatment of BII phobias. A case study by Panzarella and Garlipp (1999) describes the integration of cognitive techniques into a behavioural treatment. The case they presented was considered atypical of blood-injury-injection phobia since the woman described had never fainted. There was extensive avoidance of medical and dental care. Whilst treatment commenced with a verbal introduction to the behavioural components of treatment (relaxation, desensitisation and flooding), the use of a thought diary was introduced in the second session. This seemed to be the main 'cognitive' feature of the therapy, although there was some attempt at cognitive restructuring through role play and re-evaluating beliefs. However, the cognitive techniques appeared to be applied as an additional strategy in therapy, and did not seem to be integrated into a comprehensive cognitive-behavioural formulation. By the end of treatment the patient
made significant improvements and managed to accomplish her most feared target (venipuncture and a flu injection). Although some cognitive changes had clearly occurred, this may have been an artefact of therapy since cognitive approaches were less evident. An alternative explanation may be that having helped the patient identify negative appraisals and provide some opportunity to practice challenging them was sufficient for the patient to learn to apply these strategies for herself. It is also likely that identifying fearful cognitions and beliefs enabled the therapist to better tailor exposure to the patient’s needs.

The treatment approaches for BII phobia considered so far appear to be based on the assumption that exposure is a necessary condition for the reduction of anxiety, even in those treatments emphasising the importance of cognitive factors. It has been argued that whilst exposure to feared stimuli can be sufficient for fear reduction it may not be a necessary condition (De Silva & Rachman, 1981). A further case study describing cognitive behavioural treatment of an injection phobia places a major emphasis on identifying thoughts and emotions, and transforming meaning through a range of cognitive strategies (Perczel-Forintos & Hackmann, 1999). The design of therapy appears almost a mirror image of the study by Panzarella & Garlipp (1999), in that the use of cognitive techniques appears to be the essential mechanism in fear reduction. Although behavioural experiments involve exposure to feared situations, they are not applied systematically as a graded hierarchy but are promoted as opportunities to discover important information about the phobic patient’s fears and test out cognitive changes that had occurred through the use of discussion techniques. Perczel-Forintos and Hackmann are critical of behavioural theory, and assert that it provides a simplistic view of phobias with little explanatory value. The use of imagery is claimed to be a pivotal aspect of the treatment. It could be argued that this is simply imaginal exposure, as the phobic patient was asked to recall an earlier aversive experience of being given unexpected injections at the dentist which caused anxiety so extreme she thought she would die. However, the mechanism for change appears not to have been habituation to the image since this exercise was not repeated, but the way in which meanings attached to the situation were changed. As a result of this intervention, the patient’s perceived ability to cope increased (this has parallels with the observations of Öst, Fellenius, & Sterner, 1991). Moreover, she felt
better equipped to face previously feared situations involved injections, despite exposure having been a minimal part of therapy.

**Summary and Conclusion**

This review has attempted to address the question whether applied tension is a sufficient treatment to promote fear reduction in the treatment of blood-injury-injection (BII) phobia. Although blood-injury-injection phobia is categorised as a subset of specific phobias (APA, 1994), its key defining feature sets it apart from other phobias in that it is frequently accompanied by a rapid decrease in blood-pressure and heart-rate result in fainting. The treatment of choice is considered to be applied tension in conjunction with graded exposure (eg. Hellstrom, Fellenius, & Öst, 1996). Whilst there is much evidence for the effectiveness of this approach, total confidence in the results of treatment cannot be assumed. A major criticism of these studies is that participants do not appear to be representative of BII phobics. Other studies investigating dental anxiety (a phobia that has many features in common with BII phobia) provides evidence that people fearful of dental and medical procedures are not a homogeneous group, but range from those whose fears are very circumscribed to the phobic situation and are not generally anxious to those likely to who have other significant psychiatric difficulties (Locker, Liddell, & Shapiro, 1999). Other authors also suggest that anxiety disorders are more common in individuals with dependent personality disorders (eg. Beck et al., 1990). Butler (1989) provides an outline of cognitive-behavioural therapy for phobias, and stresses the importance of cognitions in the onset and maintenance of phobic anxiety. There is further evidence of the importance of cognitions in blood-injury-injection phobias from theoretical publications as well as treatment studies, and it is clear that the inclusion of strategies for cognitive change are an important development in treatment.

The conclusion to be drawn from this review is that whilst Öst and Hellstrom (1997) describe their treatment as an example of good cognitive-behavioural therapy, cognitive changes that may occur are not the result of a direct cognitive intervention. Whilst there is good evidence for the effectiveness of applied tension as a treatment of
blood-injury-injection phobia, research has shown that it cannot be sufficient to promote and maintain improvements.
References


Abstract:

Measures of competence in cognitive-behaviour therapy have been in existence from 1980, most notably those of Young and Beck (1980, 1988) and more recently by Blackburn, James, Milne, Baker, Standart, Garland, and Reichelt (2001). Whilst the Young and Beck measures were devised for assessing competency in the cognitive treatment of depression, it has been used as a disorder-wide measure of general cognitive-behaviour therapy (CBT) skill. Blackburn et al. have taken this shortcoming into account and have demonstrated reliability across the spectrum of psychological disorders. Whilst such measures may provide a useful means of assessing developing skills of therapists undergoing training in CBT, it may be argued that they are not sufficiently sensitive to the discrete skills and techniques which may be unique to the treatment of a particular disorder. In particular, it is argued by many researchers (eg. Startup, Jackson, and Pearce, 2002) that there is a need for measures of therapist skill and competence that is specific to individual disorders in order to further enhance the claims of several randomised control trials which offer evidence that CBT is the most effective treatment (eg. For panic disorder (Clark, Salkovskis, Hackmann, Middleton, Anastasiades, & Gelder, 1994), in schizophrenia (eg. Thornicroft & Susser, 2001; Haddock, Tarrier, Spaulding, Yusupoff, Kinney, & McCarthy, E, 1998), obsessive-compulsive disorder (eg. Abramowitz, 1997).

This study describes the development of a new scale to measure integrity of the treatment of obsessive-compulsive disorder (OCD-CTS) and tests its reliability. Twenty video-tapes obtained from therapists experienced in the cognitive-behavioural treatment of OCD were
assessed. Therapists were asked to choose tapes which, in their subjective opinion, represented a 'good' and 'bad' CBT session with each patient. As a control group, 9 videotapes of 'good' behaviour therapy (exposure and response prevention) from the participating therapists were also assessed.

The results show that the OCD-CTS demonstrates good discriminant validity as sessions identified as 'good' by the therapists were rated as significantly better than those identified as 'less good'. The comparison of CBT and ERP also showed significant differences. Inter-reliability for total and specific items were also found to be significant, but just missed significance for general items.
Assessing quality in the treatment of obsessive-compulsive disorder: the
development of the Obsessive-Compulsive Disorder Cognitive Therapy Scale
(OCD-CTS)

Introduction:

Background
There has been a growing demand for short-term, evidence based psychological treatments. In particular, cognitive-behaviour therapy has demonstrated a phenomenal growth in popularity (eg. Freiheit & Overholser, 1997) particularly as it has provided an increasing body of evidence of its efficacy for many psychological disorders (eg. panic (Clark, Salkovskis, Hackmann, Middleton, Anastasiades, & Gelder, 1994), depression (eg. Scott, 1995), schizophrenia (eg. Thornicroft & Susser, 2001), obsessive-compulsive disorder (eg. Abramowitz, 1997). This has led to an increase in the number of therapists seeking training in cognitive-behaviour therapy, and also in the number of qualified therapists who would describe their approach as cognitive-behavioural, although they have undergone no formal training. There is also an increasing emphasis on dissemination of the therapeutic skills developed and advocated in the treatment of these individual disorders. These factors raise the issue of how competence in cognitive-behavioural therapy can be adequately assessed. Assessing outcome of training in CBT is one issue. A further consideration is integrity of treatment in treatment trials.

Cognitive-behavioural therapy prides itself on being an evidence-based approach. The numerous outcome studies use objective, well-validated measures to evaluate their efficacy. Whilst outcomes are relatively straightforward to assess, adherence to treatment protocols has often not been subjected to the same rigorous scrutiny, not least because of the difficulties in doing so (eg. Startup & Shapiro, 1993). The first attempt to systematically evaluate the integrity of cognitive therapy was Young and Beck’s Cognitive Therapy Scale (1980, and a
revised version in 1988). It was developed to assess therapists' skills in the cognitive-behavioural treatment of depression, although it has subsequently been utilized as a general measure of cognitive therapy skill (eg. To measure emerging competency of trainees on Cognitive Therapy Training courses). The 1988 version has been the most widely used, and its format became the basic standard for other measures of CBT skill that have subsequently been developed. However, until recently no other scale had been a contender for such widespread use. As Blackburn et al. (2001) state, a measure of competence is required that assesses adherence to CT methods and levels of skilfulness in the application of these methods in order to demonstrate the effectiveness of training.

Few, if any of randomised control trials have provided adequate demonstrations of therapist adherence to treatment manuals. The importance of doing so should not be underestimated. A common criticism of outcome studies is that it is often difficult to replicate the results of randomised controlled trials. There is a need to be able to objectively evaluate the intervention to provide evidence of comparability. In a review of treatment fidelity of studies published in several major psychology journals in the period between 1980 and 1988, Moncher and Prinz (1991) report that the majority of studies did not report the use of treatment manuals, supervision of therapists, or any check of adherence to treatment protocol. Only 18.1% checked adherence to protocol, and of these approximately 23% were subjective evaluations by either the therapist or patient. It should be noted that these studies were selected from four general domains: clinical psychology, behaviour therapy, psychiatry, and marital and family therapy.

If treatment outcome studies report positive findings, it is necessary to be certain that the results are due to an effective intervention rather than some idiosyncratic, random or prescribed variables or techniques (such as teaching breathing control in cognitive-therapy for panic disorder) in therapy. Conversely, if the treatment approach has not been found to be effective (although negative findings tend to be underreported in the literature) it is critical to
identify whether the treatment really was ineffective or just poorly delivered (Moncher & Prinz, 1991). Referring to Kazdin, 1986, Moncher & Prinz caution that it is possible for treatments to have high integrity, but not to be sufficiently distinct. Startup, Jackson, Pearce (2002) comment similarly and again cite Kazdin (1986): ...“It is possible for treatments to differ but still not be implemented as intended, or for treatments to be implemented as intended but still not be sufficiently distinct”. This observation should be borne in mind whilst considering the properties of the available scales. It raises several questions about what an appropriate and comprehensive measure of competency in CBT should consist of.

The following sections describe and discuss rating scales used for rating general competency in CBT (which shall be referred to as pan-disorder measures since they are not specific to the treatment of a particular psychological disorder) and those devised for measuring competency in the cognitive-behavioural treatment of specific disorders.

A brief overview of pan-disorder measures of Cognitive Therapy Skill:

The Cognitive Therapy Scale (CTS)
As stated earlier, the Cognitive Therapy Scale (Young & Beck, 1980, 1988) was the first attempt to systematically evaluate the integrity of cognitive therapy and was adopted as a scale to measure general competence in CBT skills, rather than exclusively in the treatment of depression for which it was originally designed.

The original 1980 version of the CTS consisted of 11 dimensions. These dimensions are divided into 2 major sections measuring: i) general interpersonal and relationship factors (a total of 6 items) and ii) use of cognitive therapy techniques (5 items). This version has been validated by Dobson, Shaw, & Vallis (1985), and their results are described in more detail below. A further two dimensions were added to the 1988 version to include items about professionalism and use of guided discovery. A further revision divided the items into three
sections:

i) General interview procedure (items 1 – 4)

ii) Interpersonal effectiveness (items 5 – 7)

iii) Specific cognitive-behavioural techniques (items 8 – 13)

These items are listed in Table 1 below:

<table>
<thead>
<tr>
<th>Table 1: Items on the Cognitive-Therapy Scale (CTS) (Young &amp; Beck, 1988)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Agenda setting</td>
</tr>
<tr>
<td>2. Eliciting feedback</td>
</tr>
<tr>
<td>3. Collaboration</td>
</tr>
<tr>
<td>4. Pacing and efficient use of time</td>
</tr>
<tr>
<td>5. Empathic skills</td>
</tr>
<tr>
<td>6. Interpersonal efficiency</td>
</tr>
<tr>
<td>7. Professionalism</td>
</tr>
<tr>
<td>8. Guided discovery</td>
</tr>
<tr>
<td>9. Conceptualisation</td>
</tr>
<tr>
<td>10. Focus on key cognitions</td>
</tr>
<tr>
<td>11. Application of cognitive techniques*</td>
</tr>
<tr>
<td>12. Application of behavioural techniques</td>
</tr>
<tr>
<td>13. Use of homework</td>
</tr>
</tbody>
</table>

The items were assessed using a 7-point Likert-type scale, and the scale values are accompanied by detailed descriptions of observable therapist behaviours. An example of an item from the section rating specific cognitive-behavioural techniques is as follows:
8. Use of Guided Discovery

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>The therapist relied primarily on debate, persuasion, or lecturing. Therapist seemed to be cross-examining the patient. Patient appeared on the defensive as therapist appeared to force his/her view on the patient.</td>
</tr>
<tr>
<td>2</td>
<td>Therapist relied heavily on persuasion and debate rather than on guided discovery. Therapist’s style was supportive so that patient did not seem to feel attacked or defensive.</td>
</tr>
<tr>
<td>4</td>
<td>Therapist, for the most part, worked to help the patient see new perspectives through guided discovery rather than debate. Used a primarily questioning format.</td>
</tr>
<tr>
<td>6</td>
<td>Therapist was adept at using guided discovery. Used a questioning format in the therapy and worked to assist the patient in reaching conclusions.</td>
</tr>
</tbody>
</table>

Items and ratings are further elucidated in a rating manual. However, some authors are critical of the scale. Whisman (1993) asserts that one of the limitations of the scale is that the rater is required to make inferences regarding the different levels of the scale because only alternate points on the scale are defined (ie. scoring criterion for 0, 2, 4 and 6) which leaves the remainder open to the vagaries of interpretation by individual raters. For this reason, Blackburn et al. (2001) claims that ratings on the CTS do not discriminate well between different levels of competence. Similarly, Haddock et al. (2001) propose that “raters require a good knowledge of CBT principles and practice to use this scale”, thus inferring that it may not be reliable in the hands of a novice rater. This seems to contradict the reliability reported of the original version of the CTS in the investigation of its psychometric properties conducted by Dobson, Shaw, & Vallis (1985). Indeed, even with extensive experience of cognitive-behaviour therapy, it is not obvious what would constitute a score of, say, 1 or 3: if
the therapist did not seem to be 'cross-examining' the patient thus causing the patient to be
defensive, but was not using guided discovery, should this attract a score of 1? Another
possibility is that the therapist used guided discovery most of the time, but occasionally
lapsed into quite heavy debate akin to cross-questioning. The dilemma arises whether this
should be rated as 3 since although guided discovery was used most of the time (which rates
as 4), there was still substantial evidence of debate (which rates as 2). However, because the
therapist’s style had at times been quite hectoring, should the item be rated lower to reflect
this (a rating of 1), but not as low as zero since there is some evidence of acceptable guided
discovery skills.

In their study, Dobson, Shaw, and Vallis (1985) summarise the requirements of a measure
of the quality of cognitive therapy thus:

"In addition to the techniques of cognitive therapy, the conduct of any
psychotherapy rests upon the general interpersonal skills of the therapist. The
therapist-patient collaboration or alliance is deemed to be as essential in cognitive
therapy as in other therapeutic modes (Beck, Rush, Shaw, & Emery, 1979; Arnkoff,
1983). There is an explicit recognition of the need for the therapist to be warm,
understanding and empathic (Rogers, 1957; Truax & Carkhuff, 1967), while, at the
same time, holding a clear conceptualisation of the patient's syndrome and
experiences and initiating procedures to effect therapeutic progress".

(p. 295)
From this perspective, the Cognitive Therapy Scale (CTS) devised by Young and Beck (1980, 1988) would appear to be sufficient as these factors are reflected in the following items:

- General interpersonal skills – items 1, 4, 5, 6, 7
- Therapist-patient alliance – items 3, 5, 6, 7
- Empathy and warmth – items 2, 3, 5
- Clear conceptualization of the patient’s problem – items 8, 9
- And of their experiences – items 8, 9, 10
- Initiating procedures to effect therapeutic progress – items 8, 10, 11, 12, 13

It can be seen that there is much overlap, with many of the above qualities reflected in a number of items, although it appears that they may conform to what Dobson, Shaw, & Vallis describe as two “rationally defined” sections (general interpersonal and relationship factors (a total of 6 items) and use of cognitive therapy techniques (the remaining 5 items on the original scale).

To establish reliability of the CTS, Dobson, Shaw and Vallis analysed: i) inter-item correlations, ii) item-total score correlations, and iii) inter-rater reliabilities. They found that the majority of CTS items (apart from “Homework”) correlated highly with total scores. They conclude that this is evidence that the CTS largely measures one construct, and go on to hypothesise that it may be that the two “rationally defined” sections are not in fact independent. This lends support to the observation above that there is much overlap between items, and in fact Whisman (1993) criticised the scale because of the way in which multiple concepts were addressed by one item. The CTS was also found to have high inter-rater reliability for total scores. This means that reasonable confidence could be assumed in the total scores provided by other comparable raters (in this case, they were experienced cognitive therapists). However, inter-rater reliability for individual items was found to be
more variable (from moderate to strong). Dobson and colleagues note that this may be of importance owing to the possibility that the raters may have arrived at comparable total scores but for different reasons, warning that if that were so, "the predictive validity of the CTS will be productive only for total scores, and individual items may not be reliable enough for examination of their prediction validity" (p. 299). A summary of their results is shown on Table 2.

The Revised Cognitive Therapy Scale (CTS-R)
The Revised Cognitive Therapy Scale (CTS-R) was devised by Blackburn et al. (2001) to improve on the 1988 version of the CTS (Young and Beck, 1988). Their version attempted to eliminate overlap between items, improve the scoring system, and define individual items more clearly. Unlike the CTS (which measures only competence), the CTS-R combines the measurement of adherence to a particular therapy protocol and competence. It also includes measures of general therapeutic skills. The authors describe their specific aims as: i) to devise a rating scale which is defined at every point of the scale and is based on existing scales of acquisition, ii) to base the scale "on the principles that competence consists not only of adherence to prescribed CT methods and of skillfulness in the application of these methods, but also a pan-theoretical component, which is the therapeutic alliance" (p.434), and iii) to assess the psychometric status of the CTS-R.

The first stage of Blackburn et al.'s revision of the CTS was to define competence from a 'pantheoretical' viewpoint. Video-taped therapy sessions by 'expert' cognitive therapists were rated by two independent raters, neither of whom were CT practitioners (one was a clinical psychologist and the other from a non-therapy profession). No definition of 'expert' is given in this context, although it can be assumed that they were drawn from the therapists with extensive clinical, teaching, and supervisory CBT experience on the Newcastle Post-Qualification Certificate in Cognitive Therapy Course who were involved in the later stages of development of the CTS-R.
### Table 2: A Summary of the Psychometric Properties of Various Cognitive Therapy Rating Scales

<table>
<thead>
<tr>
<th>Title of Scale</th>
<th>Generic or Specific Disorder</th>
<th>Disorder(s) upon which psychometric properties assessed</th>
<th>Total no. of items</th>
<th>No. of specific CBT skills</th>
<th>No. of points on scale</th>
<th>Sample size</th>
<th>Reliability</th>
<th>Internal Consistency</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTS (Young &amp; Beck, 1980)</td>
<td>Generic</td>
<td>Depression</td>
<td>11</td>
<td>5</td>
<td>7</td>
<td>N=42</td>
<td>TOTAL 0.94</td>
<td>0.95</td>
</tr>
<tr>
<td>CTS-R (Blackburn et al., 2001)</td>
<td>Generic</td>
<td>Depression, Social Phobia, Panic, OCD, GAD</td>
<td>14</td>
<td>7?</td>
<td>7</td>
<td>N=102?</td>
<td>TOTAL 0.63</td>
<td>(p&lt;.001)</td>
</tr>
<tr>
<td>CTACS (Barber, Liese, &amp; Abrams, 2003)</td>
<td>Generic</td>
<td>Cocaine dependency</td>
<td>25</td>
<td>9?</td>
<td>7</td>
<td>N=134</td>
<td>Total sample: Adherence 0.80, Competence 0.80</td>
<td>Competence 0.93</td>
</tr>
<tr>
<td>CTS-Psy (Haddock et al., 2001)</td>
<td>Psychosis</td>
<td>Psychosis</td>
<td>10</td>
<td>5</td>
<td>7</td>
<td>N=24</td>
<td>TOTAL 0.94</td>
<td>General Skills 0.95, Technical Skills 0.80</td>
</tr>
<tr>
<td>CTPAS (Startup et al., 2002)</td>
<td>Psychosis</td>
<td>Psychosis</td>
<td>12</td>
<td>12</td>
<td>7</td>
<td>N=29</td>
<td>&gt;0.7 for 9 items (not clear for others)</td>
<td>0.47</td>
</tr>
</tbody>
</table>
Taking the recommendations of the independent raters into account and their own experiences of using the CTS, Blackburn and colleagues revised the scale. Most of the items from the CTS were retained, although Empathic Skills (item 5), Interpersonal Efficiency (item 6), and Professionalism (item 7) were amalgamated into a single item on the CTS-R that they called Interpersonal Effectiveness as Blackburn et al. considered them to have substantial overlap. This seems a sensible revision for a further reason: they are more diffuse skills that could be reasonably assumed to occur in a competent therapy session, regardless of theoretical orientation (Blackburn et al.'s concept of a pan-theoretical component referred to earlier), rather than competencies specific to the practice of CBT and as they note, 'Professionalism' is "not discriminatory among mental health professionals and [is] also legitimately part of 'Interpersonal Effectiveness'" (p.436). The CTS-R items are listed in Table 3 below:
Table 3: Items on the Revised Cognitive-Therapy Scale (CTS-R)

<p>| | |</p>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Agenda setting</td>
</tr>
<tr>
<td>2.</td>
<td>Feedback</td>
</tr>
<tr>
<td>3.</td>
<td>Collaboration</td>
</tr>
<tr>
<td>4.</td>
<td>Pacing and efficient use of time</td>
</tr>
<tr>
<td>5.</td>
<td>Interpersonal effectiveness</td>
</tr>
<tr>
<td>6.</td>
<td>Charisma/ flair</td>
</tr>
<tr>
<td>7.</td>
<td>Facilitation of emotional expression</td>
</tr>
<tr>
<td>8.</td>
<td>Guided discovery</td>
</tr>
<tr>
<td>9.</td>
<td>Conceptualisation</td>
</tr>
<tr>
<td>10.</td>
<td>Identifying key cognitions</td>
</tr>
<tr>
<td>11.</td>
<td>Application of cognitive change methods</td>
</tr>
<tr>
<td>12.</td>
<td>Application of behavioural techniques</td>
</tr>
<tr>
<td>13.</td>
<td>Use of homework</td>
</tr>
<tr>
<td>14.*</td>
<td>Non-verbal behaviour</td>
</tr>
</tbody>
</table>

*Item 14 is described as optional as it can only be rated from videotapes.

The most important revision of the CTS that Blackburn and colleagues have made is to the rating system. Whilst retaining the same 7-point scale, Blackburn et al. modified the original descriptions but, most notably, added descriptions to the interim points on the scale. To further elucidate competencies measured by each item, it is preceded by a full description of the function and features of that particular skill. An example of this is shown in Table 4 below:
Table 4: Item 7 – Eliciting key cognitions

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

Three features need to be considered:

(i) eliciting cognitions that are associated with distressing emotions (ie. Selecting key cognitions or hot thoughts);

(ii) the skillfulness and breadth of the methods used (ie. Socratic questioning; appropriate monitoring, downward arrowing, imagery, role-plays, etc.);

(iii) choosing the appropriate level of work for the stage of therapy (ie. Automatic thoughts, assumptions, or core beliefs).

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

<table>
<thead>
<tr>
<th>Competence Level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Therapist fails to elicit relevant cognitions.</td>
</tr>
<tr>
<td>1</td>
<td>Inappropriate cognitions and emotions selected, or key cognitions/emotions ignored.</td>
</tr>
<tr>
<td>2</td>
<td>Some cognitions/emotions elicited, but links between cognitions and emotions not made clear to the patient.</td>
</tr>
<tr>
<td>3</td>
<td>Some cognitions/emotions (or one key cognition) elicited in a competent way, although some problems evident.</td>
</tr>
<tr>
<td>4</td>
<td>A number of cognitions/emotions (or one key cognition) elicited in verbal or written form, leading to a new understanding of their relationship. Minor problems evident.</td>
</tr>
<tr>
<td>5</td>
<td>Effective eliciting and selection of a number of key cognitions/emotions (or one key cognition), which are generally dealt with appropriately. Minimal problems.</td>
</tr>
<tr>
<td>6</td>
<td>Excellent work done on key cognition(s) and emotion(s), or very good work done in the face of difficulties.</td>
</tr>
</tbody>
</table>

From James, Blackburn, & Reichelt (2001)
The detailed scoring manual further elaborates the descriptions, provides examples, and suggests further questions that raters should consider in order to make an accurate rating. Blackburn et al. (2001) then investigated the psychometric properties of the CTS-R. CBT experts used the scale to rate 102 videotapes. The tapes were obtained from 21 therapists undergoing training in CBT of treatment sessions with patients with a range of psychological disorders (depression, social phobia, panic, obsessive-compulsive disorder, and generalized anxiety disorder). Three tapes were obtained for each patient to reflect competencies at different stages of therapy. Their results demonstrate high internal consistency. Discriminant validity was demonstrated by the way in which improvement in scores was found from initial to later sessions, which Blackburn et al. propose reflects trainees’ emerging skill during training. Overall, inter-rater reliability was found to be highly significant, although much variation was found between pairs of raters ranging from highly significant to non-significant levels. The results are summarized in Table 2. Blackburn et al. conclude that it is difficult to achieve high inter-rater reliability, that even expert raters find it hard to concur about what constitutes demonstrable competency in any given skill, and that despite their attempts to fully describe each level on the rating scale interpretations by raters contain idiosyncracies.

The Cognitive Therapy Adherence and Competence Scale (CTACS)

The Cognitive Therapy Adherence and Competence Scale (CTACS) was devised by Barber, Liese, and Abrams (2003). Although like the CTS-R (Blackburn et al., 2001) it is based on the CTS, the authors claim that it “attempts to provide a wider coverage of cognitive-therapists’ activities”. It is a 25-item scale with a variety of items to cover 5 domains as follows:
1. Cognitive Therapy Structure (9 items)
2. Development of a collaborative therapeutic relationship (6 items)
3. Development and application of the case conceptualization (6 items)
4. Cognitive and behavioural techniques (3 items)
5. Overall performance (1 item)

A full list of items of the CTACS is shown in Table 5 below:

<table>
<thead>
<tr>
<th>Table 5: Items of the Cognitive Therapy Adherence and Competency Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Item no.</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td><strong>Cognitive Therapy Structure</strong></td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
</tr>
<tr>
<td>6.</td>
</tr>
<tr>
<td>7.</td>
</tr>
<tr>
<td>8.</td>
</tr>
<tr>
<td>9.</td>
</tr>
<tr>
<td><strong>Development of a collaborative therapeutic relationship</strong></td>
</tr>
<tr>
<td>10.</td>
</tr>
<tr>
<td>11.</td>
</tr>
<tr>
<td>12.</td>
</tr>
<tr>
<td>13.</td>
</tr>
<tr>
<td>14.</td>
</tr>
<tr>
<td>15.</td>
</tr>
<tr>
<td><strong>Development and application of the case conceptualisation</strong></td>
</tr>
<tr>
<td>16.</td>
</tr>
<tr>
<td>17.</td>
</tr>
<tr>
<td>18.</td>
</tr>
</tbody>
</table>
Addressing key issues
Case conceptualisation
Sharing the conceptualization with patient

*Cognitive and behavioural techniques*

22. Guided discovery, use of open-ended questions
23. Asking for evidence/ alternative views
24. Use of alternative cognitive and behavioural techniques (rater to specify)

*Overall performance*

25. Overall performance as a cognitive therapist

Ratings on the CTACS were facilitated by descriptive anchors that varied for each item, but were on a continuum from 0 (none or poor) to 6 (thorough or excellent).

The CTACS was devised as a scale for assessing both therapists’ adherence to cognitive therapy for cocaine abuse and their competence in applying appropriate strategies and techniques. Investigations into its psychometric properties were carried out on audio-taped therapy sessions from this client group, rating a total of 134 sessions. Of these, 92 were cognitive therapy (CT) and 22 were of supportive-expressive dynamic therapy. It was found to demonstrate good criterion validity and was able to distinguish between CT and other psychosocial interventions. The study also concludes that inter-rater reliability is acceptable, and that it “compares favourably with other measures of adherence and competence” (eg. CTS; Vallis et al., 1986), and that it had good internal consistency. However, adherence and competence were found to be highly correlated on this scale despite the authors’ efforts to “capture the distinction between conducting an intervention at a suitable frequency and skillfully delivering the intervention”.

Barber, Liese, and Abrams conclude that the results of their study indicate that the CTACS may represent an improvement over the CTS since it measures both adherence and competence. It is proposed that although it was developed for assessing treatment for
cocaine-dependency it could be readily applied to assessing CT skill and adherence in treatment of other disorders, although further investigation is required to establish reliability and validity with different clinical populations.

**Is a generic measure of CBT competence sufficient?**

The scales considered above have many features in common, especially since the Cognitive Therapy Scale (CTS; Young & Beck, 1980, 1988) has provided the template for the subsequent development of both the CTS-R (Blackburn et al., 2001) and the CTAC (Barber, Liese, & Abrams, 2003). Both seem to compare favourably with the CTS in terms of psychometric properties, and have refinements that improve upon the original. For example, the CTACS covers 5 domains in an attempt to cover the breadth of both general (eg. therapeutic alliance) and specific cognitive-therapy skills (eg. Socratic questioning, case formulation) with more items overall to increase the sensitivity of the measure. The CTS-R also covers both general and specific CBT skills, and is exemplary in its development of detailed definitions for each item and each of the 7 anchor points on the rating scale. A further aspect that these scales have in common is that, although they are not dissimilar in content, they have been shown to have validity in the rating of treatment of very different disorders (although only Blackburn et al., 2001, have applied their scale across a range of diagnoses). Although this is commendable in many ways, it raises the question whether cognitive-behavioural therapy is a homogeneous activity where identical skills, techniques, and strategies would be drawn on regardless of the presenting problem, or do some disorders require quite specific strategies that may even be distinctive to the cognitive-behavioural treatment of that disorder.
In a discourse on the nature of competence, Blackburn et al. (2001) assert that:

"...competence may vary according to context variables, for example the type of presenting problems and characteristics of the patient, which may be taken into consideration in the rating scales"...

(Blackburn et al., 2001; p. 434)

This suggests that there may be ways in which the presentation of the patient, or their symptoms, and behaviours may compromise the therapist’s ability to apply CBT skills in some way. There also seems to be an implicit assumption that raters may have particular expectations of the skills and strategies they would expect to be applied according to the presenting problem (for example, an excellent panic conceptualization based on Clark (1996) could be completed in the session, but it would be undermined if the application of behavioural techniques involved breathing control (considered to be a safety-seeking behaviour; eg. Salkovskis, 1991). Thus it appears that there is a need to identify the salient characteristics of cognitive-behavioural therapy for different disorders.

A study by Startup & Shapiro (1993) attempted to identify the components of CBT that were the most important arbiters of change in CBT for depression. From their results, they conclude that it is important to introduce behavioural methods early in treatment in order to engage the patient, enable them to restore functioning, and lift mood. The importance of homework is thus emphasized. Focus on cognitions is deemed to be more appropriate once the patient is more engaged. They also suggest that the quality of the interpersonal relationship is only likely to emerge once these more concrete strategies have been adequately applied. These features pose methodological problems for a generic rating scale which may not be able to adequately the nuances that Startup and Shapiro observed in the treatment of depression, as components would feature to varying degrees at different points during treatment. A question thus arises whether there are components that are specific (or even
unique) to other disorders that should be taken into account, and that generic scales may be insufficiently sensitive to rate accurately or in a meaningful way.

If it is the case that appropriate CBT techniques are not universal across the disorders, it lends further credence to the assertion by Moncher and Prinz (1991), who contend that treatment fidelity consists of two related but distinct issues: adherence and competence. They define adherence as the degree to which therapists use the techniques proposed by the treatment protocol and avoid those that are proscribed. Whilst for the most part therapy sessions are not bound by the constraints of a ‘treatment protocol’ in the way that sessions in a treatment trial would be, CBT treatments are derived from established theories that encompass certain requirements. An example of this in relation to Moncher and Prinz’s view, the cognitive-behavioural approach to the treatment of panic is now well established (eg. Clark, 1986; Salkovksis, et al., 1997). It contains key components for its successful treatment which include identification and modification of catastrophic misinterpretations of bodily sensations (cognitive components), and behavioural experiments which include dropping safety behaviours and overcoming avoidance. If these components were present in a session, it would indicate adherence to the protocol. An example of a ‘proscribed’ technique in this instance might be the use of breathing control (see above). Competence is said to be less well defined, and is rather vaguely described by Startup, Jackson, & Pearce (2002) as “the degree to which therapists takes into account relevant aspects of the therapeutic context and respond to the context appropriately” (Waltz, Addis, Koerner, & Jacobson, 1993).

Cognitive-behavioural approaches to other psychological disorders also have specific requirements, or proscriptions. For example, the CBT approach to the treatment of psychotic symptoms in schizophrenia requires the implementation of specific intervention strategies for some features of the problem that are not a general feature of other disorders (Morrison, 1998). He explains that where the problems of psychotic patients are similar to those of non-psychotic patients (eg. lack of a social life, anxiety in certain situations, etc.) these would be treated in the same ways. However, the occurrence of delusions and hallucinations are a common symptom in psychosis but rare or absent in other disorders and require a particular
approach. The strategies used are derived from standard CBT skills, and still focus on identifying thoughts and feelings, verbal reattribution and the use of behavioural experiments. The difference is the focus of those strategies. An example of this is that a psychotic patient may misinterpret racing thoughts as an indication that they are under alien attack (Morrison, 1998). In such a situation, it would not be deemed appropriate to attempt to disprove this (in fact it would be proscribed), but to look at the meanings attached to the occurrence of the thoughts and provide a plausible alternative explanation of their experiences. This has similarities with the CBT approach to the treatment of obsessive-compulsive disorder, where it is the meaning attached to the occurrence of intrusive thoughts that is challenged rather than their content (eg. Salkovskis, Forrester & Richards, 1998a, Salkovskis, Richards & Forrester, 1995). A further consideration in the differences in delivery of CBT for different disorders is the timing of particular aspects of treatment. As cited earlier, the importance of behavioural activation early on in treatment of depression was identified (Startup & Shapiro, 1993). Yet in the treatment of OCD, the use of behavioural strategies may not occur until therapy is well underway and the patient has a grasp of the cognitive model and thus earlier sessions are likely to emphasise normalization of their obsessional experience (eg. Salkovskis, Forrester, Richards, & Morrison, 1998b). In psychosis, strategies for ‘keeping well’ are likely to feature throughout treatment as patients are encouraged to be mindful of prodromal signs (eg. Startup & Jackson, 2002). Such an emphasis may be considered a contra-indication in the treatment of anxiety disorders as it has the potential to increase attentional focus on bodily sensations (in panic or social phobia) or the occurrence of intrusive thoughts (in OCD). Whilst this is not an exhaustive account of the differences and idiosyncracies in the focus, timing, and choice of cognitive-behavioural techniques it lends weight that competent, skilled practice of CBT is not simply a matter of applying CBT methods in a systematic way, but that discernment is required in selecting appropriate strategies for effective therapy. This suggests that a broad measure of CBT competence or skill is likely to be insufficient when evaluating integrity of treatment for a specific disorder. It would appear, then, that there are a number of sound reasons for developing disorder specific rating scales. Whilst the CTS (Young & Beck, 1980, 1988) was originally devised to measure integrity in the treatment of depression, it was applied more commonly as a measure
of competence in the practice of CBT across many disorders. Startup, Jackson, & Pearce (2002) refer to what they describe as “the most thorough assessment of fidelity to date” by Sensky, Turkington, Kingdon, Scott, Scott, Siddle, O’Carroll, & Barnes (2000), but express doubts about the adequacy of the study which used the Cognitive Therapy Rating Scale (CTRS – also referred to as the CTS; (Vallis, Shaw & Dobson 1986)) since the scale was not designed to rate CBT for psychosis. Whilst the CTS-R (Blackburn et al., 2001) was specifically designed to be used to evaluate the effect of training on CBT skills, it remains a pan-disorder measure of competency and is likely to lack the necessary sensitivity to adequately assess adherence to and competence in the implementation of treatment protocols designed for specific psychological disorders. There seems to be sufficient evidence to support the development of therapist competency and adherence rating scales for specific disorders.

Disorder-specific Cognitive Therapy Rating Scales

Some researchers have devised their own scales that are intended to measure adherence to their particular treatment protocol (such as Startup, Jackson, & Pearce (2002) and Haddock, Devane, Bradshaw, McGovern, Tarrier, Kinderman, Baguley, Lancashire & Harris (2001) for psychosis). Others exist in an unpublished form (eg. Cognitive Behaviour Therapy for Panic Scale, Clark & Salkovskis, 1992). However, no suitable scale exists for obsessive-compulsive disorder. The importance of such scales is that they reflect the specific aspects of a treatment and take into account both standard and non-standard CBT strategies (eg. Haddock, et al., 2001). Such factors are particularly important in evaluating therapy conducted in treatment trials, where the ability to verify adherence is crucial. This is especially relevant to facilitating the replication of treatments, and where others seek to apply similar treatment approaches. For example, some preliminary studies have been done to assess the outcome of training health professionals other than those with a mental health
qualification to carry out treatments developed for particular disorders using treatment manuals (eg. Baker & Neimeyer, 2003). A means of measuring adherence and competence in such circumstances is crucial.

*The Cognitive Therapy Scale for Psychosis (CTS-Psy)*

The Cognitive Therapy Scale for Psychosis (CTS-Psy) was developed by Haddock, Devane, Bradshaw, McGovern, Tarrier, Kinderman, Baguley, Lancashire, and Harris (2001) to evaluate the outcome of training in psychosocial interventions with psychotic patients. At the time, there were no published scales specifically for that task. They considered the Cognitive Therapy Scale (CTS) (Young & Beck, 1980) to have a number of elements in common with those used in work with psychotic clients, and the development of the CTS-Psy resulted from a combination of clinical experience with this client group and the content of the CTS. The authors asserted that “CBT for psychosis clearly has many principles and actions in common with CBT for anxiety and depression although it does have a number of significant departures, mainly due to the nature of the psychotic disorder” (p.223). The aspects of psychosis which they considered to be major defining factors (eg. regulation of attention and arousal, and processing of cues in the social environment) tend to be more idiosyncratic and therefore require a more flexible approach in therapy. Similarly, the scale needed to have the capacity to accommodate the non-standard nature of some aspects of the treatment approach.

The CTS-Psy consists of 10 items, divided into two separate sections. Section I covers general issues in treatment:

a) agenda setting  
b) obtaining feedback  
c) therapist understanding  
d) interpersonal effectiveness  
e) collaboration.
Section II is concerned with specific therapeutic activities and techniques relevant to 
CBT for psychosis:

f) use of guided discovery
g) focus on key cognitions
h) choice of intervention
i) homework
j) quality of intervention

The items on the scale vary in how specific and discrete they are. For example, items (f) (use 
of guided discovery) and (i) (setting of homework) are very specific. By contrast, (h) is very 
loosely described to meet the authors’ requirement of adequate flexibility to suit the non-
standard aspects of the treatment approach. Items (f) and (h) are shown in Table 6 below, 
along with the coding key used.

Table 6: Examples from the Cognitive Therapy Scale for Psychosis (CTS-Psy)

<table>
<thead>
<tr>
<th>Coding key: 1 = appropriately included</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = inappropriately omitted</td>
</tr>
<tr>
<td>9 = appropriately omitted</td>
</tr>
<tr>
<td>(9 set to 1 in total score, 9 initially scored to give differentiation between</td>
</tr>
<tr>
<td>included and omitted)</td>
</tr>
</tbody>
</table>

f) Guided discovery

1 Therapist used questions to determine the meaning a client attached to an event or circumstance.
2 Therapist used questions to show incongruities or inconsistencies in patient’s conclusions without
demeaning the person.
3 Therapist used questions to help patient explore various facets of a problem.
4 Therapist used questions to examine patient’s arbitrary conclusions or assumptions.
5 Therapist used questions to elicit alternative ways of solving a problem.
6 Therapist used questions to consider alternative explanations.
h) Choice of intervention

1. Therapist selected cognitive-behavioural techniques of intervention.
2. The overall strategy was specifically related to the patient's problem.
3. Each individual cognitive-behavioural technique was relevant to one of the key problems of the patient.
4. Strategies used were directly related to a formulation.
5. The techniques chosen had demonstrable (via research evidence, etc.) potential for change with respect to the problems at which they were targeted.
6. Therapist sought adequate feedback from the patient regarding the strategy for change.

Instead of having individual anchor-points from which to select an appropriate rating, each item is divided into 6 discrete statements describing aspects of the intervention. Each item is scored as either appropriately present in the session (score = 1) or absent (score = 0). Thus a therapist performing at a very high level of CBT skill is likely to score on each of the statements (achieving up to a maximum of 6 points on each item). Where a strategy has not been applied, but it is deemed appropriately absent (for example, for item (a) Agenda, the therapist may have noted the patient's current emotional state with regard to agenda setting (score = 1), established an agenda (score = 1), prioritized agenda items (score = 1) which were appropriate for the time available (score=1), and discussed events or problems occurring since the previous session (score = 1) (a total of 5 out of a maximum 6). However, an unexpected crisis during the session meant that the agenda was not adhered to. In such an instance, it would have been inappropriate to attempt to adhere to the agenda. A coded score of 9 would be given, which is set to 1 in the total score, giving a total score of 6 (reflecting the highest level of CBT skill or competence).

The CTS-Psy exhibits a number of features that would facilitate its use. Haddock et al.'s use of a coding key provides a means of preventing inaccurately low scores in adverse therapy.
situations that the scales featured so far are unable to adequately measure. This represents a sensitive refinement in comparison with other scales (for example, in contrast to Young and Beck’s CTS where any omission, even if valid, would not be scored). This is particularly salient to the treatment of disorders where a flexible approach is vindicated.

A further helpful feature of the CTS-Psy is that individual steps or criterion are outlined for each item. This helps reduce ambiguity for raters since, for the most part, they describe discrete, observable therapist behaviours. However, some items are too loosely defined (see item (h) on Table 6 above for an example). Whilst adequate flexibility in the scale is a prerequisite, using such loose constructs is potentially problematic as it a) assumes that the rater will know which techniques are appropriate and relevant, and b) is open to interpretation which could lead to variance in scores. Also, there is the potential for a therapist who uses only one technique (but does it well) to be rated as skilled and/or competent as a therapist who manages to appropriately apply a range of techniques and strategies in the course of the sessions. Although high inter-rater reliability was found overall, only a moderate correlation was found for inter-rater reliability on scores for specific CBT skills. Consistent with the criticisms above, “choice of CBT intervention”, “feedback”, “focus on key cognitions”, and “guided discovery” are listed as those with the least consistency between raters. This may reflect the fact that criteria for these items are less well defined. Haddock et al conclude that the CTS-Psy is a useful tool for evaluating emerging competence during training in CBT for psychosis, and could also be employed to assess treatment fidelity during research trials.

The Cognitive Therapy for Psychosis Adherence Scale (CTPAS)
The Cognitive Therapy for Psychosis Adherence Scale (CTPAS) (Startup, Jackson, & Pearce, 2002) was devised in response to the outcome of several RCTs providing good preliminary evidence that CBT is effective in the treatment of schizophrenia. The authors noted that none of the trials they reviewed had provided complete demonstrations of therapist adherence, perhaps because no suitable rating scale existed at the time. They were critical of the use of
the CTS (which they refer to as the Cognitive Therapy Rating Scale or CTRS) because CBT for psychosis requires therapists to directly:

... “address clients’ psychotic symptoms and help them develop a shared understanding of the nature of their psychotic disorder”

and,

... “since the CTRS makes no mention of such content, therapists can score highly on this scale without focusing on psychosis at all if, for example, they focus instead on the depression, anxiety or traumas that often accompany psychotic disorders”

They are similarly dismissive of the CTS-Psy (Haddock et al., 2001) asserting that this scale also omits to focus on psychosis, despite the authors’ claims that it was devised to specifically “take into account the non-standard nature of some CBT work with psychotic clients and to take account of the way CBT has been adapted and developed for use with psychotic clients” (p.233).

The CTPAS consists of 12 items which aimed to capture the main therapist activities that were required to meet four out of six major clinical objectives outlined in the manual of CBT for psychosis by Fowler(1995) (cited in Startup, Jackson, & Pearce, 2002):

1. Facilitating adaptive strategies to cope with psychotic symptoms
2. Developing an understanding of psychosis in collaboration with the client
3. Modifying delusional beliefs and beliefs about voices
4. Relapse prevention and the management of social disability

(Startup et al., 2002)
The authors assert that Fowler's remaining clinical objectives (building and maintaining a therapeutic relationship and treating ingrained patterns of self-defeating thought and behaviour) could be adequately assessed using 36 items from the Cognitive Therapy (CB) and Facilitative Conditions (FC) subscales in the Collaborative Study Psychotherapy Rating Scale (Evans et al., 1984; Hill et al., 1992), and have not included items to rate the application of more general CBT skills or the therapeutic alliance. Table 7 below lists the items of the Cognitive Therapy for Psychosis Adherence Scale (CTPAS):

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recognising problems</td>
<td>... help the client recognize or acknowledge he/she was experiencing problems?</td>
</tr>
<tr>
<td>2. Assessing psychotic experiences</td>
<td>...assess antecedents, consequences, quality and impact of the client’s psychotic experiences?</td>
</tr>
<tr>
<td>3. Enhancing self-regulatory strategies</td>
<td>...help the client improve self-regulatory strategies or review effectiveness of strategies previously discussed or practiced?</td>
</tr>
<tr>
<td>4. Evidence for delusional beliefs</td>
<td>...assess the evidence the client uses to support his/her delusional beliefs?</td>
</tr>
<tr>
<td>5. Columbo style</td>
<td>...help the client explain his/her reasons for holding a belief by apologizing for being confused but then carefully questioning to gain the details?</td>
</tr>
<tr>
<td>6. Developing a narrative perspective</td>
<td>...help the client construct a narrative account of his/her experiences as a meaningful sequence of events, and to develop and explore this narrative?</td>
</tr>
<tr>
<td>7. Verbal challenge of delusions</td>
<td>...challenge the client’s beliefs through discussion?</td>
</tr>
<tr>
<td></td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td>8. Validity testing</td>
<td>...encourage the client to (1) engage in specific behaviours for the purpose of testing the validity of his/her beliefs OR (2) make explicit predictions about external events so that the outcomes of those events could serve as test of those predictions OR (3) review the outcome of previously devised validity tests?</td>
</tr>
<tr>
<td>9. Developing a model of psychosis</td>
<td>...work with the client to develop a shared understanding of the nature of their psychotic disorder?</td>
</tr>
<tr>
<td>10. Normalising</td>
<td>...help the client recognize that his/her psychotic experiences are similar to the experiences of many people who do not have mental illnesses?</td>
</tr>
<tr>
<td>11. Resolving ambivalence</td>
<td>...help the client resolve his/her ambivalence about possible courses of action?</td>
</tr>
<tr>
<td>12. Keeping well</td>
<td>...help the client to develop strategies for the active management of his/her psychotic disorder in the future?</td>
</tr>
</tbody>
</table>

The CTPAS is rated on a 7-point scale for each item with 4 anchor points. Examples of the anchor points are: 'Not at all' (scoring 1), 'Somewhat' (scoring 3), 'Considerably' (scoring 5), and 'Extensively' (scoring the maximum of 7 for an individual item). It is at the discretion of the raters to decide what constitutes a score between those anchor points. A detailed manual accompanies the scale that further defines and elaborates each item. Brief transcripts of therapy dialogue help illustrate the differences between levels of competency in therapists' interventions, and specific rules are given for the rating of each item with guidance about the distinctions to be made between items.

Investigating the reliability of the CTPAS, Startup, Jackson, and Pearce (2002) point out the difficulties inherent in rating reliably sessions of a single modality since raters are required to
be extremely sensitive to the subtle nuances in the delivery of those prescribed procedures, asserting that inter-rater reliability can be achieved more readily when rating two or more different treatment approaches. Notwithstanding this difficulty, significant inter-rater reliability was shown on the majority of CTPAS items \( (p < .05) \), apart from validity testing and normalizing. Startup et al. note that mean scores on all items tended to be low (the average of the mean ratings across all items being only 1.95, although the maximum score per item is 7), and that this was particularly true of those items which did not reach significance (which had ratings of less than 2 on more than 80% of sessions). They defend these low ratings as the result of focusing on patients’ non-psychotic problems (which would involve the use of generic CBT skills rather than those specific to psychosis; Morrison, 1998). It is also asserted by Startup et al. that some items are erroneously assumed to be infrequent occurrences in therapy (e.g. the use of normalizing) but are strategies that are used extensively with particular patients. Conversely, other strategies or interventions may be seldom used (the example of ‘Validity testing’ is given) but on occasions would be deemed most apt and bring about significant therapeutic impact. Although it may be reasonable to assume that therapists may appropriately omit strategies and interventions deemed specific to psychosis, it is important to know whether low scores on specific items are associated with a deficit in the use and application of general CBT skills. A criticism of the scale is that it does not measure the quality of these general CBT skills, but requires the use of a separate rating scale (Startup et al. used 36 items from the CSPRS). Whilst this may seem reasonable, it is likely that less fastidious raters may be tempted to use the CTPAS as a stand-alone measure and thus omit to rate general therapy skills that are essential to establish an accurate picture of the overall quality of an intervention.
Theoretical basis of the Obsessive-Compulsive Disorder Cognitive-Therapy Scale

In the same way that Haddock et al. (2001) propose that a rating scale for treatment of a specific disorder needs to take account the way CBT has been adapted for use with a particular client group, the development of the Obsessive-Compulsive Disorder Cognitive Therapy Scale (OCD-CTS) has made similar considerations. As referred to earlier (see page 109), no suitable scale for measuring the quality of cognitive-behavioural treatment of obsessive-compulsive disorder has yet been published. Although many general CBT skills are relevant to the treatment of obsessive-compulsive disorder (cf. treatment of psychosis; Morrison, 1998), the disorder also presents with a range of characteristic features for which specific strategies and techniques are required.

Whilst more detailed accounts of the cognitive-behavioural approach to the treatment of obsessive-compulsive disorder can be found in the literature (eg. Salkovkis, 1996; Salkovskis et al., 1998a; Salkovskis et al., 1998b), an outline of some of the distinctive aspects of treatment and features of the disorder assists in understanding the choice of items for the OCD-CTS. Responsibility appraisals are a pivotal concept in the understanding and maintenance of OCD (eg. Salkovkis et al. 1998b), and result in the obsessional’s efforts to ‘neutralise’ intrusive thoughts, urges, images, or doubts and the discomfort caused by these intrusions. The cognitive-behavioural conceptualization has at its heart the notion that it is not the occurrence of such thoughts per se, but the idiosyncratic misinterpretation and the underlying meaning attached to the occurrence of those thoughts by the individual. The overall aim of treatment is to alter such appraisals. It is in regard to intrusive thoughts that CBT for OCD has a specific application in that it is not the content of the thoughts that is challenge, but the meaning attached to their occurrence. Cognitive-behavioural theory regards the occurrence of such thoughts as normal phenomena (Salkovkis & Harrison, 1984), and one of the basic tenets of the approach is normalizing the experience of the OCD patient.
As with all CBT treatments, a combination of cognitive change strategies (such as guided discovery and looking for alternative explanations) and behavioural experiments (testing new hypotheses) are involved. However, these strategies are sometimes used in very specific ways in the treatment of OCD. These may include identifying alternative explanations for OCD (eg. is the problem contamination or worry about contamination?), reviewing evidence for misinterpretations, or using pie charts. Behavioural experiments are used to assess the extent to which neutralizing actions may play a role in maintaining the patient’s fears. The use of exposure is also an important feature of treatment, but it should be integrated into a cognitive framework by the added emphasis of testing a hypotheses in order to bring about belief change. However, caution should be exercised regarding the focus of the behavioural experiment. Whilst in many anxiety disorders beliefs can be changed through behavioural experiments which disconfirm the person’s feared consequence (eg. the panic patient can test out whether hyperventilation results in collapse) that is not often the case in OCD. Where a patient has concerns regarding contamination with HIV the focus of the exposure is not the HIV virus per se, but to toilet door handles, for instance, since avoidance of such situations fuels their concerns. Furthermore, some obsessional worries defy direct disconfirmation (setting up a behavioural experiment to test out whether one will burn in hell for all eternity as a result of not cancelling out blasphemous thoughts by tapping in a particular rhythm is a challenge for the most expert of therapists!). As treatment progresses, it is important that the patient takes increasing responsibility for designing their own behavioural experiments to eliminate the possibility of reassurance through those suggested by the therapist (‘My therapist wouldn’t have asked me to touch the toilet seat if it wasn’t okay to do so’).

A common characteristic of obsessive-compulsive disorder is reassurance seeking. Striving to eliminate uncertainty, the obsessional patient may, for example, ask how often they should wash their hands to ensure they are perfectly clean. The CBT approach emphasizes that the therapist should not collude in this but (through Socratic questioning) to help the patient understand why reassurance is not effective, and how the anxiety relief is short-lived. For
some patients, their drive to ask questions can be a feature of their obsessional difficulties that the therapist must strive to maintain an appropriate level of control over. These are further specific features of therapy that the OCD-CTS attempts to take into consideration.

The OCD-CTS aims to take into consideration the features of therapy that are specific to the cognitive-behavioural treatment of obsessive-compulsive disorder in a measure for assessing therapists’ skill. It also seeks to reflect that some CBT skills and strategies are appropriate and applicable across disorders, and that the use of disorder-specific strategies alone do not constitute a quality treatment. This study seeks to investigate the psychometric properties of this new scale.
Method

Development of the Obsessive-Compulsive Disorder: Cognitive Therapy Scale (OCD-CTS)

The OCD-CTS comprises 17 items. A further item (item 18) is excluded from the present analysis as its inclusion was a means to rate consistency with protocol for the RCT and is not generally relevant. The items are summarised in Table 10. The rating scale is in three parts: the first looks at general therapeutic skills, and the second looks at specific CBT skills with particular reference to those skills considered essential to the effective treatment of OCD. Part 3 considers the complexity of the patient (eg. interpersonal style, multiple difficulties) that may make it difficult for the therapist to adhere to treatment protocol.

The style and content (particularly of Part 1) follows closely that of the Cognitive Therapy Scale - Revised (CTS-R) by Blackburn, James, Milne, & Reichelt (2001) with kind permission of the authors.

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rationale</td>
<td>The format of therapy is clearly explained. Procedures follow an explicit theoretical model which is made clear by the therapist and understood by the client.</td>
</tr>
<tr>
<td>2. Agenda setting</td>
<td>Therapist and client establish jointly the most important and relevant issues to be addressed in the session. Specific and realistic targets should be selected, appropriate to the stage of therapy and needs of the moment.</td>
</tr>
<tr>
<td>3. Dealing with questions</td>
<td>The therapist is able to deal appropriately with questions from the client and objections or problems the client may have with any aspect of therapy or the therapeutic relationship.</td>
</tr>
<tr>
<td>4. Reassurance seeking</td>
<td>The therapist recognises reassurance seeking in the session and deals with it appropriately.</td>
</tr>
<tr>
<td>5. Clarity of communication</td>
<td>The therapist uses clear language at a level appropriate to the client’s ability, and presents information in a style which is clear and easily understood.</td>
</tr>
<tr>
<td>6. Pacing and efficient use of time</td>
<td>The session is well ‘time managed’ in relation to the agenda, and allows smooth progression through start, middle, and concluding phases.</td>
</tr>
<tr>
<td>Title</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7. Interpersonal effectiveness</td>
<td>The client is put at ease by the therapist’s verbal and non-verbal behaviour whilst professional boundaries are maintained.</td>
</tr>
<tr>
<td>8. Reviewing previously set homework</td>
<td>The therapist reviews homework and measures, and integrates the information into the session.</td>
</tr>
<tr>
<td>9. Use of feedback and summaries</td>
<td>The therapist seeks regular feedback to increase understanding of the client, ascertain the client’s understanding, and facilitate the client’s ability to form new insights.</td>
</tr>
<tr>
<td>10. Guided discovery</td>
<td>An open and inquisitive style and the use of socratic questioning leads the client towards new ways of looking at things.</td>
</tr>
<tr>
<td>11. Conceptual integration and focus on OCD related cognitions</td>
<td>The therapist helps the client understand how perceptions and interpretations, beliefs, attitudes and rules relate to their current problems.</td>
</tr>
<tr>
<td>12. Normalising the client’s experience</td>
<td>The therapist utilises a normalising approach which emphasises the way in which the client’s concerns are an exaggeration of their normal concerns rather than a sign of ‘madness’, ‘deviance’, or an underlying biological/pathological factor.</td>
</tr>
<tr>
<td>13. Application of appropriate strategies for cognitive change and modifying compulsions</td>
<td>The therapist appropriately utilises a range of strategies and techniques with skill.</td>
</tr>
<tr>
<td>14. Therapeutic focus</td>
<td>The therapist maintains an appropriate level of focus on short, medium, and longer term goals but is sufficiently flexible to encompass important issues arising within the session.</td>
</tr>
<tr>
<td>15. Integration of exposure into a cognitive framework</td>
<td>Exposure in the form of behavioural experiments is integrated into therapy in a collaborative manner.</td>
</tr>
<tr>
<td>16. Homework setting</td>
<td>Homework that is consistent with the formulation, should be appropriate to the stage of therapy. It should be collaboratively agreed with an emphasis on the client’s increasing responsibility for setting their own tasks.</td>
</tr>
<tr>
<td>17. Client complexity*</td>
<td>The nature of the presenting problem is not necessarily the defining feature in terms of client complexity. Comorbidity can interfere with standard procedures, as can the patient’s interpersonal style, level of comprehension, ‘psychological mindedness’, etc. These factors may not be evident in every session thus raters are asked to make separate judgments for each session.</td>
</tr>
</tbody>
</table>

*nb. Item 17 is score from 0 to 4, unlike other items.
Many of the items refer to general CBT skills and have been retained from the CTS-R, but have been given slight modifications to increase their OCD relevance. The 'Use of homework' item from the CTS-R has also been split into two separate items (item 8 'Reviewing previously set homework' and item 16 'Homework setting') as it was considered that these were two distinct therapist activities. Items 4, 11, 12, 13, and 15 are considered to be specific to CBT for OCD, as described on page 119. The final item (not used for this study) is intended to give an indication of adherence to treatment protocol should the scale be used as a measure of treatment integrity. The full version of the OCD-CTS can be found in Appendix II.

Each item on the scale (with the exception of item 16, described below) was rated on a 7-point scale from 0 to 6. A rating of 0 would generally be applied where a particular quality, skill or strategy is completely absent from the session. A rating of 6 would be applied where the therapist demonstrated a particular quality, skill or strategy of the highest level and would be considered to highly effective skills that would be considered to show expertise. The scale is accompanied by a detailed manual which a similar structure and style. For each item, the manual provides:

a) a detailed definition of the item with a summary of its key features
b) an elaborated description of the item with examples of good and bad practice
c) specific rules for rating the item
d) important distinctions to be made between items.

The manual is included in Appendix I.
Participants

Participants were referrals to the Centre for Anxiety Disorders and Trauma who were receiving treatment for obsessive-compulsive disorder. Whilst all met DSM-IV criteria for obsessive-compulsive disorder, some participants also met criteria for other concurrent disorders such as major depression or panic disorder. Treatment given was solely for their obsessional difficulties. If further treatment was required for concurrent difficulty, it would be offered at a future date following completion of therapy for their OCD. Some of the participants were receiving treatment as part of a randomised control trial (RCT) comparing CBT for OCD with exposure and response prevention. The cognitive-behavioural therapy administered to non-trial participants was delivered according to treatment manual protocol and involved an identical number of sessions of the same duration (generally 1 hour). Those participants receiving exposure and response prevention were also treated according to a specified protocol which involved the same number of therapy sessions of comparable duration. Treatment consisted of up to 15 weekly sessions, followed by 3 follow-up (or booster) sessions that were spaced at the discretion of the therapist to suit individual participant needs.

Therapists

Treatment was provided by qualified therapists (clinical psychologists and nurse therapists with ENB 650 qualifications) employed at the Centre for Anxiety Disorders and Trauma, and had completed a post-qualification course in cognitive therapy (University of Oxford Diploma in Cognitive Therapy or similar). The therapists were experienced in the treatment of OCD (having between 3 and 11 years of specialist experience of treating OCD), and further experience of treating other mental health problems. In addition, they had received specialist training for treatment of participants in the RCT.
Sample for ratings

Therapists were requested to identify two sessions with each patient, one of which they considered to be a 'good' CBT session (ie. was representative of excellent or very good CBT practice in general, but also adhered closely to the treatment protocol) and the other a 'less good' session (where they did not consider to have demonstrated competent CBT skills but not at the highest level of skill, or the session deviated from the protocol). Routine practice at the Centre is to videotape all therapy sessions which facilitated the rating procedure. Raters were blind to therapists' subjective evaluation of the sessions. An independent person kept a record of 'good' and 'less good' sessions until the data was analysed.

Sessions were selected between the third and fifteenth sessions (inclusive). The rationale for this is that generally the initial therapy sessions are often used for gathering further information about the presenting problem, devising a formulation, and familiarising (or 'socialising') the participant with the content and format of therapy, and explaining what will be expected of them during treatment.

As a comparison group, a further sample of therapy tapes were rated of 'good' ERP sessions conducted by the same therapists in order to ascertain whether the OCD-CTS had discriminant validity between skills and strategies considered specific to CBT treatment, and those of ERP.

A total of 29 therapy sessions were rated: 10 'good' sessions, 10 'less good' sessions, and 9 good ERP sessions.

Raters

Ratings were made by an experienced clinical psychologist who had been instrumental in the preparation of the treatment protocol, and was also a trial therapist. Inter-rater reliability was carried out by a second rater, who was a newly qualified clinical psychologist but had undergone a specialist OCD placement at the Centre and had 6 months experience of CBT for OCD according to the present protocol.
Training of raters consisted of reading the manual for the OCD-CTS, followed by discussions about the meaning of each item and discussions about appropriate ratings. The order of individual ratings had been agreed by presenting the graded responses for each item on the scale in random order. All trial therapists were asked to rank order the responses from '0' (the therapist did not demonstrate skills consistent with CBT) to '6' (the therapist demonstrated CBT of the highest level of expertise and skill), with interim points allocated according to the appropriateness of competency that would be expected at each level. Consistency was found amongst therapists’ ratings.

**Hypotheses**

1. Discriminant validity will be demonstrated by higher scores for sessions that were subjectively defined by the therapist as examples of a ‘good’ standard of cognitive-behaviour therapy by the therapist, showing increased adherence to and skilfulness in CBT methods.
2. Scores for General Therapeutic Skills will be comparable for ‘good’ CBT sessions and the ERP controls, but less so for ‘bad’ CBT sessions.
3. The OCD-CTS will have acceptable inter-rater reliability and adequate internal consistency.

**Treatment of data**

Reliability analyses were computed using Chronbach’s Alpha for internal consistency. The primary analysis of validity was the 16-item total. Inter-rater reliability for the scale totals was calculated using non-parametric correlations (Kendall Tau) because of the small number of observations and the uncertain distribution of scores.

Firstly, the totals for the ‘good’ CBT sessions were compared to the totals of the ‘less good’ CBT sessions. Then ‘good’ ERP sessions were compared with ‘good’ CBT sessions. In both validity analyses, a secondary analysis was carries out examining differences between criterion groups for both specific and general subscales. In order to make these statistically comparable, means of the two sub-scales were used in repeated measures of analyses of
variance (ANOVA). Where ratings were missing for some items (e.g., patient did not seek reassurance, so therapist had appropriately not exhibited a strategy, or the end of a tape was missing owing to \emph{in vivo} exposure outside the office and was therefore not recorded), the mode was submitted for missing data. Where there was a tie in the mode, the mid-point between the two modes was used. This was considered appropriate, since a rating of zero would have been given if the strategy was considered inappropriately absent.

Item analysis was carried out with paired $t$-tests on the following data sets: 'good' CBT compared with 'less good' CBT sessions, and 'good' CBT compared with 'good' ERP.
Results

Overview
There are three sets of results. Firstly, the within subjects comparison of ‘good’ CBT and ‘less good’ CBT sessions with the same patient; secondly, there is a comparison of ‘good’ CBT and ‘good’ ERP; and thirdly, inter-rater reliability;

The results show that the scale demonstrates good discriminant validity as sessions identified as ‘good’ by the therapists were rated as significantly better than those identified as ‘less good’. The comparison of CBT and ERP also showed significant differences. The overall difference was highly significant, with scores obtained from good ERP sessions significantly lower than ‘good’ CBT sessions. A significant interaction was found on a comparison of specific and general items, but there was still a significant difference with scores from ERP sessions being substantially lower on specifics relative to general skills. In CBT, scores for both were relatively uniform. Inter-rater reliability for total and specific items were also found to be significant, but just missed significance for general items.

As an additional analysis, scores were compared item by item for: a) ‘good’ vs ‘less good’ CBT, and b) CBT vs ERP.

Participants

“Good” vs “less good” tapes
Using $\chi^2$, the first analysis looked at gender for ‘good’ CBT and ERP. The gender ratio was 4 : 6 and 5:4 (Male : Female) respectively. There was no association between gender and group ($\chi^2 = 0.46, p > 0.4$). Using a paired $t$-test, an analysis of the session number was done. The mean session number for ‘good’ CBT sessions was 6.1 and for ‘bad’ it was 7.3. No significant difference between number of the session chosen was found ($t(9) = 1.059, p > 0.3$).
Cognitive Behaviour Therapy (CBT) vs Exposure and Response Prevention (ERP)

The mean age for the CBT condition was 39 years (SD=11.0) and 37 years for ERP (SD=10.6), independent samples \( t(17) = 0.58 \) (\( p > 0.5 \)). There was thus no significant difference in mean ages between the two groups.

The range for ‘good’ CBT sessions was from session 3 to session 13 (inclusive), session 3 to 9 in ‘good’ ERP sessions, and from 3 to 15 for ‘bad’ CBT sessions. The results were as follows:

Means of ‘Good’ CBT vs. ERP: 
CBT= 6.100
ERP= 6.22

This was not significantly different on an independent samples \( t \) test (\( t(17) = 0.1, \ p > 0.9 \))

However, using a \( t \)-test to compare patient complexity in ‘good’ CBT (mean=1.4) and ERP (mean=0.55) revealed that CBT patients were significantly more complex than ERP (\( t(17) = 2.13, \ p < 0.05 \)).

**Complexity**

Complexity ratings are obtained from item 17 on the OCD-CTS.

Mean complexity ratings for ‘good’ CBT sessions was 1.22 (SD=0.83) and 1.44 (SD=0.88) for ‘less good’. There was no significant difference in observed complexity of patients in ‘good’ and ‘less good’ sessions (\( t(8) = 1.5, \ p < 0.69 \)).
**Interrater reliability**
The mean age for the CBT condition was 35.3 years and 41 years for ERP. The gender ratio was 4 : 2 and 2 : 2 (Male : Female) respectively.

**Reliability analyses**

**Internal consistency**
For the ‘good’ tapes in CBT and ERP samples, the internal consistency was calculated across all 16 items, giving a Cronbach’s alpha score of 0.918, indicating high levels of internal consistency across items. For the eleven general items alpha was 0.833, whilst for the five specific items it was 0.913.

**Inter-rater reliability**
Test- retest for inter-rater reliability was performed on 8 cases (4 CBT and 4 ERP). For the Kendall tau, the inter-rater reliability for the total was 0.79. For the general items inter-rater reliability was 0.51, and for specific items 0.91. The total and specific items were significant even on this small sample size, although the general items just missed significance ($p = 0.08$).

**Validity analyses**

‘Good’ vs. ‘Less good’
The primary analysis was of the total score on the OCD-CTS. This is the total of scores on items 1-16, and provides an overall rating of the quality of treatment including both specific OCD related items and more general items likely to be relevant across a range of problems. This analysis indicated that ‘good’ CBT sessions were rated as significantly higher (mean = 61.7, $SD = 11.09$) on the scale than ‘less good’ (mean = 42.89, $SD = 6.03$). This difference was found to be significant on paired $t$ ($t(9) = 3.66, p< 0.001$).

In order to evaluate the relative contribution of specific as opposed to non-specific items in this difference, the data was divided as described in treatment of data in to these two factors, and these results were entered as means (total subscale score
divided by number of items) into a repeated measures Analysis of Variance (ANOVA) with two repeats factors (good vs less good and specific vs general). Both main effects were significant and there was no interaction. The main effect of 'good' vs 'less good' was thus significant \( F_{(1,8)} = 15.6, p < 0.005 \) as was the specific vs general main effect \( F_{(1,8)} = 8.0, p < 0.05 \). These results were not modified by the interaction \( F_{(1,8)} = 2.4, p > 0.15 \).

Figure 1 shows these results, which indicate that 'good' sessions were rated as significantly better than 'less good', regardless of the specificity of the factors rated.

---

**Figure 1:** Graph to show OCD Specific and General subscales for "good" and "less good" CBT sessions

Cognitive Behaviour Therapy (CBT) vs Exposure and Response Prevention (ERP)

The primary analysis was again total scores on items 1-16. An independent samples t-test showed that the ratings for CBT (mean = 60.1, SD = 10.7) were significantly higher than those for ERP (mean = 39.1, SD = 5.2); \( t_{(17)} = 5.53, p < 0.0001 \).

The secondary analysis was again of specific vs general subscales, but as the second factor was between subjects (patients having ERP vs those having CBT) the ANOVA was a mixed model with treatment as grouping factor and specific vs general items as the within subjects (repeats) factor. Results are shown in Figure 2; this time both main effects and interaction were significant.
The main effect of specific vs general items was significant \( F_{(1,17)} = 167.1, p < 0.0001 \). The main effect of group (ERP vs CBT) was also significant \( F_{(1,17)} = 47.0, p < 0.0001 \). These main effects were modified by the interaction \( F_{(1,17)} = 142.4, p < 0.0001 \). In order to understand the source of the interaction, a simple main effects analysis was carried out for the two subscales. These analyses indicated that there were significant differences between CBT and ERP (favouring CBT) for both the specific items \( F_{(1,18)} = 100.9, p < 0.0001 \) and general items \( F_{(1,18)} = 11.1, p < 0.005 \). Paired t-tests then showed that the specific vs general comparison was not significant in the CBT group \( t_{(9)} = 0.74, p > 0.4 \) but was for the ERP group \( t_{(8)} = 16.8, p < 0.0001 \). These results indicate that the ratings of the quality of CBT were better on both subscales (specific and general), and that for ERP the specific items were found to be particularly low, and significantly lower than the general items, which were in turn significantly lower than the general items rated in the ‘good’ CBT tapes.

Item analyses

‘Good’ vs. ‘Less good’ CBT

Differences were found for 10 out of the 16 items (results are shown in Table 8). The differences were greatest for those items rating skills that are highly specific to the
CBT treatment of OCD (items 4, 11, 13 and 15) \((p < 0.005\) to \(p < 0.01\)), and relatively lower for some of the general therapy skills (items 3, 6, 8, 10, 14, and 16). No significant difference was found for items 1, 2, 5, 7, 9 and 12 (all of which are general skills) between ‘good’ and ‘less good’ sessions.

Table 8: Item analysis comparing means for “good” and “less good” CBT sessions

<table>
<thead>
<tr>
<th>Item</th>
<th>Means “Good”</th>
<th>Means “less good”</th>
<th>(t)</th>
<th>probabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rationale</td>
<td>3.2 (1.5)</td>
<td>2.7 (1.2)</td>
<td>1.2</td>
<td>(p &gt; 0.2)</td>
</tr>
<tr>
<td>2. Agenda</td>
<td>2.2 (1.9)</td>
<td>1.2 (1.6)</td>
<td>1.0</td>
<td>(p &gt; 0.3)</td>
</tr>
<tr>
<td>3. Dealing</td>
<td>4.0 (1.0)</td>
<td>3.1 (0.3)</td>
<td>2.5</td>
<td>(p &lt; 0.05)</td>
</tr>
<tr>
<td>4. Reassurance</td>
<td>3.2 (0.7)</td>
<td>2.4 (0.9)</td>
<td>3.5</td>
<td>(p &lt; 0.01)</td>
</tr>
<tr>
<td>5. Clarity of communication</td>
<td>4.9 (0.8)</td>
<td>4.1 (0.8)</td>
<td>1.8</td>
<td>(p &gt; 0.01)</td>
</tr>
<tr>
<td>6. Pacing</td>
<td>4.3 (1.1)</td>
<td>2.8 (1.0)</td>
<td>2.5</td>
<td>(p &lt; 0.05)</td>
</tr>
<tr>
<td>7. Interpersonal effectiveness</td>
<td>4.8 (0.8)</td>
<td>4.0 (0.7)</td>
<td>2.1</td>
<td>(p &gt; 0.065)</td>
</tr>
<tr>
<td>8. Reviewing homework</td>
<td>3.7 (1.4)</td>
<td>2.1 (1.5)</td>
<td>3.1</td>
<td>(p &lt; 0.05)</td>
</tr>
<tr>
<td>9. Use of feedback</td>
<td>3.3 (1.3)</td>
<td>2.3 (0.7)</td>
<td>1.7</td>
<td>(p &gt; 0.1)</td>
</tr>
<tr>
<td>10. Guided Discovery</td>
<td>4.2 (0.7)</td>
<td>2.9 (0.7)</td>
<td>4.6</td>
<td>(p &lt; 0.005)</td>
</tr>
<tr>
<td>11. Conceptual Integration</td>
<td>4.2 (1.0)</td>
<td>2.8 (0.4)</td>
<td>3.8</td>
<td>(p &lt; 0.005)</td>
</tr>
<tr>
<td>12. Normalising</td>
<td>4.3 (1.4)</td>
<td>3.0 (1.2)</td>
<td>1.7</td>
<td>(p &gt; 0.1)</td>
</tr>
<tr>
<td>13. Appropriate strategies for change</td>
<td>3.9 (0.9)</td>
<td>2.4 (0.5)</td>
<td>3.5</td>
<td>(p &lt; 0.01)</td>
</tr>
<tr>
<td>14. Focus</td>
<td>4.4 (0.7)</td>
<td>3.3 (0.5)</td>
<td>3.2</td>
<td>(p &lt; 0.05)</td>
</tr>
<tr>
<td>15. Exposure</td>
<td>3.2 (0.4)</td>
<td>1.5 (0.9)</td>
<td>5.0</td>
<td>(p &lt; 0.001)</td>
</tr>
<tr>
<td>16. Homework setting</td>
<td>3.7 (1.1)</td>
<td>2.1 (0.9)</td>
<td>3.5</td>
<td>(p &lt; 0.01)</td>
</tr>
</tbody>
</table>

‘Good’ CBT vs. ERP

Mean ratings of CBT sessions were higher for all items than those for ERP. Differences were found for 9 out of the 16 items (results are shown in Table 9). The differences were greatest for items 10, 11, 12, 13, 14, and 15 \((p < 0.0001)\), and relatively lower for items 3, 4, and 16 \((p < 0.05)\). A trend was found for item 9 \((p = 0.081)\). No difference was found between scores obtained on items 1, 2, 5, 6, 7 and 8. These results indicate that the ratings of CBT sessions were significantly higher on all items measuring skills specific to the CBT treatment of OCD, but also for many of the general cognitive therapy skills.
Table 9: Item analysis comparing means for “good” CBT and “good” ERP

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean “good” CBT (SD)</th>
<th>Mean “good” ERP (SD)</th>
<th>t</th>
<th>Probabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rationale</td>
<td>3.2 (1.4)</td>
<td>3.1 (1.1)</td>
<td>0.15</td>
<td>p &gt; 0.8</td>
</tr>
<tr>
<td>2. Agenda</td>
<td>2.0 (1.9)</td>
<td>1.1 (1.1)</td>
<td>1.25</td>
<td>p &gt; 0.2</td>
</tr>
<tr>
<td>3. Dealing</td>
<td>3.9 (1.0)</td>
<td>3.0 (0)</td>
<td>2.7</td>
<td>p &lt; 0.05</td>
</tr>
<tr>
<td>4. Reassurance</td>
<td>3.2 (0.6)</td>
<td>2.1 (1.3)</td>
<td>2.4</td>
<td>p &lt; 0.05</td>
</tr>
<tr>
<td>5. Clarity of communication</td>
<td>4.9 (0.7)</td>
<td>4.6 (0.5)</td>
<td>1.16</td>
<td>p &gt; 0.3</td>
</tr>
<tr>
<td>6. Pacing</td>
<td>4.4 (1.1)</td>
<td>4.3 (0.5)</td>
<td>0.17</td>
<td>p &gt; 0.9</td>
</tr>
<tr>
<td>7. Interpersonal effectiveness</td>
<td>4.7 (0.8)</td>
<td>4.6 (0.9)</td>
<td>0.37</td>
<td>p &gt; 0.7</td>
</tr>
<tr>
<td>8. Reviewing homework</td>
<td>3.5 (1.4)</td>
<td>3.1 (1.3)</td>
<td>0.62</td>
<td>p &gt; 0.5</td>
</tr>
<tr>
<td>9. Use of feedback</td>
<td>3.2 (1.3)</td>
<td>2.3 (0.5)</td>
<td>1.85</td>
<td>p = 0.81</td>
</tr>
<tr>
<td>10. Guided Discovery</td>
<td>4.2 (0.6)</td>
<td>1.2 (0.4)</td>
<td>11.6</td>
<td>p &lt; 0.0001</td>
</tr>
<tr>
<td>11. Conceptual Integration</td>
<td>4.1 (1.0)</td>
<td>1.7 (0.5)</td>
<td>6.64</td>
<td>p &lt; 0.0001</td>
</tr>
<tr>
<td>12. Normalising</td>
<td>4.4 (1.3)</td>
<td>0.2 (0.4)</td>
<td>8.84</td>
<td>p &lt; 0.0001</td>
</tr>
<tr>
<td>13. Appropriate strategies</td>
<td>3.9 (0.9)</td>
<td>1.2 (0.4)</td>
<td>8.26</td>
<td>p &lt; 0.0001</td>
</tr>
<tr>
<td>14. Focus</td>
<td>4.5 (0.7)</td>
<td>2.9 (0.8)</td>
<td>4.71</td>
<td>p &lt; 0.0001</td>
</tr>
<tr>
<td>15. Exposure</td>
<td>3.2 (0.4)</td>
<td>1.2 (0.7)</td>
<td>7.81</td>
<td>p &lt; 0.0001</td>
</tr>
<tr>
<td>16. Homework setting</td>
<td>3.6 (1.1)</td>
<td>2.4 (0.7)</td>
<td>2.71</td>
<td>p &gt; 0.05</td>
</tr>
</tbody>
</table>
Discussion
This study investigated the psychometric properties of the Obsessive-Compulsive Disorder Cognitive Therapy Scale (OCD-CTS). The OCD-CTS was an attempt to measure both general and specific features of cognitive-behaviour therapy for obsessive-compulsive disorder.

In terms of discriminant validity, within-subjects analysis compared sessions for the same patient that the therapist had subjectively rated as relatively high (excellent or very good) or relatively low quality (generally competent, but not their best work). The OCD-CTS was sensitive to this difference, with the overall score being markedly higher for ‘good’ sessions. This demonstrates that not only were CBT skills were applied more expertly and with greater refinement in ‘good’ sessions, but that there was closer adherence to the treatment protocol. Whilst it might be argued that some patients may make it easier to be a ‘good therapist’ because they are straightforward in terms of diagnosis and presentation, are compliant and open in their communications and ‘psychologically minded’, no significant difference in observed complexity of patients in ‘good’ and ‘less good’ sessions was found. The secondary analysis indicated that this difference was present uniformly for the items measuring general CBT skills and those measuring skills specifically relevant for the cognitive-behavioural treatment of obsessive-compulsive disorder. This suggests that in ‘good’ sessions, therapists tended to demonstrate greater skill and competence overall. This finding contrasts with those for the CTS-Psy, where Haddock et al. (2001) found the greatest differences for total and items specific to the treatment of psychosis rather than general skills. As they remark, this is nevertheless logical since they were rating emerging skills following training in CBT skills for psychosis and therapists already possessed good quality general therapeutic abilities. Blackburn et al. (2001) similarly rated emerging skills in CBT training, but their findings showed greater internal consistency. They offer a number of possibilities for these results. One is that some items are not sufficiently distinct or that the scale attempts to address too many concepts within an item (Whisman, 1993). It is further suggested that raters are influenced by a ‘halo’ effect, and that a therapist would attract similar ratings across all items. Most interestingly, Blackburn et al. also propose that high internal consistency may reflect the way that emerging skills are manifested across the range,
and that this is because cognitive therapy skills are learned (and taught) globally. Whilst this argument cannot be applied directly to the findings of this study, a possibility is that when the therapist is ‘having a bad day’ this would not be manifest in reduced scores on a few items, but would be reflected by their general performance in the therapy session. The corollary naturally would apply.

In the other analysis of validity, CBT for OCD was compared with exposure and response prevention (ERP). For the main analysis again there was a marked difference favouring CBT. This provides firm evidence that the OCD-CTS provides a measure of CBT skill, although it might be argued that a similarity in more general therapeutic skills would be reflected in scores between the two treatments and that differences would be greatest on those items measuring more specific CBT skills. To recapitulate an earlier quote (see p.96), Dobson, Shaw, and Vallis (1985) state that the therapeutic alliance and the therapist’s general interpersonal skills are no less essential in CBT than in any other therapy and propose that a measure of the quality of cognitive therapy should reflect that. In the development of the OCD-CTS, there was little disagreement over which items were OCD-specific but some debate ensued about which items reflected general CBT skills and which were more ‘diffuse’ skills that Blackburn et al. assume to occur in any competent therapy session, regardless of theoretical orientation. However, in the secondary analysis comparing specific with general items a rather different pattern of results emerged. Although both specific and general items showed ERP to be lower, the specific skills were shown to be markedly and significantly lower than the general items. This seems quite surprising in light of the line of reasoning taken by Dobson, Shaw, & Vallis and Blackburn et al. A possible interpretation of this finding is that even general items in the OCD-CTS are measuring features that are standard practice in CBT, but may actually be general therapy skills. Taking these results together, there is support not only for the use of the OCD-CTS but also the value of including disorder specific items in addition to along with items reflecting general CBT skill. The CTPAS was earlier criticised for not incorporating a measure of quality of these general skills (p. 117); these findings add substance to such a criticism.
Item analysis yielded notable results. Significant differences were found for all items in a comparison of individual item ratings for ‘good’ and ‘less good’ CBT sessions. However, the differences were greatest for those items rating skills that are highly specific to the CBT treatment of OCD. Interestingly, there was no significant difference in the use of normalising during ‘good’ and ‘less good’ sessions. There seems no obvious reason for this, although a possibility may be that normalising is used more widely earlier on in treatment, and that most sessions rated were roughly midway through therapy (mean session numbers being 6.1 for ‘good’ CBT and 7.3 for ‘bad’, respectively). This argument has some consistency with the study by Startup and Shapiro (1993), where the application of behavioural methods in CBT for depression tended to be more extensive during the earlier phase of therapy. It is unlikely that any rating scale could adequately reflect such factors.

Ratings for ‘good’ CBT sessions were also found to be significantly better than for ERP for general CBT skills, such as dealing with questions, use of guided discovery, and focus on OCD-relevant cognitions. Homework setting was also found to be rated significantly better. The thread that seems to link these items is the use of a collaborative, Socratic approach. The level of collaboration shown may also explain the significant differences in homework setting both between ‘good’ and ‘less good’ CBT sessions, but also between ‘good’ CBT and ERP. Lower ratings would be given if homework is assigned rather than arrived at collaboratively. The more prescriptive nature of ERP makes it likely that this is the case, although that is entirely appropriate for that approach. A further reason for a low rating on this item would be if no homework had been agreed. Since poorer pacing was demonstrated in ‘less good’ CBT sessions, raters observed that homework had on occasions been omitted.

Interestingly, no significant differences were found between scores on a number of general items. Although the concept of ‘standard’ CBT skills was put forward earlier, it seems that the OCD-CTS is not only able to reflect those therapeutic qualities referred to by Dobson, Shaw, & Vallis (1985), but also shows something about the structure of the therapy session. To clarify this, no difference was found between ‘good’ and ‘less good’ CBT sessions for:
- delivery of a rationale for treatment
- setting an agenda
- clarity of communications
- interpersonal effectiveness
- use of feedback

A similar pattern emerged in the comparison of 'good' CBT and 'good' ERP, although there was less use of feedback in ERP. This showed a trend rather than a significant difference. Where there are no differences, it is reasonable to assume that these are skills generally associated with good therapy. Homework was reviewed equally thoroughly in ERP and 'good' CBT, but was done significantly less well in 'less good' CBT sessions.

Inter-rater reliability for total and specific items were significant, although the general items just missed significance. One of the reasons for this is the low number of cases on which test-retest was done (a total of 8 cases; 4 CBT and 4 ERP). This is perhaps one of the key methodological flaws in the study, which shall be further discussed below.

As the authors of many of these studies have indicated (eg. Blackburn et al., 2001; Startup, Jackson, & Pearce, 2002) the measurement of competence in therapy presents many methodological issues. In considering the present study, it can be seen that there are some general design and methodological issues which might limit confidence in its findings. The sample size is relatively small compared to other studies discussed. This was particularly true for ERP sessions. A serious limitation of the study is that 'good' 'less good' tapes were provided by a single therapist, with a second therapist providing a small selection of ERP tapes. Whilst all therapists had been requested to identify examples of 'good' and 'less good' therapy sessions, few did so. There appeared to be a general reluctance to do so, perhaps because of anxieties about the prospect of their 'competency' being rated. The title of the scale itself (in common with the other scales discussed) is problematic with its implication of being measured or assessed in some way. Similarly, deciding upon a suitable definition of the two 'standards' of CBT session proved a major taxonomical complexity in order to avoid the use of terms like 'good' and 'bad'. In order to address this difficulty, the rather
clumsy term 'less good' was chosen as it had fewer negative connotations. One of the reasons therapists expressed for not providing tapes was that, in their experience, therapy sessions with a particular patient tended not to show great variation: they were either generally good, or generally less good overall. This poses an interesting question in respect to further applications of the OCD-CTS.

Very few ERP sessions were rated for the study. One reason for this is that ERP is a treatment only offered as part of a treatment trial for OCD. The trial as a whole only included a proportion of OCD sufferers referred to the Centre, as co-morbidity was one of the main exclusion criteria. These people were still offered treatment at the Centre, but that treatment was CBT. To further reduce the number of suitable ERP cases available for the study, the widespread use of *in vivo* exposure meant that not all therapy sessions would be recorded.

It is acknowledged that inter-rater reliability samples were inadequate. A better design would have been for a number of therapists to submit session video-tapes for rating, and also to rate those of a colleague rather than their own. This requires a heavy time commitment and co-operation from therapists who have heavy case loads. The second rater for the study was a newly qualified clinical psychologist who had recently joined the team. Because of the time constraints for completion of the study, insufficient time was available for practice and training session tapes to be reviewed by the raters in order to discuss what each anchor point meant in terms of observable behaviours (despite providing descriptions at each point, a certain amount of inference by the rater is still required). In the absence of a clearly agreed consensus about each anchor point, raters are likely to have differed when rating the videotapes in the study. The task of reliably rating sessions of a single therapeutic modality is a challenge, according to Startup & Jackson (2002). They also suggest that it is easier to achieve inter-rater reliability when assessing two different treatment approaches. This study does not support this view, although this is more likely to be the result of the second rater being a less experienced clinician with no training or experience in ERP.
Summary and conclusion

This study has described a number of measures developed for rating cognitive-therapy skill. The CTS (Young & Beck, 1980; 1988) provides a measure of generic skill, and despite having been validated only for the cognitive treatment of depression, it has been embraced as measure for general competency in cognitive therapy. Whilst Barber, Liese, & Abrams (2003) conclude that the CTACS represents a significant improvement on the CTS, the CTS-R (Blackburn et al., 2001) is the only cognitive therapy rating scale to be empirically validated across a range of disorders. It was questioned whether there was evidence to support the development of therapist competency and adherence rating scales for specific disorders. Whilst few have been published, the CTS-Psy (Haddock et al., 2001) and the CTPAS (Startup, Jackson, & Pearce, 2002). The development of the OCD-CTS was described, and its psychometric properties investigated on a restricted sample.

Despite the criticisms of inter-rater reliability found in this study, it is encouraging to know that specific items had particularly good reliability. Barber, Liese, and Abrams (2003) summarise a number of studies which suggest that inter-rater reliability on the CTS is not as strong as might be desired, yet it to date it has been the most well-used measure of competence in cognitive therapy. Since the original scale on which the OCD-CTS was based (CTS-R) is known to have good test-retest reliability, there is no reason to suspect this would not be true of the OCD-CTS if further tapes were obtained for rating from more therapists, and with better training of raters.

Notwithstanding these flaws, the study has been able to fully support the hypotheses that discriminant validity would be demonstrated by higher scores for sessions that were subjectively defined by the therapist as examples of a ‘good’ standard of cognitive-therapy for OCD, and that whilst ratings of CBT were overall higher than those for ERP on general skills, they were significantly higher on ratings for skills specific to the CBT treatment of OCD.

Whilst the psychometric properties of the OCD-CTS still require further investigation, its development opens up exciting opportunities for further research. An interesting
question to explore would be how it compares to the CTS-R. Once its reliability has been firmly established, it is hoped to use it as a measure of treatment integrity for a randomised control trial for OCD. From a clinical perspective, it could be applied similarly since quality of treatment offered is open to scrutiny in a climate which favours evidence-based therapies. Similarly, an investigation into the relationship between treatment integrity and outcome is a question that should be answered.
References


Appendix I

Manual for

OBSESSIVE-COMPULSIVE DISORDER: COGNITIVE THERAPY SCALE

About the rating scale

This is a scale for assessing therapists' skill in Cognitive Therapy for obsessive-compulsive disorder. Whilst a widely used Cognitive Therapy Scale (Young and Beck, 1980, 1988) has been available for some time, and a more recent variant developed (Cognitive Therapy Scale- Revised, James, Blackburn, & Reichelt, 2001), both provide a measure of generic cognitive therapy skills. The development of the Cognitive Behaviour Therapy for Obsessive-Compulsive Disorder: Cognitive Therapy Scale (OCD-CTS) is derived from the premise that some disorders require very specific strategies and interventions, and although one might be a skilled cognitive therapist in general terms, it is not always the case that one is skilled at CBT for a particular disorder. Whilst it can be treated as a 'stand alone' scale, it is intended to be a supplementary scale to the Revised Cognitive Therapy Scale (CTS-R) (James, Blackburn, & Reichelt, 2001).

Because of the detail and clarity of the CTS-R (James, Blackburn, & Reichelt, 2001), an earlier version of this scale was adapted to utilise a similar format and range of criteria. It has been divided into 3 parts:

1) General therapeutic skills: Some cognitive therapy skills provide the core to a good intervention, and in general apply across the spectrum of disorders.

2) Conceptualisation, strategy, and technique: Whilst some of the items included in this section may still be considered to apply across all disorders, there are a number of strategies and techniques that have particular salience in the treatment of OCD.

3) Observations regarding the therapeutic intervention: This section considers the complexity of the patient (e.g. interpersonal style, multiple difficulties) which may make it difficult for the therapist to adhere to the general treatment protocol. As a research team, it is also of importance to assess whether the way in which the therapy was delivered fits sufficiently closely with treatment trial protocol as we strive for consistency amongst trial therapists.

Use of the rating scale

The seven point scales utilised for this measure extend from (0) where the therapist did not adhere to that aspect of therapy (non-adherence) to (6) where there is not only 'adherence' to the protocol, but the therapist demonstrates a very high level of skill. Thus the checklist assesses both adherence to therapy method and skill of the therapist. To aid with the rating of each item on the scale, an outline of the key features for each item
is provided at the top of each section. A description of the various rating criteria is given in the right hand margin.

The examples are intended as useful guidelines only. They are not meant to be used as prescriptive rating criteria, but as illustrative anchor points and guides. The assessor should be familiar with the protocol for cognitive-behavioural treatment for OCD, and have sufficient clinical expertise to be able to identify particular skills and strategies, and to recognise acceptable variations in the basic approach and be proficient to score them accordingly. However, the manual and the checklist provide sufficient detail for the novice therapist to be able to use it in their practice, and identify strengths and weaknesses of the therapy sessions in a meaningful way. That is, the checklist scale provides a description of appropriate cognitive-behaviour therapy skills at different levels of expertise. It should enable the practitioner to identify aspects in need of improvement with appropriate suggestions for doing so, as well as providing feedback on aspects that are examples of good practice.

Example of the rating layout

**Key features:** This is an operationalised description of the item (see examples within the scale).

Circle the rating pertaining to the level to which you think the therapist has fulfilled the core function. The descriptive features on the right are designed to guide your decision.

If the therapist does not quite meet all criteria for a level, it is acceptable to circle two levels (the resulting rating will be the average eg. level 3 and 4 = 4.5).

The following is intended as an overall guide:

<table>
<thead>
<tr>
<th>Competence level</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incompetent</strong></td>
<td>0 absence of feature, or highly inappropriate performance</td>
</tr>
<tr>
<td><strong>Novice</strong></td>
<td>1 inappropriate performance, with major problems evident</td>
</tr>
<tr>
<td><strong>Advanced beginner</strong></td>
<td>2 evidence of competence, but numerous problems and lack of consistency</td>
</tr>
<tr>
<td><strong>Competent</strong></td>
<td>3 competent, but some problems and/or inconsistencies</td>
</tr>
<tr>
<td><strong>Proficient</strong></td>
<td>4 good features, but minor problems and/or inconsistencies</td>
</tr>
<tr>
<td><strong>Expert</strong></td>
<td>5 very good features, minimal problems and/or inconsistencies</td>
</tr>
<tr>
<td></td>
<td>6 excellent performance, or even very good in the face of patient difficulties</td>
</tr>
</tbody>
</table>
It should be noted that items 18 and 19 are not scored in this way (see below for a detailed explanation).

Rating distribution

It should be noted that the rating profile for this scale should approximate to a normal distribution (ie. Mid-point 3), with relatively few therapists rating at the extremes. Raters should refer to page 3 of the Manual of the Revised Cognitive Therapy Scale (CTS-R) for a full explanation of the scoring system. The CTS-R has a maximum score on the scale of 72 (ie. 12 items x Maximum 6 points per item), and the Newcastle Cognitive Therapy Centre sets a minimum ‘competency’ standard of 36, which would be an average of 3 marks per item. The OCD-CTS has a total of 18 items, 16 of which are scored on a 6 point scale, with item 17 (Client Complexity) scored on a 4 point scale, and item 18 (Consistency with Trial Protocol) rated simply as Yes/Subthreshold/No. This final item would not be included in a total score as it was included for the purpose of setting a minimum standard for therapy skills whilst training therapists to conform to treatment protocol for a randomised control trial and does not necessarily provide a measure of skill in cognitive therapy for the treatment of OCD (for example, a highly skilled therapist may successfully and appropriately use schema change techniques with an obsessional patient, but would be deemed as not adhering to trial protocol as the remit prescribes adherence to specific strategies).

Because the OCD-CTS contains more items, any overall score is not directly comparable with the CTS-R. Ratings on the OCD-CTS are not in fact intended to give an overall score, but can be used on the accompanying summary sheet to give a general profile. This is thought to be more helpful in identifying aspects where sufficient levels of skill are evident, and where attention should be paid to refining emerging competencies. Educational research has shown that this is a wise move (eg. Black & Wiliam, 1998): when students are provided with a mark or grade, they pay more attention to this than to any qualitative feedback even when such feedback is fulsome in its praise of a particular piece of work.

References:


Obsessive-compulsive disorder: Checklist of Therapist Skill

Contents:

Part 1: GENERAL THERAPEUTIC SKILLS

1. Rationale
2. Agenda setting
3. Dealing with questions
4. Reassurance seeking
5. Clarity of communication
6. Pacing and efficient use of time
7. Interpersonal effectiveness

Part 2: CONCEPTUALISATION, STRATEGY AND TECHNIQUE

8. Reviewing previously set homework
9. Use of feedback and summaries
10. Guided discovery
11. Conceptual integration and focus on OCD related cognitions
12. Normalising the client’s experience
13. Application of appropriate strategies for cognitive change and modifying compulsions
14. Therapeutic focus
15. Integration of exposure into a cognitive framework
16. Homework setting

Part 3: OBSERVATIONS REGARDING THE THERAPEUTIC INTERVENTION

17. Client complexity
18. Consistency with trial protocol
Part 1: GENERAL THERAPEUTIC SKILLS

Introduction:

This section enables the assessor to reflect on the general therapeutic skills evident in the treatment session. Some of these skills are not specific to cognitive-behavioural therapy for OCD, but are more general skills in either the practice of CBT or therapy from a different theoretical orientation. For example, interpersonal effectiveness, clarity of communication, pacing and effective use of time, and dealing with questions are quite broad skills which any therapist would reasonably be expected to demonstrate a basic command.

Rating of this section may not necessarily be done in strict order; indeed, it may be appropriate for the assessor to return to the questions once the entire therapy session has been reviewed as some items rely on an overall impression (for example, interpersonal effectiveness) or can only be adequately assessed at the end of the session (eg. pacing and efficient use of time).

1. RATIONALE

The way in which a rationale is presented can vary according to the stage in therapy. Initially, the therapist would be expected to clearly and thoroughly explain the treatment rationale (ie. provide an overview of the theoretical model).

Rationale is not necessarily explicit. As treatment progresses, it is likely (and hopeful) that the client will have taken on board the theoretical model. In that case, the rationale may become implicit, ie. it is evident from the content of the dialogue and the kinds of behavioural experiments and homework activities that there is a firm theoretical underpinning to the session which is clearly shared by both client and therapist.

Examples of Level 1 rationale might be that the therapist proposes that an exposure-based experiment is carried out “to prove that the things you worry about don’t happen”.

Examples of Level 5/6: therapist uses Socratic questioning to check the client’s understanding, eg. when devising an appropriate behavioural experiment or homework exercise. Examples would include, “In what way do you think it would be helpful to do...”, or “Why do you think it would be better to do [something extreme like deliberately ‘contaminate’ bottles for re-cycling] when it’s not what most people would do?”.

Key features: The format of therapy is clearly explained. Procedures closely follow an explicit theoretical model which is made clear by the therapist and understood by the client.
0 No rationale given for any procedures used, and no attempt to establish client's understanding of procedures used.

1 Rationale attempted, but is wrong, misleading, or poorly delivered. No attempt to establish client's understanding.

2 Appropriate rationale is provided, but major difficulties evident (e.g. vague, confusing or incomplete, poorly delivered). Some attempt to check client's understanding, but explicit feedback not sought and misunderstandings not clearly identified or addressed.

3 Appropriate rationale is provided, some difficulties present (e.g. unclear at times, problems in content or style of delivery). Some attempts to check patients understanding and obtain feedback, misunderstandings not fully addressed.

4 Appropriate rationale provided, generally clear, well delivered, client's understanding is established, feedback sought, and difficulties or misunderstandings addressed. Minor difficulties evident (e.g. unclear at times, explanations not always complete).

5 Highly appropriate rationale, given clearly and well delivered, client's understanding is checked, feedback sought, and misunderstandings addressed. Minimal problems.

6 Excellent rationale given clearly, client's understanding checked, feedback sought, and misunderstandings addressed collaboratively or appropriate rationale delivered clearly and well, understanding and feedback sought in the face of difficulties.

2. AGENDA SETTING

Introduction:

"The agenda ensures that the most important issues are addressed in an efficient manner. Therapist and patient must establish these issues jointly. The agenda should review items from the previous session(s), in particular the homework assignment, and include one or two items for the session. Once set, it should be appropriately adhered to. However, if changes are necessary, because of a new issue arising, the deviation from the agenda should be made explicit" (from James, Blackburn, & Reichelt, 2001, page 4).

Agenda setting may be formal or informal. An example of a 'formal' approach to agenda setting may be where the therapist explicitly says, for example, "Let's begin by setting an agenda for today's session", and then goes on to do so with the assistance of the client. A more informal approach (and equally acceptable) may be when the therapist forestalls the client's eagerness to launch into what is pressing for them (perhaps they are too eager to give feedback on homework, or launch into reasons why they've had a bad week, for example), and attempts to contain this by drawing up an agreed outline for the session with the client. The therapist may have to deftly field any topics the client introduces which are not appropriate or helpful to cover in the session (e.g. the client may wish to talk about a recent argument at work which is unrelated to their OCD problem). Without unilaterally vetoing the client, the therapist is likely (in such a scenario) to ask how the client feels that their 'agenda' fits with the overall focus of therapy. Without addressing it directly, the therapist may help reach an acceptable compromise by suggesting that it might be appropriate and timely to look at the way in which emotional upsets (such as that arising from the argument) contribute to the experience of OCD. In
In this way, both specific current concerns of the client and the overall rationale and goals for therapy are reflected in the agenda. As with 'Rationale', clients who are more familiar with the format of therapy may automatically 'adhere' to an implied agenda, where the therapist has no need to formally itemise feedback on developments between sessions or even setting of homework. The client would in that case have the expectation that this is the way in which the session will progress - they will automatically give feedback at the beginning of the session, and may even specify what they think they need to cover in the session (with minimal prompting from the therapist, who may simply ask: “So what would it be useful to cover today?” and allow the client to take responsibility - a longer term goal in CBT for OCD - for setting an appropriate agenda).

It is also important that any agenda is not too elaborate or lengthy. There should not be so many agenda items that it is unrealistic to expect to cover everything adequately. Where the client has multiple needs, a highly skilled therapist would help the client to identify what would be most fitting to cover in this session, and perhaps to either reserve other topics for a future date or to leave time at the end of the session to review whether or not lower priority issues may have been adequately tackled through targeting key matters arising. In a similar vein, some clients will highlight numerous unrelated matters that they consider of equal importance. It is crucial that the therapist avoids a 'fly-swatting' approach by tackling each issue individually. This can be a particular issue with obsessional clients where a tendency to view not dis-similar problems/ occurrences as matters requiring individual attention. In terms of aiding the development of an overall shared understanding of OCD problems it is essential that the therapist does not conclude with that, but encourages the client to consider these seemingly disparate issues under one 'umbrella'. For example, when the client says “I know that if I just let the thoughts about being contaminated with toxoplasmosis just come and go naturally without trying to fix them at all, or trying to push them out of my head, but it’s different when I get images of stabbing my dogs...”.

2. AGENDA SETTING

**Key features:** In order to make optimal use of time available in the therapy session, discrete, appropriate and realistic topics need to be identified for the session. The agenda should be set in a collaborative way, reflecting both specific current issues which the client may have, and the overall rationale and goals for therapy.

0 No agenda set, or highly inappropriate.

1 Inappropriate agenda set (eg. lack of focus, unrealistic, no account of client’s presentation, homework not reviewed).

2 An attempt at an agenda made, but major difficulties evident (eg. unilaterally set). Poor adherence.

3 Appropriate agenda, which was set well, but some difficulties evident (eg. poor collaboration). Some adherence.

4 Therapist worked with the client to set a mutually satisfactory agenda that included specific problems in understanding or overcoming OCD. Minor difficulties evident (eg. no prioritisation), but appropriate features covered (eg. review of homework). Moderate adherence.
Appropriate agenda set with discrete and prioritised targets, reviewed at the end. Agenda adhered to. Minimal problems.

Excellent agenda set which was highly appropriate for available time and stage in therapy, or highly effective agenda set in the face of difficulties.

3. DEALING WITH QUESTIONS

Introduction:

The therapist should be able to deal appropriately with questions which the client may raise during the sessions, whilst being able to maintain appropriate control over the agenda to avoid unscheduled deviations and to prevent using up too much time in the session on non-agenda matters. Some questions are, of course, entirely appropriate. For example, the client may be seeking clarification, or feedback on a particular matter. In such cases, dealing with questions is unlikely to pose much of a problem for the therapist: the questions will be dealt with swiftly and deftly as part of an overall uninterrupted therapeutic dialogue. It will be neither time consuming or lead to a gross deviation.

However, in obsessive-compulsive disorder, clients' questions can be a particular feature of the presentation of their obsessional difficulties. Constant reassurance seeking, for example, can mean that the client is continually seeking for the therapist to put their mind at ease about whether, say, they had become contaminated by a bottle of detergent they had spotted on their way in to the office. In other cases, questions are driven by a need 'to be sure': 'to be sure' they've understood what therapy entails, 'to be sure' they know when today's session had started, or would finish, 'to be sure' the therapist had understood the point they were trying to make. Such a constant barrage of question undeniably eats into therapy time, can obstruct any agenda that may have been set, lead to unprofitable deviations, and sabotage any attempts to target the obsessional problem in any helpful and meaningful way.

It can be difficult for the therapist to maintain an appropriate level of control with such clients, but it is crucial to being able to conduct satisfactory therapy. There are various methods of dealing with frequent questions. These range from simply answering the question to the adoption of a more collaborative means where the client is encouraged to decide whether the question is a 'genuine' one (ie. they do not know the answer, and it is relevant to the present discourse) or an 'obsessional' one (ie. they may have already asked the question, they're trying to make themselves feel less anxious or more certain, it does not relate to what is being discussed in the present). With frequent 'questioners', the therapist may propose that they keep their questions until the end of the session when time would be made available to address any that have not been adequately dealt with as part of the content of the therapy session (if this is a problem that has previously been encountered with the client, 'question time' should be included on the agenda at the outset.)
3. DEALING WITH QUESTIONS

Key features:

An important aspect of good therapy is to be able to deal with any questions from the patient and objections or problems that the patient may have with any aspect of the therapy or therapeutic relationship. The therapist should elicit any problems or objections and deal with them sensitively and directly, also obtaining feedback on this in the session. This is similar to but distinct from eliciting feedback on the therapy session as a whole.

0 Therapist fails to acknowledge questions, dismisses them or makes no attempt to answer them.
1 Therapist shows no understanding of questions, and responds inappropriately, inadequately, or too briefly.
2 Therapist responds to patient's questions, but major difficulties evident (eg. some misunderstanding, answers may be unclear, client does not understand answer).
3 Therapist is sensitive to questions, generally understands them, and has some success in answering appropriately and clearly, some difficulties evident (eg. some answers may be incomplete or overly detailed, fails to check client's understanding of/ response to the answer).
4 Therapist is sensitive to questions, answers them clearly and appropriately, generally seeks feedback from client. Minimal problems.
5 Therapist is sensitive to, and understands questions, answers them appropriately, and seeks feedback from patient.
6 Therapist is sensitive to, and understands questions, answers them appropriately, and seeks feedback from patients. Makes links between questions and conceptualisation or broader picture.

4. REASSURANCE SEEKING

Introduction

Reassurance seeking is frequently encountered in the treatment of OCD. This is particularly prevalent during early sessions (when the client is not familiar with the theoretical understanding of their problem), but may persist (or re-emerge) later on - perhaps because they have not fully understood the rationale for treatment and that seeking reassurance is a means of 'neutralising' obsessional worries.

A full explanation of reassurance seeking can be found in the introduction to item 3 'Dealing with Questions'.
4. REASSURANCE SEEKING

Key features: The counterproductive nature of reassurance seeking is an issue that is well established in the cognitive approach to the treatment of OCD. Therapists must be mindful that reassurance can be sought in many subtle ways, and when this occurs should be identified and dealt with appropriately in the session.

0 Therapist ignores or shows no understanding of direct or indirect requests for reassurance.

1 Therapist responds to requests by providing reassurance when it is inappropriate to do so, or has difficulty in recognising reassurance-seeking.

2 Therapist is generally sensitive to requests for reassurance, and attempts to deal with them appropriately, but some difficulties evident (eg. gets hooked into a debate regarding the focus of the OCD concern, misses more subtle methods of reassurance-seeking, overly didactic or vague in their response).

3 Therapist is sensitive to requests for reassurance, tries to deal with them collaboratively and generally responds effectively. Minor difficulties (eg. inconsistent, may miss indirect requests).

4 Therapist recognises direct and indirect requests for reassurance, and responds effectively, enabling client to become more aware of the effect of reassurance seeking in maintaining the problem.

5 Consistent and competent recognition of and response to direct and indirect requests for reassurance, or very good work done in the face of difficulties.

6 Excellent recognition of and response to all forms of reassurance seeking. Facilitates the client to recognise this behaviour, and to identify when this is happening without prompting by therapist.

5. CLARITY OF COMMUNICATIONS

Introduction

Good therapy demands clarity of communication. This means that the language which the therapist uses should be clear and at a level which is appropriate to the client's ability. Jargon should be avoided, although it is entirely appropriate to introduce the client to appropriate terminology not in every day usage with which to talk about their problems. For example, 'neutralising' is not a term commonly understood but is a useful term for the kinds of things the client does to reduce their anxiety in OCD - relevant situations. However, if the client already has their own term for what they do (eg. 'fixing' thoughts), it is often better if the therapist continues too use their term rather than introducing what may be considered unnecessary jargon.

In more general terms, therapists should strive to employ vocabulary which the client can easily understand and not use words that the client is unlikely to understand. As a rule of thumb, plain English should be the norm and the therapist should not try to 'impress' by
showing off their knowledge of difficult or obscure language. However, the therapist also needs to guard against appearing 'patronising' to clients who may feel that their intelligence is being insulted if too simple language is used, or the therapist constantly explains things in detail when there is no evidence that such an explanation is required. It is often sensible for the therapist to adopt generally a straightforward language style which would need few alterations to meet the needs of individual clients.

Clarity of communication does not only apply to kind of vocabulary used. The therapist should also demonstrate a sound grasp of the treatment approach, and be able to present this in a clear, well-ordered fashion. At the highest level, the therapist should be able to rephrase easily for the benefit of a client who may not have readily understood the point they had been making rather than simply reiterating their original statement.

The use of analogies and metaphors is encouraged to help elucidate further. However, these should be appropriate to both the point being made, and the experience of the client. For example, a metaphor using the concept of home insurance can be useful to illustrate how the cost of the client's rituals may far outweigh the perceived benefits, but may not be fitting for younger clients who are not home-owners or acquainted with the details of insurance policies. Similarly, metaphors about traffic lights can sometimes be lost on non-drivers.

5. CLARITY OF COMMUNICATION

**Key features:**  
An essential aspect of good therapy is clarity of communication. This involves clear use of language at a level which is appropriate to the client's ability, avoiding jargon, and generally presenting information in a style which is clear and easily understood.

0 Therapist was muddled in their presentation of information and overused jargon, or used language which was highly inappropriate for the client's level of understanding.

1 Therapist had difficulty presenting information in straightforward language. Overuse of jargon.

2 Therapist generally presented information in a coherent fashion, but was overly technical, or found it hard to simplify information to aid client's understanding.

3 Therapist was generally clear in their communications, but at times struggled to get appropriate points across. Did not use examples to illustrate, or used inappropriate examples.

4 Therapist presented information in a clear way. Some minor problems evident (eg. occasionally lapsed into jargon, used language which the client may struggle to comprehend).

5 Therapist presented information in a clear and well-ordered fashion, using language and terminology appropriate to the client. Provided appropriate examples/metaphors. Minimal communication problems.

6 Therapist had excellent communication skills, and used language and terminology appropriate to the client. Used many appropriate examples/metaphors which were highly effective in illustrating specific points.
6. PACING AND EFFICIENT USE OF TIME

Introduction

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

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

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

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

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

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

(From James, Blackburn, et al. 2001.)
6. PACING AND EFFICIENT USE OF TIME

Key features: The session should be well 'time managed' in relation to the agenda, and to allow smooth progression through start, middle, and concluding phases. Work must be paced to suit client's needs (e.g. learning speed), and whilst important issues need to be followed, unproductive digressions should be dealt with smoothly. The session should not go over time, without good reason.

0 Poor time management leads to either an aimless or overly rigid session or therapist made no attempt to manage manifestations of OCD, which enabled the client to dominate the session completely.

1 The session is too slow or too fast for the current needs and capacity of the client,

2 Reasonable pacing, but digression or repetitions from therapist and/or client lead to inefficient use of time, or therapist unable to appropriately manage the client's obsessional behaviour manifested during the session. Unbalanced allocation of time, or session over-ran without good reason.

3 Good pacing evident some of the time with discrete start, middle and concluding phases, but diffuse at times. Some problems evident (e.g. therapist had some difficulties managing obsessional behaviours which interfered with efficient use of time).

4 Balanced allocation of time with discrete start, middle, and concluding phases. Minor problems evident (e.g. therapist occasionally lets session become dominated by obsessional behaviours).

5 Good time management skills evident, session runs smoothly. Therapist working effectively in controlling the flow within the session, and for the most part able to limit inappropriate or unproductive discussions. Minimal problems.

6 Excellent time management enabling the agenda to be covered in its entirety, or highly effective management evident in the face of difficulties. Therapist able to limit inappropriate or unproductive discussions, and helps the client to recognise them as a feature of their obsessional difficulties.

7. INTERPERSONAL EFFECTIVENESS

Introduction

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

"In order that the appropriate levels of [these] 3 features are conveyed, careful judgment is required from the therapist. Personal and contextual needs must be taken into account. For example, towards the end of therapy lower levels of warmth may be used, as compared to the beginning, in order to promote patient disengagement. Empathy concerns the therapist's ability to make the patient aware that their difficulties are recognised and understood on both an emotional and cognitive level. The therapist
needs to show that he/she shares the patient's feelings imaginatively. For example, the promotion of a shared value system between therapist and patient will help to enhance this aspect of the relationship. The therapist should avoid appearing distant, aloof or critical."

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

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

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

(From James, Blackburn, et al. 2001.)

7. INTERPERSONAL EFFECTIVENESS

Key features:  
The client is put at ease by the therapist's verbal and non-verbal (e.g. listening skills) behaviour. The client should feel that the core conditions (e.g. warmth, genuineness, empathy and understanding) are present. However, it is important to maintain professional boundaries.

0  Therapist has poor interpersonal skills. Their manner and interventions make the client disengage and become distrustful and/or hostile (e.g. the therapist seemed hostile, demeaning, or in some other way destructive towards the client).

1  Therapist had difficulty showing empathy, genuineness, and warmth or had difficulty conveying confidence and competence.

2  Therapist's style (e.g. intellectualisation) at times impedes his/her empathic understanding of the client's communications or therapist displayed little confidence.

3  The therapist is able to understand explicit meanings of client's communications, resulting in some trust developing. Some evidence of inconsistencies sustaining the relationship.

4  The therapist is able to understand both implicit and explicit meanings of client's communications, and demonstrates it in his/her manner. Minor problems evident (e.g. inconsistent). Displays a satisfactory degree of warmth, concern, confidence, genuineness, and professionalism.

5  The therapist demonstrates very good personal effectiveness. Client appears confident that he/she is being understood, which facilitates self-disclosure. Minimal problems.

6  Excellent interpersonal effectiveness, or highly interpersonally effective in the face of difficulties. Therapist displayed optimal levels of warmth, genuineness, professionalism, etc. appropriate for this particular client in this session.
8. REVIEWING PREVIOUSLY SET HOMEWORK

Introduction:

Since homework is considered an essential part of therapy, it is crucial that its importance is reflected by a thorough review in the therapy session. Besides discovering how successful the client has been with tasks, the therapist also needs to obtain feedback about the client’s experience of carrying out the homework, identify any difficulties there had been, and (perhaps most importantly) what the client had learned from the task. Information gained from reviewing the homework should ideally be incorporated into the agenda for that session, in order to build on the conceptualisation in a concrete way (i.e. to test out hypotheses generated by the treatment model). An example of this might be that the client believed that he would be unable to sleep as his mind would be beset by ruminations about how dirty he was if he did not bathe in his usual (obsessional) manner before retiring. The homework task may have required him to go to bed without washing at all. After doing so, the client may report that although he initially spent time worrying he eventually fell asleep and slept soundly until morning.

Reviewing questionnaire measures is equally important. Clients often find completing them difficult - perhaps because of the way their OCD interferes with completing the task, or because they stir up feelings they are trying to suppress, or simply because they find them tedious due to the frequency with which they are requested to complete them. It is important that the therapist does not simply accept them and file them away without even a cursory glance. Whilst care should be taken not to allow the entire therapy session to be taken up by a review of measures, it is helpful to the therapeutic process to briefly assess changes that have been detected, particular in levels of anxiety and depression, which should then be discussed in the light of recent experiences (perhaps adverse life events may account for an increase in depression scores, or a reduction of anxiety may be the result of avoiding situations which trigger OCD symptoms rather than habituation!). Questionnaires that focus on responsibility appraisal provide important information about strength of beliefs, and can help identify the reasons for resistance to changing behaviour. It is important to target these in treatment. Conversely, less eloquent clients may demonstrate significant decreases in compulsive behaviour but be unable to express what has facilitated their behavioural changes. By providing examples of OCD-relevant appraisals, the client is better able to recognise the beliefs under which they are operating.

To summarise, the role of homework assignments is to bring about a cognitive shift. Similarly, the use of questionnaires is to provide a measure of change. Thus the importance of reviewing these activities, and incorporating them into the overall format of therapy is essential.
8. REVIEWING PREVIOUSLY SET HOMEWORK

Key features: Homework is an essential part of therapy in order to test out ideas, develop new understanding, and try new experiences. In order to ascertain how successful the client has been with the tasks, and what they have learned, it is important to allocate time to review their activities. Homework should regularly involve self-directed exposure, which the client should be actively engaged in between sessions. In order to monitor changes (which are often minimised by clients once they have managed to achieve a particular exposure goal) it is important that these activities are monitored and measured. Similarly, questionnaire responses are clinically important as they can identify belief changes which have resulted from behavioural changes, or to highlight strongly-held beliefs which may hinder improvements. Review of questionnaires and other measures/records reinforces the importance of 'homework'.

0 Therapist did not review previous homework, nor look at measures or exposure diary.

1 Therapist took a cursory look at previous homework, measures, or diary, but did not comment or commented in an unhelpful manner.

2 Therapist reviewed homework/measures/exposure diary, but commented on it in a cursory fashion. Did not attempt to elicit what the client had learned from the experience.

3 Therapist reviewed homework/measures/exposure diary, noted any changes and made some attempt to use this information in the session. Some problems evident, eg. Review not integrated into main body of agenda, or failed to address some of the points identified in the session. Some problems and inconsistencies evident.

4 Therapist reviewed previous homework/exposure/measures in detail and had some success in clarifying its outcome or what the client had learned from the task. Minor problems evident eg. insufficient time allowed for discussion, inconsistent use of Socratic questioning to establish client's learning, but generally competent.

5 Therapist skilfully reviewed previous homework/exposure/measures, identified problems, established the outcome of the homework/exposure assignment, and was generally able to work with the client to maximise what could be learned from the assignment. However, little or no attempt was made to integrate any new learning into everyday life. Only minimal problems evident.

6 Therapist skilfully reviewed previous homework/exposure/measures, identified any problems, established the outcome of the assignment, worked with the client to maximise what could be learned from the assignment, and identified how any new learning could be integrated into daily life.

10. USE OF FEEDBACK AND SUMMARIES

Introduction

The therapist should both provide and elicit feedback throughout the session. The therapist's feedback should occur at regular intervals and is particularly important at the end of the session. The way in which the feedback is given can be brief and concise, perhaps just reflecting back to the client, or rephrasing what has been said in a succinct way. At other times (particular when there has been a major cognitive shift) feedback
should be more detailed, and ideally the client should also be encouraged to make the summary. Feedback helps to focus the patient on the main therapeutic issues and assists in reducing vague or amorphous issues into manageable units. It also helps both client and therapist to determine whether they have a shared understanding of the problems and concerns.

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

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

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

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

10. USE OF FEEDBACK AND SUMMARIES

Key features: The client's and therapist's understanding of key issues should be helped through the use of two-way feedback. The main ways of doing this are through the use of a general summary and chunking important units of information (capsule summaries). The therapist should seek regular feedback from the client to help him/her understand the patient's situation and to ascertain the client's understanding of therapy and so facilitate the client's ability to gain new insights and make therapeutic shifts. It also keeps the patient focussed.

0 Therapist did not ask for feedback to determine the patient's understanding at any point during the session, or feedback was highly inappropriate

1 Minimal appropriate feedback (verbal and/or written)

2 Appropriate feedback, but not given frequently enough by therapist, with insufficient attempts to elicit and give feedback (eg. feedback too vague to provide opportunities for understanding and change).

3 Appropriate feedback given and elicited frequently, although some difficulties evident in terms of content or method of delivery.
4  Appropriate feedback/ summaries given and elicited during the session, facilitating moderate therapeutic gains. Session summarised at the end. Minor problems evident (e.g. inconsistent, or didactic).

5  Highly appropriate feedback given and elicited regularly throughout the session (e.g. at beginning and end of session), facilitating shared understanding and enabling significant therapeutic gains. Time for therapist and client to reflect on sessions. Therapist encourages client to summarise at the end of session. Minimal problems.

6  Excellent use of feedback throughout the session (e.g. at beginning and end), or highly effective feedback given and elicited in the face of difficulties. Time for therapist and client to reflect on session.

11. GUIDED DISCOVERY

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11. GUIDED DISCOVERY

Key features: The client should be helped to develop hypotheses regarding his/her current situation and to generate potential solutions for him/her through guided discovery. To facilitate this, the therapist should maintain an open and inquisitive style and use Socratic questioning to lead the client towards new ways of looking at things.

0 No attempt at guided discovery (eg. hectoring or lecturing). Therapist seemed to be 'cross-examining' the client, putting the client on the defensive, or forcing his/her view on the client.

1 Therapist relied heavily on persuasion or 'lecturing', with little opportunity for discovery by the client. However, the therapist's style was sufficiently supportive so the patient did not feel attacked or defensive.

2 Minimal opportunity for discovery. Some use of questioning, but unhelpful in assisting the patient to gain access to his/her thought or emotions or to make connections between themes.

3 Some reflection evident. Therapist uses primarily a questioning style which is following a productive line of discovery.

4 For the most part, the therapist helped the client see new perspectives through the skilled use of questioning (eg. examining the evidence, considering alternatives) rather than through debate. Minor problems evident eg. some inconsistency, occasionally lapses into a didactic approach.

5 Effective reflection evident. Therapist uses skilful questioning style leading to reflection, discovery, and synthesis. Minimal problems.
Therapist was adept at using guided discovery during the session to explore OCD related problems, and help the client draw his/her own conclusions. Achieved a balance between skilful questioning and other modes of intervention. Evidence of a deeper understanding having been developed.

12. CONCEPTUAL INTEGRATION AND FOCUS ON OCD RELATED COGNITIONS

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

The conceptualisation process involves initially socialising the patient to the therapeutic rationale and a less threatening explanation of their experience. For example, at the beginning of therapy the obsessional patient may believe that his thoughts mean that he is a child molester, a potential murderer, a blasphemer and so on. Given such beliefs, it is not surprising that he seeks to deal with the situation by fighting his thoughts and neutralising any consequence of their occurrence in attempts to ensure that he cannot be responsible for any harm or be otherwise blamed. It is therefore necessary that in the early stages of treatment the patient is helped to see that there may be an alternative explanation of the difficulties they are experiencing. The patient is introduced to an idiosyncratically based cognitive model which offers a quite different and less threatening account of their problems. The therapist and patient work together to draw a diagram summarising the formulation agreed, using the specific beliefs and reactions discussed during the session (from Salkovskis, Forrester, Richards, & Morrison, 1998. An example of the general format of the conceptualisation or formulation can also be found there).

Whilst the formulation (on diagrammatic form) should be devised early on in therapy (usually within the first three sessions), throughout treatment the two possible explanations for the patient’s problems are considered alongside each other, and the details of the formulation are used to guide and ‘drive’ the therapeutic process. It is often necessary to review the formulation from time to time in order to ascertain whether it can explain other OCD symptoms which the patient presents with (i.e. Whether the formulation is able to provide a more general model of OCD concerns).

Thus, the conceptualisation should provide a thread to link all therapy sessions. As well as identifying maintaining features to the problem (the ‘here and now’) as a vicious circle (or more likely, a cluster of vicious circles), it should also incorporate broader influences upon the development of the problem (such as historical factors, underlying core beliefs, etc.). Following the formulation, the patient must acquire the knowledge of what needs to be changed and the most appropriate change mechanisms (e.g. the importance of exposure to situations which trigger OCD concerns, the role of neutralising in the maintenance of obsessional beliefs, etc.). The appropriately constructed formulation should be able to explain most of the features of the patient’s difficulties (historical and present), and as a shared ‘frame of reference’ with the therapist, then leads on to choice of treatment techniques that help inform potential change mechanisms.
Conceptualisation is one of the key processes of therapy through which change takes place. It provides the theoretical overview of the work. Its absence can lead to disjointed therapy, which might prevent major insight being gained by the patient. When it is not appropriately integrated within therapy, the work may lose its focus and only consist of a set of unrelated techniques.

It is of note when scoring this item that the conceptualisation per se (i.e. the actual diagram) is not necessarily used in each session, but the focus of the intervention should reflect the model (both implicitly and explicitly) through the topics of discussion and change techniques used.

12. CONCEPTUAL INTEGRATION AND FOCUS ON OCD RELATED COGNITIONS

Key features: A comprehensive conceptualisation of the presenting problem is crucial to the effective treatment of OCD as it underpins the focus of the intervention. The therapist should help the client gain an understanding of how his/ her perceptions and interpretations, beliefs, attitudes and rules relate to their current problems, their historical factors that may be responsible for their development, and current maintaining factors.

0  The absence of an appropriate conceptualisation.
1  Lack of an appropriate OCD conceptualisation which leads to aimless application of procedures.
2  Evidence of a rudimentary conceptualisation, but does not lead to a clear rationale for interventions. Therapist failed to elicit or discuss meanings attached to the occurrence of intrusive thoughts, images, or urges.
3  Conceptualisation partially developed with some integration with goals of therapy. Therapist discussed in general terms the role of meanings attached to the occurrence of OCD phenomena and/ or the role of responsibility appraisals. However, the therapist failed to focus on the client’s specific appraisals. Some difficulties evident, although sufficient foundation for a coherent intervention.
4  Conceptualisation is moderately developed and integrated within therapy. Therapist elicited and discussed idiosyncratic meanings attached to the client’s OCD phenomena and was able to link these to the model.
5  Well developed conceptualisation. Therapist generally able to utilise it effectively in the session, and share it with the patient in a useful way. Minor problems evident (eg. some difficulties generalising the model to explain other obsessional concerns).
6  Excellent development and integration evident. Therapist skilfully elicited and discussed relevant meanings and appraisals specific to OCD, established their role in the maintenance of the problem, and linked them to the cognitive model of OCD. Or highly effective in the face of difficulties.

13. NORMALISING THE CLIENT’S EXPERIENCE

Introduction: As an essential component of providing an alternative, less threatening explanation of the patient’s experience, it is important that the therapist emphasises that obsessional
thoughts are not abnormal phenomenon \textit{per se}. Many patients consider the obsessional thoughts to be so strange that they fear that they amount to insanity, or worry that the frequency of their occurrence means that they are in danger of losing control.

One of the major goals of therapy is to help the patient recognise that intrusive thoughts are likely to occur, but that the problem lies with the way in which they interpret the occurrence and content of the thoughts that is in fact the problem.

The therapist should take every opportunity to provide normalising information during therapy. In the early stages of treatment in particular it can be helpful to use example to illustrate. ‘Normalising’ can simply take the form of a Socratic question, such as: ‘What kind of person would be most likely to be worried by thoughts about the devil?’. It can also be helpful to illustrate the way in which a non-clinical population often behave in a manner that is similar to that of OCD sufferers. An example of this is the way in which most people (including mental health professionals) are reluctant to write down ‘I wish that ___ would die horribly in an accident’, completing the blank with the name of a loved one (and those who do frequently score out what they have written, or tear up the paper).

12. CONCEPTUAL INTEGRATION AND FOCUS ON OCD RELATED COGNITIONS

\textbf{Key features:} Normalising the client’s experience of his/ her problems is an essential aspect of reaching a shared understanding and facilitating change. It helps reduce clients’ anxiety about what is happening (e.g. that they are not ‘going mad’) and engenders a positive attitude towards overcoming their problem. Whilst it may be done as a discrete topic addressed in therapy, the accomplished therapist successfully interweaves normalising as a thread that runs throughout therapy.

0 Therapist makes no attempt to normalise the client’s experience, or uses a biological/ pathological explanation (e.g. brain ‘hiccups’).

1 Therapist makes some rudimentary attempts to normalise the client’s experience, but uses highly inappropriate examples (e.g. leans towards a biological/ pathological explanation). Major problems evident.

2 Therapist exhibits some competence at normalising, but numerous problems and lack of consistency (e.g. applied as a technique, weak examples, etc.).

3 Competent use of normalising, uses some good examples, but applied as a technique.

4 Good features. Some indication that normalising is an emerging thread in therapy, but minor problems and inconsistencies (e.g. misses opportunities to normalise recent experiences described by the client).

5 Therapist uses normalising skilfully, often using opportunities arising during the session to do so. Minimal problems.

6 The therapist appropriately emphasises the way in which obsessional concerns are an exaggeration of the client’s normal concerns, reactions to ideas they find unacceptable, etc. and this is interwoven with therapy. Facilitates the patient to use a normalising explanation.
14. APPLICATION OF APPROPRIATE STRATEGIES FOR COGNITIVE CHANGE AND MODIFYING COMPULSIONS

Introduction

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

The therapist skillfully uses, and helps the patient to use, appropriate cognitive and behavioural techniques in line with the formulation. The therapist helps the patient to devise appropriate cognitive methods to evaluate the key cognitions associated with distressing emotions, leading to major new perspectives and shifts in emotions. The therapist also helps the patient to apply behavioural techniques in line with the formulation. The therapist helps the patient to identify potential difficulties and think through the cognitive rationales for performing the tasks.***Whilst the methods provide useful ways for the patient to test out cognitions practically and gain experience in dealing with high levels of emotion, in the treatment of OCD, the fundamental mechanism of change would be for the client to establish (through a combination of discussion techniques and behavioural experiments) that the formulation does indeed provide an accurate maintenance model of their difficulties.****the methods allow the therapist to obtain feedback regarding the patient’s level of understanding of prospective practical assignments (ie. by the patient performing the task in-session). During earlier stages, the therapist is also likely to ‘model’ some tasks (eg. touching the sole of their shoe before eating a sandwich).

Three features need to be considered:

i) the appropriateness and range of both cognitive methods (eg. cognitive change diaries, continua, responsibility pie charts, evaluating alternatives, examining pros and cons, determining meanings, imagery restructuring, etc.) and behavioural methods (eg. behavioural diaries, behavioural tests, role play, graded task assignments, response prevention, reinforcement of patient’s work, modelling, etc.);

ii) the skill in the application of these methods - however, skills such as feedback, interpersonal effectiveness, etc. should be rated separately under their appropriate items;

iii) the suitability of the methods for the needs of the patient (ie. not too difficult or complex).
In deciding the appropriateness of a method it is important to determine whether the technique is a coherent strategy for change, following logically from the formulation.

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

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

As with the application of cognitive techniques, the therapist must display skill in applying behavioural methodologies. The rationale for employing the tasks should be carefully explored, and clear learning goals established. It is important to remember that behavioural tasks play a key role with respect to reinforcement of new learning. For example, by engaging a patient in a role-play, one can assess whether the theoretical information has been truly learned and integrated into his/her behavioural repertoire. The role-play will also allow the person to practice new skills. Behavioural tasks are also useful methodologies to employ prior to asking the patient to use the activity in a homework task. Initially, the therapist would model the required behaviour and then observe the client. However, the client is encouraged to take increasing responsibility for the task (to avoid either deliberate or inadvertent reassurance). Eventually, the client is expected to assign their own behavioural tasks without discussion with the therapist (in order to assume complete responsibility for their actions). Again, it is important that behavioural methodologies are timely. For example, encouraging response prevention before the client has understood the formulation is likely to lead to failure which may compromise further attempts at response prevention.

In addition, the therapist needs to elicit and develop practical plans with the patient in order that effective change takes place (eg. the where, what, when, and how of an exposure programme). Indeed, part of the process of producing effective behavioural change is the development of plans that will help test out hypotheses and break unhelpful patterns of behaviour. In planning the task, relevant questions should be asked of the person's concepts, cognitions, affective and physiological states, and behavioural repertoire.
14. APPLICATION OF APPROPRIATE STRATEGIES FOR COGNITIVE CHANGE AND MODIFYING COMPULSIONS

Introduction:
Change methods are cognitive and behavioural strategies employed by the therapist which are consistent with the cognitive rationale and/or formulation and designed to promote therapeutic change. The potency of the techniques may depend on whether they are applied at the appropriate stage in therapy, and the skill with which they are applied, although sometimes change with OCD patients is slower and the fruits of particular techniques may not be immediately apparent but contribute to more gradual change over time. The rater should bear this in mind when rating the item as it is the skill with which a technique is applied rather than how effective it appears to have been at the time (the rater may wish to consider whether the technique seems timely and logical, and is likely to facilitate a change in the way the patient appraises their situation). It is important to note that during some sessions it may not be appropriate to use a wide range of methods; the rater should take this into account when scoring this item.

In deciding the appropriateness of a method it is important to determine whether the technique is a coherent strategy for change, following logically from the patient's formulation and the content of the discussion. The indiscriminate use of a range of techniques is not considered a demonstration of advanced skill.

14. APPLICATION OF APPROPRIATE STRATEGIES FOR COGNITIVE CHANGE AND MODIFYING COMPULSIONS

Key features: A range of techniques can be used to promote cognitive change. These include identifying alternative explanations for OCD (e.g. is the problem contamination or worry about contamination?), reviewing evidence for misinterpretations, pie-charts, probability step analysis, designing behavioural experiments, etc. Nb. The focus is on the quality of the therapist's strategy, not on how effective the strategy was.

0 Therapist fails to use or misuses techniques for cognitive change or modifying neutralising behaviours.

1 Therapist applies either insufficient or inappropriate methods, or attempts to challenge intrusive thoughts rather than their meaning. Limited skill or flexibility evident.

2 Therapist selected appropriate techniques for cognitive change and/or modifying neutralising behaviours. However, major difficulties evident (e.g. techniques did not seem promising for the client, therapist had limited repertoire of techniques and/or had difficulties moving between them).

3 Therapist applies a number of methods in competent ways, although some problems evident (e.g. interventions are incomplete).

4 Therapist applies a range of methods with skill and flexibility, enabling the client to develop new perspectives. Minor problems evident.

5 Therapist systematically applies an appropriate range of methods in a creative, resourceful and effective manner. Minimal problems.
Excellent range and application, or successful application in the face of difficulties. Therapist followed a coherent, consistent therapeutic strategy incorporating the most appropriate techniques for cognitive change and modifying neutralising behaviours.

15. THERAPEUTIC FOCUS

Introduction:
Therapeutic goals should be discussed and agreed at the outset of therapy. They should be discreet, readily achievable, and concrete objectives that the client and therapist have collaboratively agreed. Ideally, they should be divided into short, medium and long-term aims.

The focus of the therapy should thus be directed towards achieving those goals, which should be consistent with the formulation. However, it is important that the therapist does not become so ‘goal-driven’ that the sessions become so task oriented that there is insufficient flexibility to encompass important issues raised during the session. The therapist should be generally adept at picking up on other issues arising and making links with the presenting problem. This is particularly salient with the patient who introduces a problem which they view as ‘different’ to their presenting obsessional concern. An example of this may be the person who worries a lot about contamination and has extensive rituals to prevent accidental poisoning of their family who then complains that ‘another problem’ has occurred that is quite different, and that they keep having intrusive thoughts about deliberately pushing people into a busy road. In such cases, it is important that the therapist does not become side-tracked by this but is able to help the client fit this new experience into their existing formulation in order to generalise their understanding of the way in which obsessional problems work.

The interpersonal style of the patient can mean that they are not very focussed, and have a tendency to try to talk about a range of subjects which bear no relevance to therapy (from discussing the weather and the queue at the bus stop, to asking the therapist about their family, or seeking information about other problems that the therapist is not qualified to comment on such as health or financial concerns). The therapist should be mindful of this tendency, and be able to tactfully bring the patient back to the appropriate therapeutic focus (for which a firm agenda is extremely useful). However, the skilful therapist should be able to elicit whether the digression is likely to lead to information relevant to therapy and be able to guide the patient towards the point they are attempting to make.

On occasions, it is appropriate to put aside therapeutic focus. This is likely when a patient arrives at the session in a greatly distressed state, maybe as a result of a recent incident or life event. Whilst responding sensitively and constructively to the presenting crisis, the highly skilled therapist should be able to make appropriate reference to the OCD problem (eg. examining the effect of recent events to their OCD).

From time to time, ‘golden moments’ may occur in treatment. Perhaps a patient who has struggled with the conceptualisation or has been sceptical about the approach has had an experience that has changed their view. It is equally important in such situations that the therapist can be flexible in their focus to enable to work effectively with the material elicited, and capitalise on the momentum these golden moments can engender.
15. THERAPEUTIC FOCUS

Key features: Therapy maintains an appropriate level of focus on short, medium, and longer term goals. However, there is sufficient flexibility to encompass important issues raised during the session (eg. therapist capitalises on 'golden moments'). Such flexibility maintains consistency with overall goals.

0 No focus. The therapist follows anything raised by the client, or completely ignores issues raised by him/her.

1 Very little focus evident. The therapist is frequently sidetracked by clearly irrelevant digressions, and is ineffective at averting them.

2 Therapist remains reasonably focussed during the session, but some problems or inconsistencies (eg. easily sidetracked, or struggles to allow appropriate attention to other issues that may arise that are outside the presenting problem).

3 Generally appropriate therapeutic focus. Some difficulties present eg. spending too long on some agenda items, getting sidetracked by minor issues, misses some opportunities to pick up on other issues (ie. inflexible).

4 Maintains a clear focus. Generally adept at picking up on other issues arising and making links with the presenting problem. Minor problems evident, eg. occasional difficulties at averting unproductive or irrelevant diversions. Or sufficient flexibility to put aside goal-oriented intervention when clinically indicated (eg. following a bereavement), but makes insufficient links with overall goals.

5 Maintains a clear focus. Skilfully picks up on other issues arising and is able to utilise them in a useful and productive manner. Identifies unproductive diversions with clear reference to goals. Or flexibility to put aside goal-oriented intervention when clinically indicated (eg. following a bereavement) whilst maintaining consistency with overall goals (eg. examining the effect this may have on their OCD).

6 Adeptly integrates issues raised during the session and negotiates a revised agenda with client. Identifies 'golden moments' and works effectively with material elicited in the session.

16. INTEGRATION OF EXPOSURE INTO A COGNITIVE FRAMEWORK

Introduction:
Salkovskis (1996) suggested that interactions between cognitive and behavioural elements are involved in the maintenance of all anxiety problems, and discusses the close co-ordination of both cognitive and behavioural techniques. Thus behavioural experiments are an essential component of therapy for OCD. In OCD, behavioural experiments generally involve the behavioural principle of 'exposure' with the added emphasis of testing a hypotheses. However, caution should be exercised regarding the focus of the behavioural experiment. Where a patient has concerns regarding contamination with HIV the focus of the exposure is not the HIV virus per se, but to toilet door handles, for instance, since avoidance of such a situation is one of the key components fuelling the concern. The therapist is not attempting to disprove the
likelihood of contracting HIV but is reinforcing the alternative (psychological) view of their presenting problem as one of worry. Thus, behavioural experiments directly test appraisals, assumptions, and processes hypothesised to be involved in the patient’s obsessional problems (eg. demonstrating that attempts to suppress a thought lead to an increase in the frequency with which it occurs) (from Salkovskis, Forrester, Richards, & Morrison, 1998).

Considering exposure in the context of behavioural experiments, it may therefore involve a range of strategies including the following categories:

1. To assess the extent to which a particular process may be maintaining the patient’s concerns (eg. checking the door repeatedly makes them feel more rather than less worried about security).

2. To elicit worrisome thoughts and underlying appraisals where avoidance is prominent (ie. the patient is unable to say why they feel so driven to wash their hands twenty times because they do so automatically without allowing the feared consequence of not doing so to enter their mind).

3. In typical behavioural fashion, to discover that anxiety levels eventually decrease when no neutralising action is performed (ie. habituation occurs). However, this is not the sole message that should be derived from the exposure task. It should be couched within a cognitive-behavioural framework, with the therapist asking questions such as, ‘What have you learned from that?’ rather than the more didactic, ‘Your anxiety will reduce if you resist carrying out neutralising rituals’.

Exposure or behavioural experiments should be relevant to the content of the session. For the most part, they should be devised collaboratively based on the conceptualisation and the client’s understanding of what appears to be maintaining his/ her problem. In the initial stages of therapy, the client is likely to require more guidance on appropriate task. This can still be done in a way that actively engages the client in the task, perhaps by asking questions such as, ‘How could you find out why you feel so afraid of touching the toilet seat?’ in situations where rituals are used to prevent direct exposure. Even when the client is reluctant to make suggestions, the therapist needs to guard against being prescriptive, although it is permissible to make suggestions for the patient to consider in a Socratic manner. Above all, the exposure task should be relevant to content of the session, and must have a clear rationale which is understood by the client.

As therapy progresses it is beneficial for the client to take increasing responsibility for devising their own exposure task. The ultimate goal would be for the client to carry out a suitable experiment of his or her own design, without discussing it with the therapist beforehand. When reporting back in the following session, they should do so in broad terms about how successful they thought it had been and what they had learned, but without divulging the actual activity as this could be a way of subtly obtaining reassurance from the therapist (more details about reassurance seeking are described in item 4).

16. INTEGRATION OF EXPOSURE INTO A COGNITIVE FRAMEWORK
Key features: Exposure is an important part in cognitive-behavioural therapy for OCD. The key difference between exposure in CBT and behaviour therapy is the way in which it is set up as a behavioural experiment. Such behavioural experiments should be derived collaboratively with the client, rather than prescriptively, and have a specific hypothesis which the experiment is devised to test.

0 Therapist fails to use exposure either in the session or as homework task.
1 Therapist utilises exposure, but in a prescriptive fashion. Rationale given was behavioural (e.g. habituation) or no rationale given.
2 Therapist attempts to set up exposure task as a behavioural experiment, but numerous problems evident, e.g. hypotheses unclear, no rationale given, task not arrived at collaboratively.
3 Competent application of exposure as a behavioural experiment. Reasonable hypotheses. Some problems, e.g. minimal collaboration, not clearly linked to session.
4 Competent application of exposure as a behavioural experiment, arrived at collaboratively. Clear hypotheses. Obtains feedback to ascertain client’s understanding of the task. The therapist ‘got out of their chair’, and modelled first in experiments/exposure task, where appropriate. Minor problems/inconsistencies.
5 Very competent application of exposure as a behavioural experiment. Relevant to the content of the session. Therapist elicited feedback to ascertain client’s understanding of the task and identified and discussed potential obstacles to the client’s success with the task. Minimal problems.
6 Excellent application of exposure. Client understands and can apply the cognitive model, and is able to set up his/her own behavioural experiments, or very good application in the face of difficulties.

17. HOMEWORK SETTING

Introduction:
Progress is more likely to occur when patients are able to apply the concepts learned in the therapy sessions to their lives outside; homework assignments are the bridges between therapy and the real world. Homework helps transfer within-session learning to real-life settings. To facilitate the transfer, the homework material is usually based upon material discussed in the session (adapted from James, Blackburn, & Reichelt, 2001).

In item 15 (above), the integration of exposure into a cognitive framework has been outlined. Whilst it is de facto a major component of the homework, homework may incorporate a range of other activities relevant to the content of the session. For example, the patient may be asked to keep a Daily Diary where they record situations in which obsessional concerns are triggered, their appraisals of the concerns, and then a balanced view (i.e. modification of responsibility appraisals), or some reading may be suggested to further their understanding of some aspect of their problem.

Homework may involve discrete activities as described above, or may involve some broader changes. For example, where OCD has become the main focus of the person’s life to the exclusion of all other activities, it is important to fill the vacuum that reducing (or eliminating) rituals would leave. To this end, homework may involve finding out about
evening classes or applying for a part-time job, or a similar activity that is geared towards medium- and long-term goals.

Comments about the need for a collaborative approach in homework setting, and a task consistent with the conceptualisation apply in the same way as for item 15 above.

17. HOMEWORK SETTING

**Key features:** Homework tasks should be appropriate for the stage of therapy, consistent with the conceptualisation, and have precise and clear goals. Later on in therapy, it is appropriate to encourage client's to take responsibility for setting their own homework. Homework should always be reviewed at the next session.

0 Therapist fails to set homework, or sets inappropriate homework.

1 Therapist did not negotiate homework. Insufficient time allotted for adequate explanation, leading to ineffectual task being set.

2 Therapist negotiates homework unilaterally and in a routine fashion, without explaining the rationale for new homework.

3 Therapist has set an appropriate new homework task, but some problems evident (eg. not explained sufficiently and/or not developed jointly).

4 Appropriate new homework jointly negotiated with clear goals and rationales. However, minor problems evident.

5 Appropriate homework negotiated jointly and explained well, including an exploration of potential obstacles. Minimal problems.

6 Excellent homework negotiated, or highly appropriate one negotiated in the face of difficulties.

Part 3: OBSERVATIONS REGARDING THE THERAPEUTIC INTERVENTION

18. CLIENT COMPLEXITY

**Introduction**

Whilst the initial assessment carried out prior to accepting the patient for treatment will have detailed information about complexity and co-morbidity, on the rating scale the rater is asked to assess how complex they judge the person to be on the basis of their subjective judgment of the session being rated. Whilst co-morbidity is not always apparent in the session, what is more important is the way in which the client presents on a specific occasion. For example, interpersonal style may vary from one session to the next and a patient who is often compliant may on occasions become quite obstructive, or a recent life event can change the complexity of the case. These factors can affect scores obtained on previous items, and this item is intended to give an indication of whether this is likely.
18. CLIENT COMPLEXITY

**Key feature:** The nature of the presenting problem is not necessarily the defining feature in terms of client complexity, but involves factors such as interpersonal style, level of comprehension, 'psychological mindedness', etc.

0 Client is straightforward in terms of diagnosis and presentation.

1 Client meets diagnosis for more than one disorder, but is relatively straightforward.

2 Client meets diagnosis for one or more disorders, and presents some difficulties (e.g., adverse life circumstances, irregular attendance, some non-compliance either within or between sessions, has difficulty understanding concepts, etc.).

3 Client is often difficulty to work with, e.g. uncommunicative, highly distractable or chaotic in their presentation, manifestation of OCD during session makes adherence to agenda difficult, etc.

4 Client is invariably difficult to work with, e.g. constantly attempts to dominate the session, refuses to work collaboratively, consistently dismisses therapist's attempts at a coherent intervention.

19. CONSISTENCY WITH TRIAL PROTOCOL

**Introduction**
This item is optional, and is included because the scale was developed as a method of measuring adherence in treatment trials using cognitive-behaviour therapy for obsessive-compulsive disorder.

19. CONSISTENCY WITH TRIAL PROTOCOL

**Key feature:** Particular criterion need to be met for the standard of therapy to meet the requirements of treatment trials. The rating is not a question of 'is this a good therapist?' or whether the intervention was good or effective, but whether the method and standard of delivery is consistent with the stringent requirements of a treatment trial. As such, it is important to strive for homogeneity amongst trial therapists.

No For the most part, the therapist works outside the remit of the trial protocol.

Sub-threshold Generally consistent with trial protocol, but some problems and/or inconsistencies.

Yes Style and content is consistent with trial protocol.

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Part 1: GENERAL THERAPEUTIC SKILLS

1. RATIONALE

Key features: The format of therapy is clearly explained. Procedures closely follow an explicit theoretical model which is made clear by the therapist and understood by the client.

0 No rationale given for any procedures used, and no attempt to establish client's understanding of procedures used.

1 Rationale attempted, but is wrong, misleading, or poorly delivered. No attempt to establish client's understanding.

2 Appropriate rationale is provided, but major difficulties evident (e.g. vague, confusing or incomplete, poorly delivered). Some attempt to check client's understanding, but explicit feedback not sought and misunderstandings not clearly identified or addressed.

3 Appropriate rationale is provided, some difficulties present (e.g. unclear at times, problems in content or style of delivery). Some attempts to check patients understanding and obtain feedback, misunderstandings not fully addressed.

4 Appropriate rationale provided, generally clear, well delivered, client's understanding is established, feedback sought, and difficulties or misunderstandings addressed. Minor difficulties evident (e.g. unclear at times, explanations not always complete).

5 Highly appropriate rationale, given clearly and well delivered, client's understanding is checked, feedback sought, and misunderstandings addressed. Minimal problems.

6 Excellent rationale given clearly, client's understanding checked, feedback sought, and misunderstandings addressed collaboratively or appropriate rationale delivered clearly and well, understanding and feedback sought in the face of difficulties.

2. AGENDA SETTING

Key features: In order to make optimal use of time available in the therapy session, discrete, appropriate and realistic topics need to be identified for the session. The agenda should be set in a collaborative way, reflecting both specific current issues which the client may have, and the overall rationale and goals for therapy.

0 No agenda set, or highly inappropriate.

1 Inappropriate agenda set (e.g. lack of focus, unrealistic, no account of client's presentation, homework not reviewed).

2 An attempt at an agenda made, but major difficulties evident (e.g. unilaterally set). Poor adherence.

3 Appropriate agenda, which was set well, but some difficulties evident (e.g. poor collaboration). Some adherence.

4 Therapist worked with the client to set a mutually satisfactory agenda that included specific problems in understanding or overcoming OCD. Minor difficulties evident (e.g. no prioritisation), but appropriate features covered (e.g. review of homework). Moderate adherence.

5 Appropriate agenda set with discrete and prioritised targets, reviewed at the end. Agenda adhered to. Minimal problems.

6 Excellent agenda set which was highly appropriate for available time and stage in therapy, or highly effective agenda set in the face of difficulties.
3. DEALING WITH QUESTIONS

**Key features:** An important aspect of good therapy is to be able to deal with any questions from the patient and objections or problems that the patient may have with any aspect of the therapy or therapeutic relationship. The therapist should elicit any problems or objections and deal with them sensitively and directly, also obtaining feedback on this in the session. This is similar to but distinct from eliciting feedback on the therapy session as a whole.

0 Therapist fails to acknowledge questions, dismisses them or makes no attempt to answer them.
1 Therapist shows no understanding of questions, and responds inappropriately, inadequately, or too briefly.
2 Therapist responds to patient's questions, but major difficulties evident (e.g. some misunderstanding, answers may be unclear, client does not understand answer).
3 Therapist is sensitive to questions, generally understands them, and has some success in answering appropriately and clearly, some difficulties evident (e.g. some answers may be incomplete or overly detailed, fails to check client's understanding of response to the answer).
4 Therapist is sensitive to questions, answers them clearly and appropriately, generally seeks feedback from client. Minimal problems.
5 Therapist is sensitive to, and understands questions, answers them appropriately, and seeks feedback from patient.
6 Therapist is sensitive to, and understands questions, answers them appropriately, and seeks feedback from patients. Makes links between questions and conceptualisation or broader picture.

4. REASSURANCE SEEKING

**Key features:** The counterproductive nature of reassurance seeking is an issue that is well established in the cognitive approach to the treatment of OCD. Therapists must be mindful that reassurance can be sought in many subtle ways, and when this occurs should be identified and dealt with appropriately in the session.

0 Therapist ignores or shows no understanding of direct or indirect requests for reassurance.
1 Therapist responds to requests by providing reassurance when it is inappropriate to do so, or has difficulty in recognising reassurance-seeking.
2 Therapist is generally sensitive to requests for reassurance, and attempts to deal with them appropriately, but some difficulties evident (e.g. gets hooked into a debate regarding the focus of the OCD concern, misses more subtle methods of reassurance-seeking, overly didactic or vague in their response).
3 Therapist is sensitive to requests for reassurance, tries to deal with them collaboratively and generally responds effectively. Minor difficulties (e.g. inconsistent, may miss indirect requests).
4 Therapist recognises direct and indirect requests for reassurance, and responds effectively, enabling client to become more aware of the effect of reassurance seeking in maintaining the problem.
5 Consistent and competent recognition of and response to direct and indirect requests for reassurance, or very good work done in the face of difficulties.
6 Excellent recognition of and response to all forms of reassurance seeking. Facilitates the client to recognise this behaviour, and to identify when this is happening without prompting by therapist.
5. CLARITY OF COMMUNICATIONS

Key features:  An essential aspect of good therapy is clarity of communication. This involves clear use of language at a level which is appropriate to the client's ability, avoiding jargon, and generally presenting information in a style which is clear and easily understood.

0 Therapist was muddled in their presentation of information and overused jargon, or used language which was highly inappropriate for the client's level of understanding.

1 Therapist had difficulty presenting information in straightforward language. Overuse of jargon.

2 Therapist generally presented information in a coherent fashion, but was overly technical, or found it hard to simplify information to aid client's understanding.

3 Therapist was generally clear in their communications, but at times struggled to get appropriate points across. Did not use examples to illustrate, or used inappropriate examples.

4 Therapist presented information in a clear way. Some minor problems evident (eg. occasionally lapsed into jargon, used language which the client may struggle to comprehend).

5 Therapist presented information in a clear and well-ordered fashion, using language and terminology appropriate to the client. Provided appropriate examples/ metaphors. Minimal communication problems.

6 Therapist had excellent communication skills, and used language and terminology appropriate to the client. Used many appropriate examples/ metaphors which were highly effective in illustrating specific points.

6. PACING AND EFFICIENT USE OF TIME

Key features:  The session should be well 'time managed' in relation to the agenda, and to allow smooth progression through start, middle, and concluding phases. Work must be paced to suit client's needs (eg. learning speed), and whilst important issues need to be followed, unproductive digressions should be dealt with smoothly. The session should not go over time, without good reason.

0 Poor time management leads to either an aimless or overly rigid session or therapist made no attempt to manage manifestations of OCD, which enabled the client to dominate the session completely.

1 The session is too slow or too fast for the current needs and capacity of the client,

2 Reasonable pacing, but digression or repetitions from therapist and/ or client lead to inefficient use of time, or therapist unable to appropriately manage the client's obsessional behaviour manifested during the session. Unbalanced allocation of time, or session over-ran without good reason.

3 Good pacing evident some of the time with discrete start, middle and concluding phases, but diffuse at times. Some problems evident (eg. therapist had some difficulties managing obsessional behaviours which interfered with efficient use of time).

4 Balanced allocation of time with discrete start, middle, and concluding phases. Minor problems evident (eg. therapist occasionally lets session become dominated by obsessional behaviours).

5 Good time management skills evident, session runs smoothly. Therapist working effectively in controlling the flow within the session, and for the most part able to limit inappropriate or unproductive discussions.. Minimal problems.

6 Excellent time management enabling the agenda to be covered in its entirety, or highly effective management evident in the face of difficulties. Therapist able to limit inappropriate or unproductive discussions, and helps the client to recognise them as a feature of their obsessional difficulties.
7. INTERPERSONAL EFFECTIVENESS

**Key features:** The client is put at ease by the therapist’s verbal and non-verbal (e.g., listening skills) behaviour. The client should feel that the core conditions (e.g., warmth, genuineness, empathy and understanding) are present. However, it is important to maintain professional boundaries.

0 Therapist has poor interpersonal skills. Their manner and interventions make the client disengage and become distrustful and/or hostile (e.g., the therapist seemed hostile, demeaning, or in some other way destructive towards the client).

1 Therapist had difficulty showing empathy, genuineness, and warmth or had difficulty conveying confidence and competence.

2 Therapist's style (e.g., intellectualisation) at times impedes his/her empathic understanding of the client's communications or therapist displayed little confidence.

3 The therapist is able to understand explicit meanings of client's communications, resulting in some trust developing. Some evidence of inconsistencies sustaining the relationship.

4 The therapist is able to understand both implicit and explicit meanings of client's communications, and demonstrates it in his/her manner. Minor problems evident (e.g., inconsistent). Displays a satisfactory degree of warmth, concern, confidence, genuineness, and professionalism.

5 The therapist demonstrates very good personal effectiveness. Client appears confident that he/she is being understood, which facilitates self-disclosure. Minimal problems.

6 Excellent interpersonal effectiveness, or highly interpersonally effective in the face of difficulties. Therapist displayed optimal levels of warmth, genuineness, professionalism, etc. appropriate for this particular client in this session.
8. REVIEWING PREVIOUSLY SET HOMEWORK

Key features: Homework is an essential part of therapy in order to test out ideas, develop new understanding, and try new experiences. In order to ascertain how successful the client has been with the tasks, and what they have learned, it is important to allocate time to review their activities. Homework should regularly involve self-directed exposure, which the client should be actively engaged in between sessions. In order to monitor changes (which are often minimised by client’s once they have managed to achieve a particular exposure goal) it is important that these activities are monitored and measured. Similarly, questionnaire responses are clinically important as they can identify belief changes which have resulted from behavioural changes, or to highlight strongly-held beliefs which may hinder improvements. Review of questionnaires and other measures/records reinforces the importance of ‘homework’.

0 Therapist did not review previous homework, nor look at measures or exposure diary.

1 Therapist took a cursory look at previous homework, measures, or diary, but did not comment or commented in an unhelpful manner.

2 Therapist reviewed homework/measures/exposure diary, but commented on it in a cursory fashion. Did not attempt to elicit what the client had learned from the experience.

3 Therapist reviewed homework/measures/exposure diary, noted any changes and made some attempt to use this information in the session. Some problems evident, eg. Review not integrated into main body of agenda, or failed to address some of the points identified in the session. Some problems and inconsistencies evident.

4 Therapist reviewed previous homework/exposure/ measures in detail and had some success in clarifying its outcome or what the client had learned from the task. Minor problems evident eg. Insufficient time allowed for discussion, inconsistent use of socratic questioning to establish client’s learning, but generally competent.

5 Therapist skillfully reviewed previous homework/exposure/ measures, identified problems, established the outcome of the homework/exposure assignment, and was generally able to work with the client to maximise what could be learned from the assignment. However, little or no attempt was made to integrate any new learning into everyday life. Only minimal problems evident.

6 Therapist skillfully reviewed previous homework/exposure/ measures, identified any problems, established the outcome of the assignment, worked with the client to maximise what could be learned from the assignment, and identified how any new learning could be integrated into daily life.
9. USE OF FEEDBACK AND SUMMARIES

Key features: The client's and therapist's understanding of key issues should be helped through the use of two-way feedback. The main ways of doing this are through the use of a general summary and chunking important units of information (capsule summaries). The therapist should seek regular feedback from the client to help him/her understand the patient's situation and to ascertain the client's understanding of therapy and so facilitate the client's ability to gain new insights and make therapeutic shifts. It also keeps the patient focused.

0 Therapist did not ask for feedback to determine the patient's understanding at any point during the session, or feedback was highly inappropriate

1 Minimal appropriate feedback (verbal and/or written)

2 Appropriate feedback, but not given frequently enough by therapist, with insufficient attempts to elicit and give feedback (e.g., feedback too vague to provide opportunities for understanding and change).

3 Appropriate feedback given and elicited frequently, although some difficulties evident in terms of content or method of delivery.

4 Appropriate feedback/summaries given and elicited during the session, facilitating moderate therapeutic gains. Session summarised at the end. Minor problems evident (e.g., inconsistent, or didactic).

5 Highly appropriate feedback given and elicited regularly throughout the session (e.g., at beginning and end of session), facilitating shared understanding and enabling significant therapeutic gains. Time for therapist and client to reflect on sessions. Therapist encourages client to summarise at the end of session. Minimal problems.

6 Excellent use of feedback throughout the session (e.g., at beginning and end), or highly effective feedback given and elicited in the face of difficulties. Time for therapist and client to reflect on session.
10. GUIDED DISCOVERY

Key features: The client should be helped to develop hypotheses regarding his/her current situation and to generate potential solutions for him/her through guided discovery. To facilitate this, the therapist should maintain an open and inquisitive style and use Socratic questioning to lead the client towards new ways of looking at things.

0 No attempt at guided discovery (e.g. hectoring or lecturing). Therapist seemed to be 'cross-examining' the client, putting the client on the defensive, or forcing his/her view on the client.

1 Therapist relied heavily on persuasion or 'lecturing', with little opportunity for discovery by the client. However, the therapist's style was sufficiently supportive so the patient did not feel attacked or defensive.

2 Minimal opportunity for discovery. Some use of questioning, but unhelpful in assisting the patient to gain access to his/her thought or emotions or to make connections between themes.

3 Some reflection evident. Therapist uses primarily a questioning style which is following a productive line of discovery.

4 For the most part, the therapist helped the client see new perspectives through the skilled use of questioning (e.g. examining the evidence, considering alternatives) rather than through debate. Minor problems evident e.g. some inconsistency, occasionally lapses into a didactic approach.

5 Effective reflection evident. Therapist uses skillful questioning style leading to reflection, discovery, and synthesis. Minimal problems.

6 Therapist was adept at using guided discovery during the session to explore OCD related problems, and help the client draw his/her own conclusions. Achieved a balance between skillful questioning and other modes of intervention. Evidence of a deeper understanding having been developed.

11. CONCEPTUAL INTEGRATION AND FOCUS ON OCD RELATED COGNITIONS

Key features: A comprehensive conceptualisation of the presenting problem is crucial to the effective treatment of OCD as it underpins the focus of the intervention. The therapist should help the client gain an understanding of how his/her perceptions and interpretations, beliefs, attitudes and rules relate to their current problems, their historical factors that may be responsible for their development, and current maintaining factors.

0 The absence of an appropriate conceptualisation.

1 Lack of an appropriate OCD conceptualisation which leads to aimless application of procedures.

2 Evidence of a rudimentary conceptualisation, but does not lead to a clear rationale for interventions. Therapist failed to elicit or discuss meanings attached to the occurrence of intrusive thoughts, images, or urges.

3 Conceptualisation partially developed with some integration with goals of therapy. Therapist discussed in general terms the role of meanings attached to the occurrence of OCD phenomena and/or the role of responsibility appraisals. However, the therapist failed to focus on the client's specific appraisals. Some difficulties evident, although sufficient foundation for a coherent intervention.

4 Conceptualisation is moderately developed and integrated within therapy. Therapist elicited and discussed idiosyncratic meanings attached to the client's OCD phenomena and was able to link these to the model.

5 Well developed conceptualisation. Therapist generally able to utilise it effectively in the session, and share it with the patient in a useful way. Minor problems evident (e.g. some difficulties generalising the model to explain other obsessional concerns).

6 Excellent development and integration evident. Therapist skilfully elicited and discussed relevant meanings and appraisals specific to OCD, established their role in the maintenance of the problem, and linked them to the cognitive model of OCD. Or highly effective in the face of difficulties.
12. NORMALISING THE CLIENT'S EXPERIENCE

Key features: Normalising the client's experience of his/her problems is an essential aspect of reaching a shared understanding and facilitating change. It helps reduce clients' anxiety about what is happening (e.g. that they are not 'going mad') and engenders a positive attitude towards overcoming their problem. Whilst it may be done as a discrete topic addressed in therapy, the accomplished therapist successfully interweaves normalising as a thread that runs throughout therapy.

0 Therapist makes no attempt to normalise the client's experience, or uses a biological/pathological explanation (e.g. brain 'hiccups').

1 Therapist makes some rudimentary attempts to normalise the client's experience, but uses highly inappropriate examples (e.g. leans towards a biological/pathological explanation). Major problems evident.

2 Therapist exhibits some competence at normalising, but numerous problems and lack of consistency (e.g. applied as a technique, weak examples, etc.).

3 Competent use of normalising, uses some good examples, but applied as a technique.

4 Good features. Some indication that normalising is an emerging thread in therapy, but minor problems and inconsistencies (e.g. misses opportunities to normalise recent experiences described by the client).

5 Therapist uses normalising skillfully, often using opportunities arising during the session to do so. Minimal problems.

6 The therapist appropriately emphasises the way in which obsessional concerns are an exaggeration of the client's normal concerns, reactions to ideas they find unacceptable, etc. and this is interwoven with therapy. Facilitates the patient to use a normalising explanation.

13. APPLICATION OF APPROPRIATE STRATEGIES FOR COGNITIVE CHANGE AND MODIFYING COMPULSIONS

Key features: A range of techniques can be used to promote cognitive change. These include identifying alternative explanations for OCD (e.g. is the problem contamination or worry about contamination?), reviewing evidence for misinterpretations, pie-charts, probability step analysis, designing behavioural experiments, etc. Nb. The focus is on the quality of the therapist's strategy, not on how effective the strategy was.

0 Therapist fails to use or misuses techniques for cognitive change or modifying neutralising behaviours.

1 Therapist applies either insufficient or inappropriate methods, or attempts to challenge intrusive thoughts rather than their meaning. Limited skill or flexibility evident.

2 Therapist selected appropriate techniques for cognitive change and/or modifying neutralising behaviours. However, major difficulties evident (e.g. techniques did not seem promising for the client, therapist had limited repertoire of techniques and/or had difficulties moving between them).

3 Therapist applies a number of methods in competent ways, although some problems evident (e.g. interventions are incomplete).

4 Therapist applies a range of methods with skill and flexibility, enabling the client to develop new perspectives. Minor problems evident.

5 Therapist systematically applies an appropriate range of methods in a creative, resourceful and effective manner. Minimal problems.

6 Excellent range and application, or successful application in the face of difficulties. Therapist followed a coherent, consistent therapeutic strategy incorporating the most appropriate techniques for cognitive change and modifying neutralising behaviours.
14. THERAPEUTIC FOCUS

Key features: Therapy maintains an appropriate level of focus on short, medium, and longer term goals. However, there is sufficient flexibility to encompass important issues raised during the session (eg. therapist capitalises on 'golden moments'). Such flexibility maintains consistency with overall goals.

0 No focus. The therapist follows anything raised by the client, or completely ignores issues raised by him/her.

1 Very little focus evident. The therapist is frequently sidetracked by clearly irrelevant digressions, and is ineffective at averting them.

2 Therapist remains reasonably focused during the session, but some problems or inconsistencies (eg. easily sidetracked, or struggles to allow appropriate attention to other issues that may arise that are outside the presenting problem).

3 Generally appropriate therapeutic focus. Some difficulties present eg. spending too long on some agenda items, getting sidetracked by minor issues, misses some opportunities to pick up on other issues (ie. inflexible).

4 Maintains a clear focus. Generally adept at picking up on other issues arising and making links with the presenting problem. Minor problems evident, eg. occasional difficulties at averting unproductive or irrelevant diversions. Or sufficient flexibility to put aside goal-oriented intervention when clinically indicated (eg. following a bereavement), but makes insufficient links with overall goals.

5 Maintains a clear focus. Skilfully picks up on other issues arising and is able to utilise them in a useful and productive manner. Identifies unproductive diversions with clear reference to goals. Or flexibility to put aside goal-oriented intervention when clinically indicated (eg. following a bereavement) whilst maintaining consistency with overall goals (eg. examining the effect this may have on their OCD).

6 Adeptly integrates issues raised during the session and negotiates a revised agenda with client. Identifies 'golden moments' and works effectively with material elicited in the session.

15. INTEGRATION OF EXPOSURE INTO A COGNITIVE FRAMEWORK

Key features: Exposure is an important part in cognitive-behavioural therapy for OCD. The key difference between exposure in CBT and behaviour therapy is the way in which it is set up as a behavioural experiment. Such behavioural experiments should be derived collaboratively with the client, rather than prescriptively, and have a specific hypothesis which the experiment is devised to test.

0 Therapist fails to use exposure either in the session or as homework task.

1 Therapist utilises exposure, but in a prescriptive fashion. Rationale given was behavioural(eg. habituation) or no rationale given.

2 Therapist attempts to set up exposure task as a behavioural experiment, but numerous problems evident, eg. hypotheses unclear, no rationale given, task not arrived at collaboratively.

3 Competent application of exposure as a behavioural experiment. Reasonable hypotheses. Some problems, eg. minimal collaboration, not clearly linked to session.

4 Competent application of exposure as a behavioural experiment, arrived at collaboratively. Clear hypotheses. Obtains feedback to ascertain client's understanding of the task. The therapist 'got out of their chair', and modelled first in experiments/exposure task, where appropriate. Minor problems/ inconsistencies.

5 Very competent application of exposure as a behavioural experiment. Relevant to the content of the session. Therapist elicited feedback to ascertain client's understanding of the task and identified and discussed potential obstacles to the client's success with the task. Minimal problems.

6 Excellent application of exposure. Client understands and can apply the cognitive model, and is able to set up his/her own behavioural experiments, or very good application in the face of difficulties.
16. HOMEWORK SETTING

Key features:  
Homework tasks should be appropriate for the stage of therapy, consistent with the conceptualisation, and have precise and clear goals. Later on in therapy, it is appropriate to encourage client’s to take responsibility for setting their own homework. Homework should always be reviewed at the next session.

0  Therapist fails to set homework, or sets inappropriate homework.

1  Therapist did not negotiate homework. Insufficient time allotted for adequate explanation, leading to ineffectual task being set.

2  Therapist negotiates homework unilaterally and in a routine fashion, without explaining the rationale for new homework.

3  Therapist has set an appropriate new homework task, but some problems evident (eg. not explained sufficiently and/or not developed jointly).

4  Appropriate new homework jointly negotiated with clear goals and rationales. However, minor problems evident.

5  Appropriate homework negotiated jointly and explained well, including an exploration of potential obstacles. Minimal problems.

6  Excellent homework negotiated, or highly appropriate one negotiated in the face of difficulties.

17. CLIENT COMPLEXITY (nb. this item is rated from 0 to 4 only)

Key feature:  
The nature of the presenting problem is not necessarily the defining feature in terms of client complexity, but involves factors such as interpersonal style, level of comprehension, 'psychological mindedness', etc.

0  Client is straightforward in terms of diagnosis and presentation.

1  Client meets diagnosis for more than one disorder, but is relatively straightforward.

2  Client meets diagnosis for one or more disorders, and presents some difficulties (eg. adverse life circumstances, irregular attendance, some non-compliance either within or between sessions, has difficulty understanding concepts, etc.).

3  Client is often difficulty to work with, eg. uncommunicative, highly distractable or chaotic in their presentation, manifestation of OCD during session makes adherence to agenda difficult, etc.

4  Client is invariably difficult to work with, eg. constantly attempts to dominate the session, refuses to work collaboratively, consistently dismisses therapist’s attempts at a coherent intervention.
18. CONSISTENCY WITH TRIAL PROTOCOL (optional)

**Key feature:** Particular criterion need to be met for the standard of therapy to meet the requirements of treatment trials. The rating is not a question of 'is this a good therapist?' or whether the intervention was good or effective, but whether the method and standard of delivery is consistent with the stringent requirements of a treatment trial. As such, it is important to strive for homogeneity amongst trial therapists.

<table>
<thead>
<tr>
<th>Response</th>
<th>Description</th>
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<tbody>
<tr>
<td>No</td>
<td>For the most part, the therapist works outside the remit of the trial protocol.</td>
</tr>
<tr>
<td>Sub-threshold</td>
<td>Generally consistent with trial protocol, but some problems and/or inconsistencies.</td>
</tr>
<tr>
<td>Yes</td>
<td>Style and content is consistent with trial protocol.</td>
</tr>
</tbody>
</table>