

# Assessment of Core CBT Skills (ACCS)

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## USER MANUAL

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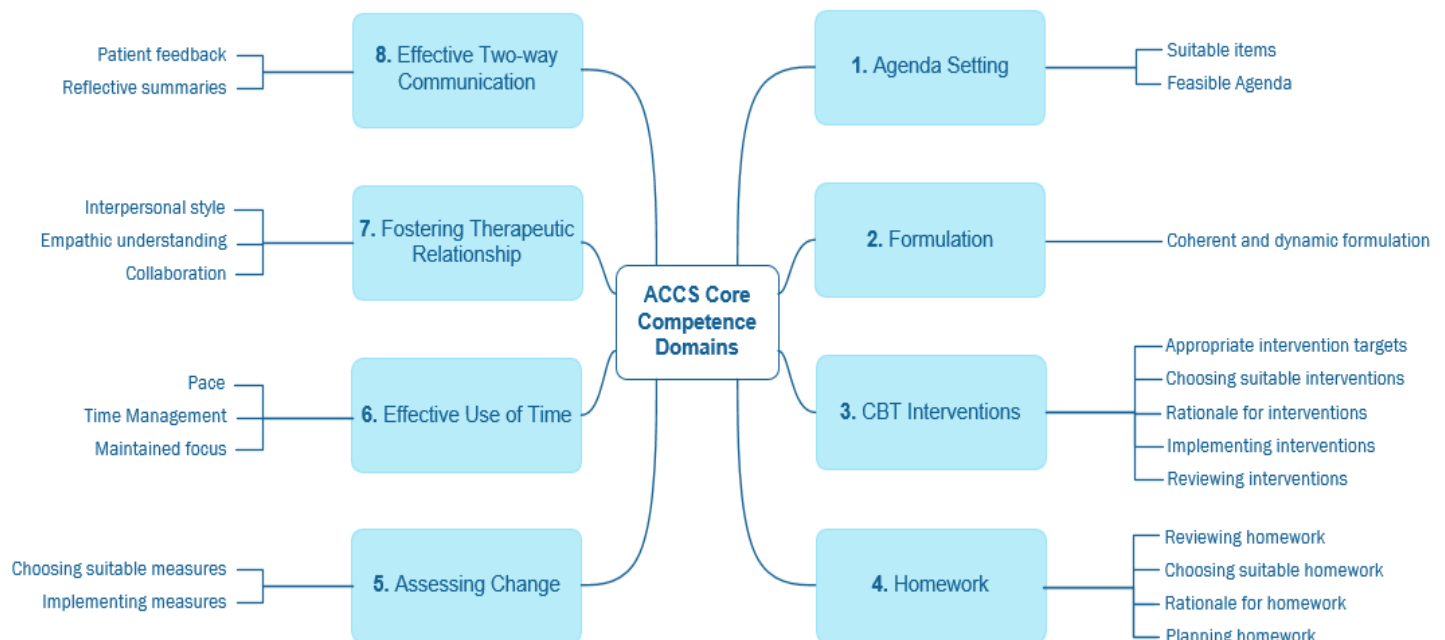
## General Guidelines

### Scale Scope

The Assessment of Core CBT Skills (ACCS) provides a framework for assessors to deliver formative and summative feedback about a therapist's performance within an observed treatment session. The scale assesses core general therapeutic and CBT-specific skills required to appropriately deliver individual cognitive-behavioural therapy to adults experiencing mental health problems. The scale focuses on competences which are transdiagnostic, rather than skills which are specific to a particular disorder or treatment protocol. The scale is also intended to assess a mid-treatment session and so it does not include skills which, although important, do not occur in most active treatment sessions (e.g. goal setting, relapse prevention etc.).

Core competences were identified for inclusion in the scale on the basis of a review of relevant literature. In particular, the authors drew upon the Cognitive Therapy Scale (CTS, or Cognitive Therapy Rating Scale: CTRS, [www.beckinstitute.org](http://www.beckinstitute.org)), the Cognitive Therapy Scale-Revised (CTS-R: Blackburn et al., 2001) and Roth and Pilling's (2007) competence framework.

As demonstrated in the figure below, the scale features eight competence domains, each of which includes one to five items:



The scale provides a numerical total score and an average item score, which are designed to identify the therapist's competence across the session overall. Numerical scores are also provided for each item in order to provide more detailed feedback as to the therapist's specific areas of strength and weakness. In addition, the feedback form includes space for assessors to include further qualitative feedback and to indicate what steps could be taken to further develop competence. Thus the scale can be used both to establish whether therapists have reached an adequate standard of competence (useful for accreditation, evaluating the impact of training, selecting and monitoring research trial therapists) and to provide detailed feedback to aid a therapist's development and progression (useful within supervision and training settings, for continuing personal development, and examining skill acquisition).

### How to use the ACCS

This manual is intended to provide guidance for assessors as to how to make judgements about the quality or skilfulness of therapists' performance using the ACCS rating scale. It is recommended that assessors spend some time reading and familiarising themselves with the manual before conducting an assessment. Initially, the manual should be consulted on an item by item basis alongside completing the feedback form. Once the assessor becomes familiar with the scale, the manual can then be used as a frame of reference which can be consulted whenever questions or uncertainties arise. It is also recommended that assessors periodically re-review the manual to prevent assessor-drift.

Step 1: Provide a numerical rating for each item

Each of the eight domains is broken down into one to five items, each of which is scored on a four-point scale. If the therapist is assessed as falling between two descriptors, the assessor can select a ½ mark (i.e. 1.5, 2.5, or 3.5). The overarching definitions of the scale are as follows:

Performance Band	Generic Definition of Performance Band
<b>1. Limited</b>	<ul style="list-style-type: none"> <li>• Therapist fails to include feature outlined.</li> <li>• <b>Or</b> therapist demonstrates a significant absence of skill or an inappropriate performance which is likely to have negative therapeutic consequences.</li> </ul>
<b>2. Basic</b>	<ul style="list-style-type: none"> <li>• Therapist's performance is somewhat appropriate with some degree of skill evident.</li> <li>• However, major substantive problems are evident.</li> </ul>
<b>3. Good</b>	<ul style="list-style-type: none"> <li>• Therapist demonstrates a good degree of skill with no major problems.</li> <li>• However, minor problems or inconsistencies are evident in the therapist's performance.</li> </ul>
<b>4. Advanced</b>	<ul style="list-style-type: none"> <li>• Therapist consistently demonstrates a high level of skill with only very few and very minor problems.</li> </ul>

Concrete examples of behaviours consistent with each scale point are provided for each item individually. These 'exemplar therapist behaviours' are intended to provide guidance as to the type of performance which is consistent with each point on the rating scale for that particular item. However, there may be occasions where a therapist demonstrates behaviours from more than one performance banding. Under these circumstances, the assessor is asked to use the overarching definitions outlined above to inform their decision as to which banding to assign. For example, within the 'choosing suitable homework' item, the therapist may have selected homework which related to key maintenance cycles discussed in-session (band 4) but the homework task was too challenging for the patient at this time (band 2). As the homework being too challenging for the patient constitutes a 'major substantive problem', the assessor would assign a rating of 2- Basic. When providing qualitative feedback the assessor has the opportunity to explain why the rating of 2-Basic was given as well as highlighting aspects of the therapist's performance which were consistent with the 4-advanced banding.

The feedback form should be used to assign a rating for each item on the scale. An overall session score can then be provided by adding the score assigned for each of the items. An average item score can also be provided by dividing the total score by 22 (the number of items).

*Issues to consider-*

- The exemplar behaviours are not able to provide an exhaustive list of possible performance indicators. Furthermore, ratings of competence will inevitably include a degree of subjectivity. However, in order to promote consensus between different assessors, it is important that assessors base their ratings on the item-specific exemplar therapist behaviours wherever possible.
- Assessors may find it helpful to make notes of about the therapist's performance that correspond with each item as they view the session. However, assessors should only score items after they have listened to the entire session.
- The 'halo effect' indicates that, when an assessor rates individual aspects of a therapist's competence, they are often unduly influenced by their overall impression of the therapist's performance (Cooper, 1981). As a result the therapist is provided with a uniformly high or low rating, rather than specific feedback as to their strengths and weaknesses. It is important for assessors to bear in mind that therapist's performance may well vary across domains- indeed a therapist can perform poorly in one competence domain and then do very well in another. It is therefore important to score each item independently of other items, and to avoid relying on an overall global impression.

Step 2: Provide qualitative feedback for each domain:

After completing numerical ratings for each domain, assessors are given space to highlight areas of strength and learning needs. Assessor can draw on the exemplar therapist behaviours provided and the session material being assessed to provide examples of what made some aspects of the therapist's performance more successful than others. Where areas of weakness are identified, assessors can suggest alternative, more skilful ways of working within this domain and highlight ways in which the therapist could further develop their skills in this area. Such in-depth feedback is invaluable in aiding further development and progression.

Step 3: Provide a global performance rating

The scale also includes a global competence item which is rated using the generic four-point scale outlined above. This global rating should reflect the assessor's overall impression of the therapist's performance within the session as a whole. This global rating will normally correspond to domain ratings. However, this will not always be the case. The assessor may, for example, wish to provide a global rating which reflects the presence or absence of specific aspects of competence which, although important, have not been included within the core competence domains of this scale because they are not relevant across patients and/or treatment sessions.

Step 4: Rate patient complexity:

Patient complexity has not been incorporated within the scoring system of individual items as this may unduly confound the ratings. Furthermore, reserving the highest ratings for performance demonstrated in the face of difficulties or added complexity may unfairly prevent those working with more straightforward cases from being awarded a high performance rating. However, assessors are asked to provide a separate patient complexity rating at the end of the scale. This is so that the context within which the therapist's performance has been evaluated can be taken into account when viewing the ACCS ratings (i.e. it identifies whether the therapist has competently delivered CBT with a patient who is straightforward to work with vs. a patient who has more complex difficulties).

**Minimum Competence Score**

A minimum total score above which a therapist can be considered competent has not been provided for the ACCS. This is because further research is required to establish an empirically proven 'tipping point' for competence using the ACCS. Furthermore, the level of competence and thus the score on the ACCS that is required may vary according to the context and purpose of the assessment. For example, when determining whether candidates are suitable for inclusion on a CBT training course, a lower level of performance may be acceptable, whereas those seeking accreditation may be required to demonstrate a higher level of performance. However, the total score which a therapist would achieve if their performance was consistently rated as 1, 2, 3, or 4 is provided to aid in interpretation of the total score: One-limited = total score of 22, Two-basic = total score of 44, Three-good = total score of 66, Four-advanced = total score of 88. The average item score also provides an indication of the therapist's average performance.

**Assessment Materials**

The ACCS is designed to assess therapists' performance within an 'active' CBT treatment session. Assessments should therefore be made on the basis of a mid-treatment session which involves CBT intervention strategies, rather than an initial assessment session or end of treatment/review session.

Ratings should be based upon source material which retains the most information possible, as this is more likely to provide the most accurate representation of the treatment session and thus the most accurate assessment of the therapists' competence (Waltz, Addis, Koerner, & Jacobson, 1993). As it is typically not possible to physically sit in on treatment sessions, ratings are usually made by viewing recordings of a treatment session. Visual recordings provide the richest source of information and can therefore be viewed as the optimal source material, followed by audio recordings. Ratings should not be made on the basis of session transcripts or therapists' verbal or written reports of the session.

It is recommended that assessors base their ratings on a full treatment session, rather than segments of a session. This is because the reliability of individual item ratings is poorer when assessors view session segments rather than full sessions, with a number of aspects of competence not being assessed at all using this method (Weck, Bohn, Ginzburg, & Ulrich, 2011).

In addition to submitting a session recording, it is recommended that therapists complete the ACCS submission cover sheet provided with this scale. This briefly outlines key contextual information such as the stage of therapy, the patient's presenting problem, the

session agenda, an outline of homework assignments, the main focus of the session, a brief summary of interventions carried out so far, a rationale for chosen treatment interventions, a treatment plan based on the formulation and treatment targets/patient's goals, and any relevant patient outcome data. Any materials completed in the session or for homework (e.g. questionnaires, diaries, thought records etc.) should also be submitted alongside the recording. Viewing this additional contextual information will help assessors make an informed rating of the therapist's performance.

### **Assessor Selection**

It is unlikely that assessors who are themselves novice therapists would be able to provide detailed formative feedback about a therapist's specific areas of strengths and weaknesses. Indeed research suggests that therapist competence cannot be reliably rated by trained novices (Weck, Hilling, Schermelleh-Engel, Rudari, & Stangier, 2011). However, at present it is unclear what expertise is necessary to assess competence. As a minimum, it is recommended that assessments are carried out by therapists who have received formal training or accreditation as a CBT therapist.

There is some evidence that assessors rate competence differently depending on their level of independence (Dennhag, Gibbons, Barber, Gallop, & Crits-Christoph, 2012a), although it is not known whose ratings are more accurate. There are a number of pros and cons involved with using either supervisors who have a relationship with the therapist or independent assessors to rate a therapist's performance using the ACCS. Independent assessors are less likely to be influenced by social demands, relationship dynamics or information other than that obtained through viewing treatment sessions (e.g. prior competence, ability in other domains). On the other hand, supervisors may have access to a greater wealth of contextual information (e.g. treatment context, therapist's broader work) and be better placed to provide appropriate formative feedback. Those selecting assessors will therefore need to weigh up these pros and cons and make a decision based on pragmatics and the purpose of the assessment. If it is decided to use supervisors, one possibility for overcoming potential biases is to implement reliability checks by independent assessors.

### **Therapist Self-ratings**

The scale can also be used by therapists to rate their own competence. As the ability to accurately rate one's own competence has been called into question, it is not recommended that self-ratings be used as a formal measure of therapist competence (Muse & McManus, 2013). However, self-ratings can be a useful learning tool. This is particularly the case when they are used in combination with assessor-ratings as this process of comparison can help to foster self-reflection and highlight on-going learning needs.

### **Cautions**

The ACCS is designed to assess whether a therapist has demonstrated the core generic and CBT specific skills required to deliver effective CBT within a given treatment session. Thus a number of aspects of competence are not assessed by the ACCS. First, the ACCS does not assess therapists' knowledge or understanding of CBT, aspects of competence which can instead be assessed using multiple choice questionnaires, essays, case reports or clinical vignettes (Muse & McManus, 2013). Second, as the ACCS focuses on 'intervention competence', broader professional skills (e.g. ethical practice, effective use of supervision) are not covered. Third, the scale focuses on competences which are transdiagnostic, rather than skills which are specific to a particular disorder or treatment protocol. Fourth, as the ACCS assesses core CBT skills evident during active, mid-treatment therapy sessions, it does not assess therapists' assessment or relapse-prevention skills. Hence it is recommended that, where the scale is used for summative assessment purposes, the ACCS should not be used as a stand-alone measure of competence. Instead the ACCS should form part of a multi-method competence assessment programme.

Although competence is often inferred from rating one or two isolated treatment sessions per therapist, recent studies suggest that a much higher sample of clinical work needs to be assessed in order to reliably assess therapist competence (Dennhag, Gibbons, Barber, Gallop, & Crits-Christoph, 2012b; Keen & Freeston, 2008). Furthermore, collecting multiple assessors' ratings of the same treatment session can increase reliability (Vallis, Shaw, & Dobson, 1986) and reduce the impact of the halo effect (Streiner & Norman, 2003). Thus in order to be confident of a reliable judgement as to a therapist's competence, multiple assessors would be used to assess a number of therapy sessions drawn across different patients (between 15 and 24 sessions rated by a single assessor, or 19 sessions rated by two assessors: Keen & Freeston, 2008). Although financial and time constraints often make this unfeasible, it is important to recognise the limitations involved in drawing conclusions about a therapist's competence and thus fitness to practice on the basis of a limited number of session ratings.

## Domain 1 - Agenda Setting

NB

This item refers to **planning and setting** an appropriate agenda **not adhering to it** which should be rated under Item 6.3 'Maintained Focus'.

### 1.1. Suitable Items

Ability to help the patient identify and prioritise specific, relevant and appropriate agenda items.

#### 1. Limited

**Absence of skill** or an **inappropriate performance**:

- Therapist made little or no attempt to outline any specific topics to be covered in the session (e.g. asked "How would you like to spend our time today?" with no further follow-up).

#### 2. Basic

Therapist helped the patient identify and prioritise topics to be covered but a **number of items** had **major substantive problems** in one or more of the following areas:

- Vague, unclear or overly general (e.g. my anxiety).
- Not suited to stage of therapy or patient's presentation.
- Not relevant to patient's presenting problem or treatment goals <sup>1</sup>.
- Unlikely to make progress in solving the problem <sup>1</sup>.
- Inappropriate given potential risk factors <sup>2</sup>.
- **And/or** a number of relevant standard items inappropriately omitted <sup>3</sup>.

#### 3. Good

Therapist helped the patient identify and prioritise items which met **most** of the following criteria, with only **minor problems or inconsistencies**:

- Well-defined, specific, and measurable (e.g. improving difficulty getting to sleep, addressing financial concerns).
- Suited to stage of therapy and patient's presentation.
- Relevant to patient's presenting problem / goals.
- Likely to make progress in solving the problem.
- Appropriate given potential risk factors.
- **And** included most relevant standard items.

#### 4. Advanced

Therapist **consistently** helped the patient identify and prioritise items which met **all** of the following criteria:

- Well-defined, specific, and measurable.
- Suited to stage of therapy and patient's presentation.
- Relevant to patient's presenting problem / goals.
- Likely to make progress in solving the problem.
- Appropriate given potential risk factors.
- **And** included all relevant standard items.

<sup>1</sup> NB: Attention may sometimes need to be given to items the patient deems important, even if these do not appear relevant to their presenting problem / treatment goals or it is unlikely that progress can be made in solving the problem (e.g. allowing the patient time to 'vent' when they have nobody else to talk to about the issue).

<sup>2</sup> Potential risk factors = risk of harm to self or others (e.g. expression of suicidal wishes), degree of distress associated with problem.

<sup>3</sup> Standard items = items which should usually be included on the agenda (e.g. mood check, week review, key learning from previous session, homework review, setting homework, session feedback etc.). NB: There may be occasions when it is appropriate *not* to include all standard items on the agenda of a session (e.g. if a routine for carrying out a mood check at the beginning of every session has been firmly established, it may not be useful to restate this agenda item).

## 1.2. Feasible Agenda

Ability to set an agenda which is realistic and feasible given the time available.

- 1. Limited**
- Therapist made little or no attempt to outline any specific topics to be covered in the session
  - **Or absence of skill** or an **inappropriate performance** in one or more of the following areas:
    - Items far too numerous, large or overwhelming to be feasible / enable any progress in solving the problem.
    - **Or** too few or insignificant items which could easily be covered in a very small time frame (e.g. reviewing a small piece of homework).

- 2. Basic**
- Major substantive problems:**
- Mismatch between available time and number of items **or** scope and significance of items- making it unlikely that adequate time could be spent on all items **or** items likely to be covered well before the end of the session.

- 3. Good**
- Good degree of skill, with only minor problems or inconsistencies:**
- Appropriate number of items with suitable scope and significance given the time available, making it likely all items could be adequately covered in- session.

- 4. Advanced**
- Consistently high level of skill:**
- Optimal number of items with ideal scope and significance given the time available, making it highly likely that maximum use could be made of the session and that all items could be thoroughly covered.



## Domain 2 - Formulation

An initial formulation is typically developed as part of the assessment process. However, a formulation should not simply precede treatment but should evolve throughout therapy as further clinical information arises and recurrent patterns and themes emerge. Thus a therapist's ability to formulate a patient's problems should be evident throughout the course of treatment.

**NB**

In addition to viewing the session recording, it is necessary to review any written or diagrammatic formulation materials in order to make an informed rating on this item.

Whether the therapist drew upon the formulation to highlight potential treatment targets and intervention strategies should be rated under domain 3 'CBT Interventions'.

### 2.1. Coherent and Dynamic Formulation

Ability to develop a clear formulation which draws upon appropriate evidence-based theory to offer a concise, comprehensive and personalised explanation of relevant history, triggers and maintaining features of the patient's problems.

#### 1. Limited

- Therapist made very little or no attempt to formulate the patient's problems.
- Or absence of skill** or an **inappropriate performance** in one or more of the following areas:
- Therapist's formulation of the patient's problems had major flaws (e.g. did not use evidence-based CBT theory <sup>1</sup>, attempted to fit the patient into an inappropriate model, inaccurately reproduced a relevant CBT model, included largely irrelevant information, failed to incorporate key features of the patient's presentation <sup>2</sup>, failed to identify links between different features of the patient's problems, formulation overly complex or far too simplistic given stage of treatment or patient's ability to understand, formulation incoherent or disjointed).
  - If new clinical material emerged, therapist seemed unwilling or unable to review or revise the formulation.

#### 2. Basic

**Major substantive problems** in one or more of the following areas:

- Therapist utilised appropriate evidence-based theory to provide an account of the patient's problems. However, this account was limited (e.g. vague or abstract, unclear or confusing, too complex or simplistic given stage of treatment or patient's ability to understand, included information of limited relevance, failed to show how features of the patient's presentation related to each other or the patient's problems in a meaningful way).
- If new clinical material emerged, therapist found it difficult to or seemed reluctant to revise the formulation.

#### 3. Good

**Good degree of skill** in the following areas, with only **minor problems or inconsistencies**:

- Therapist utilised appropriate evidence-based theory to provide an explanation of the history, triggers and maintaining features of the patient's problems. This explanation was clear and logical but had some problems (e.g. lack of personalisation, lack of concrete and specific examples, missed opportunities to include relevant strength and resilience factors, a more straightforward or detailed formulation would have better suited the stage of treatment or patient's ability to understand).
- If new clinical material emerged, therapist made some attempt to integrate this into the formulation.

#### 4. Advanced

**Consistently high level of skill** in the following areas:

- Therapist flexibly utilised appropriate evidence-based theory to provide a clear, concise, comprehensive and personalised account of relevant history, triggers and maintaining features of the patient's problems, as well as any relevant strength and resilience factors. This formulation was well suited to the stage of treatment and patient's ability to understand.
- If new clinical material emerged, therapist responded flexibly and fully incorporated this within the formulation.

<sup>1</sup> Relevant evidence-based theory should be used to inform the formulation. If a relevant evidence-based model is available, this should be used to develop the formulation (e.g. disorder-specific models such as Clark's model of panic). If not, the formulation should be based on an appropriate generic model (e.g. Beck's cognitive model of emotional disorder, personalised vicious cycles).

<sup>2</sup> Presentation features = behaviours, cognitions, emotions, physiological experiences, environmental factors, interpersonal issues.

## Domain 3 - CBT Interventions

This item refers to the selection and application of cognitive and/or behavioural interventions (also referred to as CBT 'techniques') designed to promote therapeutic change by targeting cognitions, behaviours or emotions likely to be maintaining the patient's problems. A range of CBT interventions can be used to promote change. These include, but are not limited to, cognitive restructuring, exposure/response prevention, addressing safety behaviours, imagery re-scripting, examining pros and cons, thought records, activity monitoring/scheduling, behavioural experiments, role play, graded task assignment, problem solving, assertiveness or other skills training, behaviour modification.

**NB** A number of factors other than therapist competence can influence whether an intervention is successful in bringing about change. Please, therefore, focus on the quality of the cognitive-behavioural interventions and not whether change actually occurred.

### 3.1. Appropriate Intervention Targets

Ability to skilfully define, clarify and specify intervention targets which both relevant evidence-based theory and the patient's idiosyncratic formulation suggested were highly likely to be maintaining problems.

#### 1. Limited

- Therapist did not identify any intervention targets (e.g. cognitions, behaviours, emotions).
- Or absence of skill** or an **inappropriate performance** in one or more of the following areas:
- Therapist lacked a clear rationale for selecting intervention targets (e.g. focused on cognitions, behaviours or emotions which neither evidence-based theory or the patient's formulation suggested were likely to be maintaining the patient's problems).
  - Intervention targets were not appropriate to the patient's therapeutic context <sup>1</sup> (e.g. therapist tried to re-evaluate or develop new core beliefs too early in therapy).

#### 2. Basic

**Major substantive problems** in one or more of the following areas:

- Interventions targeted cognitions, behaviours or emotions which were of limited therapeutic benefit (e.g. cognitions or behaviours were not linked to distressing emotions, relevant evidence-based theory suggested the targets could be maintaining the patient's problems but the idiosyncratic formulation suggested that the targets were irrelevant or peripheral to the patient's problems).
- Intervention targets were largely appropriate to the patient's therapeutic context but required fine tuning (e.g. therapist targeted safety behaviours which the patient was not yet ready to consider changing).

#### 3. Good

**Good degree of skill** in the following areas, with only **minor problems or inconsistencies**:

- Interventions targeted relevant cognitions, behaviours or emotions which both relevant evidence-based theory and the patient's idiosyncratic formulation suggested were maintaining problems. However, these targets were not clearly specified (e.g. were generic, vague or ambiguous).
- Interventions targets were suited to the patient's therapeutic context (e.g. therapist targeted thoughts that were more amenable to change before progressing to more strongly held beliefs).

#### 4. Advanced

**Consistently high level of skill** in the following areas:

- Interventions targeted relevant cognitions, behaviours or emotions which both relevant evidence-based theory and the patient's idiosyncratic formulation suggested were highly likely to be maintaining problems. These targets were skilfully defined, clarified and specified.
- Interventions targets were suited to the patient's therapeutic context.

<sup>1</sup> Patient's therapeutic context = patient's presenting problem, current capacity of the patient, stage of treatment etc.

### 3.2. Choosing Suitable Interventions

Ability to select cognitive-behavioural interventions which form part of a logical, coherent and unified treatment strategy which is likely to bring about therapeutic change in the treatment target(s) and is suited to the patient's therapeutic context. This selection was accurately guided by appropriate theory-based practice or practice based on evidence when possible.

#### 1. Limited

- Therapist did not select any CBT interventions
- Or absence of skill** or an **inappropriate performance** in one or more of the following areas:
- Interventions formed part of an incoherent treatment strategy (e.g. therapist appeared to select interventions in a random, hit-and-miss fashion). **And/or** this strategy was highly unlikely to bring about therapeutic change in the treatment targets (e.g. interventions were not at all matched to treatment targets, such as selecting imagery re-scripting to increase activity levels).
  - Interventions were poorly suited to the patient's therapeutic context <sup>2</sup> (e.g. intervention far too complex for current capacity of the patient).
  - Selection of interventions was not guided by theory or evidence-based CBT practice.

#### 2. Basic

**Major substantive problems** in one or more of the following areas:

- Interventions formed part of a vague, unclear or disjointed treatment strategy. **And/or** this strategy showed little promise in bringing about therapeutic change in the treatment targets (e.g. interventions were poorly matched to treatment targets, such as selecting a core belief worksheet to work with automatic thoughts).
- Interventions were largely appropriate given the patient's therapeutic context but required fine tuning (e.g. too easy or overly ambitious, challenging or complicated for the current capacity of the patient).
- Selection of interventions was guided by inappropriate theory or evidence-based CBT practice (e.g. a treatment protocol which was only vaguely related to the patient's presentation) or therapist significantly misinterpreted or misapplied appropriate theory or evidence-based CBT practice.

#### 3. Good

**Good degree of skill** in the following areas, with only **minor problems or inconsistencies**:

- Interventions formed part of a generally coherent therapeutic strategy which showed some promise in bringing about therapeutic change in the treatment targets (e.g. interventions were appropriate to the treatment targets, such as selecting activity scheduling to improve mood by increasing activity levels)
- Interventions were appropriate given the patient's therapeutic context (e.g. complexity and difficulty matched with patient's motivation and cognitive functioning).
- Selection of interventions was accurately guided by appropriate theory-based practice or practice based on evidence when possible.

#### 4. Advanced

**Consistently high level of skill** in the following areas:

- Interventions formed part of a logical, coherent and unified treatment strategy which showed a great deal of promise in bringing about therapeutic change in the treatment targets.
- Appropriate timing and grading meant that interventions were optimally suited to the individual patient's therapeutic context.
- Selection of interventions was accurately guided by appropriate theory-based practice or practice based on evidence when possible.

<sup>2</sup> Patient's therapeutic context = patient's presenting problem, current capacity of the patient, stage of treatment etc.

### 3.3. Rationale for Interventions

Ability to facilitate the patient's understanding of the importance and potential benefits of interventions.

#### 1. Limited

- Therapist did not implement any CBT interventions.
- **Or absence of skill** or an **inappropriate performance** in one or more of the following areas:
  - Therapist made little or no attempt to facilitate the patient's understanding of the rationale underpinning interventions (e.g. did not explain the importance / potential benefits).
  - If the patient did not understand, was sceptical about the rationale for interventions or asked questions, these were ignored or disregarded or therapist responded in a negative manner (e.g. defensive, hostile).

#### 2. Basic

- Major substantive problems** in one or more of the following areas:
- Therapist facilitated the patient's understanding of the rationale underpinning interventions with limited skill (e.g. developed a limited or confusing rationale for importance / potential benefits).
  - If the patient did not understand, was sceptical about the rationale for interventions or asked questions, therapist gave these limited consideration (e.g. acknowledging a question but failing to answer it).

#### 3. Good

- Good degree of skill** in the following areas, with only **minor problems or inconsistencies**:
- Therapist facilitated the patient's understanding of the rationale underpinning interventions with some degree of skill (e.g. developed a rationale for importance / potential benefits) but some minor problems were evident (e.g. did not relate rationale to the patient's presenting problems / formulation / treatment goals, conveyed the rationale with limited clarity).
  - If the patient did not understand, was sceptical about the rationale for interventions or asked questions, these were acknowledged and therapist made some attempt to discuss and resolve the issues.

#### 4. Advanced

- Consistently high level of skill** in the following areas:
- Therapist skilfully facilitated the patient's understanding of the rationale underpinning interventions (e.g. clearly and succinctly conveyed a rationale for the importance and potential benefits which aligned with the patient's presenting problems / formulation / treatment goals).
  - If the patient did not understand, was sceptical about the rationale for interventions or asked questions, therapist responded openly, fully discussed the issues and (where possible) resolved the issues (e.g. clarified any ambiguities).

### 3.4. Implementing Interventions

Ability to systematically implement intervention(s) in a fluent and articulate manner. To be sensitive and responsive to the therapeutic context and provide optimal levels of support, encouragement and praise.

#### 1. Limited

- Therapist did not implement any CBT interventions.
- Or absence of skill** or an **inappropriate performance** in one or more of the following areas:
- Interventions were misused or were implemented incorrectly in a way that was not justified by therapeutic context (e.g. omitting 'evidence for the belief' when doing a thought record, terminating exposure before any anxiety habituation occurred).
  - Therapist lacked skill in implementing interventions (e.g. therapist was inarticulate or incoherent, appeared unfamiliar with techniques).
  - Therapist showed very little or no awareness of the therapeutic context **or** responded in an unhelpful or negative manner (e.g. therapist was too forceful, appeared discouraging, ignored or dismissed very high levels of arousal or patient distress).

#### 2. Basic

- Major substantive problems** in one or more of the following areas:
- Interventions were not implemented in the manner in which they were intended and there was no clinical justification for these deviations (e.g. interventions were incomplete, were abandoned prematurely or were missing key components [e.g. therapist neglected to get ratings of pleasure/achievement in activity scheduling]).
  - Therapist implemented interventions with limited skill (e.g. at times the therapist was unclear, difficult to understand or appeared confused or muddled).
  - Therapist showed some awareness of the therapeutic context but responded with limited sensitivity (e.g. provided limited encouragement or was overly pushy) **and/or** appropriate flexibility (e.g. failed to adapt intervention despite indication that it was too distressing or complex for the patient to grasp).

#### 3. Good

- Good degree of skill** in the following areas, with only **minor problems or inconsistencies**:
- Interventions were mainly carefully and methodically implemented in the manner in which they were intended, unless there was clinical justification for deviating from this. However, some minor skill deficits or inconsistencies were evident (e.g. thought record could have been more detailed).
  - Therapist implemented interventions with adequate skill (e.g. therapist was articulate and comprehensible).
  - Therapist was largely sensitive to the therapeutic context (e.g. provided appropriate support and encouragement) and made some attempt to adapt interventions to suit the patient's needs where necessary.

#### 4. Advanced

- Consistently high level of skill** in the following areas:
- Clear and consistent evidence that interventions were carefully, thoroughly and systematically implemented from start to finish in the manner in which they were intended, unless there was clinical justification for deviating from this.
  - Therapist consistently implemented interventions with a high level of skill (e.g. therapist was fluent, articulate, clear and comprehensible).
  - Therapist was consistently sensitive to the therapeutic context (e.g. provided optimal levels of support, encouragement and praise) and was able to custom tailor interventions to suit the patient's needs where necessary (e.g. broke down a thought record into sections to make the task more manageable/less overwhelming, recognised and addressing subtle safety behaviours, modelled the intervention for a patient who felt it was too threatening).

### 3.5. Reviewing Interventions

Ability to conduct a comprehensive review of the results of interventions (whether positive or negative) in order to help the patient identify what they learned from the experience.

#### 1. Limited

- Therapist did not implement any CBT interventions.  
**Or absence of skill or an inappropriate performance:**
- Therapist failed to review **or** conducted a brief or cursory review of the results of interventions which did not help the patient identify learning (e.g. asked “how do you think that went?” with no further follow up).

#### 2. Basic

**Major substantive problems:**

- Therapist reviewed the results of interventions and made some attempt to highlight learning implications, but with limited skill (e.g. struggled to relate the results back to the relevant cognition, behaviours or emotions that they were designed to target, did not address negative results, simply told the patient what they had learned from the experience).

#### 3. Good

**Good degree of skill, with only minor problems or inconsistencies:**

- Therapist adequately reviewed the results of interventions (whether positive or negative). This review helped the patient independently draw conclusions about the learning implications (e.g. therapist used curious and Socratic questions to examine outcomes in relation to prior predictions).

#### 4. Advanced

**Consistently high level of skill:**

- Therapist skilfully engaged the patient in a comprehensive review of the results of interventions (whether positive or negative) which helped the patient to independently draw conclusions about useful and relevant learning implications. Therapist helped the patient link this learning to the relevant cognition, behaviours or emotions they were designed to target **and** to their formulation / treatment goals (e.g. used curious and Socratic questions to help the patient re-evaluate previous conclusions or construct new ideas).

## Domain 4 - Homework

### 4.1. Reviewing Homework

Ability to conduct a comprehensive review of previous homework (whether completed or not) in order to help the patient identify what they learned from the experience.

#### 1. Limited

**Absence of skill** or an **inappropriate performance** in one or more of the following areas:

- Therapist failed to review **or** conducted a brief or cursory homework review which did not help the patient identify learning (e.g. asked “how did you get on with the homework?” with no further follow up).
- Therapist responded to completed or uncompleted homework in an unhelpful or negative manner (e.g. scolding, judgemental, dismissed homework as unimportant).

#### 2. Basic

**Major substantive problems** in one or more of the following areas:

- Therapist reviewed homework and made some attempt to highlight learning implications from completing (or not completing) homework, but with limited skill (e.g. learning had limited relevance to the patient’s problems, therapist simply told the patient what they had learned from the experience).
- If relevant, therapist made some attempt to reflect on why non-completion occurred but failed to identify relevant emotional, cognitive or practical difficulties **and/or** did not identify ways to overcome future ‘blocks’ to completion.
- Completed homework was given limited recognition **and/or** therapist responded to non-completion with limited sensitivity and understanding.

#### 3. Good

**Good degree of skill** in the following areas, with only **minor problems or inconsistencies**:

- Therapist adequately reviewed homework. This review helped the patient to independently draw conclusions about the learning implications from completing (or not completing) homework (e.g. therapist used curious and Socratic questions to examine outcomes in relation to prior predictions).
- If relevant, therapist helped the patient identify relevant emotional, cognitive or practical reasons for non-completion **and** discussed ways to overcome future ‘blocks’ to completion (e.g. asked “how could you overcome xx next time?”).
- Therapist responded to completed homework with appropriate encouragement **and** to non-completion in a

#### 4. Advanced

**Consistently high level of skill** in the following areas:

- Therapist skilfully engaged the patient in a comprehensive homework review. This review helped the patient to independently draw conclusions about useful and relevant learning implications from completing (or not completing) homework and to link this learning to their formulation / treatment goals (e.g. therapist helped them to explore what it tells them about how best to understand or make progress with their difficulties).
- If relevant, therapist worked with the patient to identify relevant emotional, cognitive or practical reasons for non-completion **and** helped them identify specific ways to overcome future ‘blocks’ to completion (e.g. using a calendar for a patient who has difficulty remembering to complete homework, using problem solving to break homework down into less threatening components).
- Therapist responded to completed homework with optimal levels of encouragement and praise **and** to non-completion in a highly supportive, sensitive and open manner.

## 4.2. Choosing Suitable Homework

Ability to plan homework which is tailored to the therapeutic context and builds upon session material or previous homework.

### 1. Limited

- Therapist failed to plan further homework arising from the session or building on previous homework.  
**Or absence of skill** or an **inappropriate performance**:
- Homework was poorly suited to the patient's therapeutic context <sup>1</sup> (e.g. expecting the patient to carry out a highly feared exposure after first session or planned a difficult or large assignment for a patient with low motivation).

### 2. Basic

**Major substantive problems** in one or more of the following areas:

- Homework was largely appropriate given the patient's therapeutic context, but required fine tuning (e.g. overly ambitious, easy, challenging or complicated for the patient, 'standard' homework used without necessary adaptation).
- Homework was not related to issues (e.g. problems, cognitions, behaviours) dealt with in-session **or** previous homework, therefore restricting opportunities for relevant information gathering or generalising of concepts and skills learnt into daily life.
- Significant risk the patient would fail to benefit from homework or would have predictions confirmed in a way that was counter therapeutic.

### 3. Good

**Good degree of skill** in the following areas, with only **minor problems or inconsistencies**:

- Homework was appropriate given the patient's therapeutic context (e.g. amount and difficulty was achievable given the patient's motivation and cognitive functioning).
- Homework related to issues (e.g. problems, cognitions, behaviours) dealt with in-session **or** previous homework, therefore enabling some opportunities for information gathering and/or generalising of concepts and skills learnt into daily life. However, opportunities for more central homework tasks or further learning were missed.

### 4. Advanced

**Consistently high level of skill** in the following areas:

- Custom tailoring of homework meant it was optimally suited to the individual patient's therapeutic context (e.g. represented a moderate and realistically achievable challenge for the patient).
- Homework built upon important issues (e.g. problems, cognitions, behaviours) dealt with in-session **or** previous homework, therefore enabling opportunities for relevant information gathering and/or generalising of concepts and skills learnt into daily life.
- Therapist thoroughly considered the impact of likely outcomes of homework (e.g. set homework up as 'no lose' or worked with patient to make a plan for dealing with potential negative outcomes).

<sup>1</sup> Therapeutic context = patient's presenting problems, goals, stage of treatment, formulation, presentation etc.



### 4.3. Rationale for Homework

Ability to facilitate the patient's understanding of the importance and potential benefits of homework.

#### 1. Limited

- Therapist failed to plan further homework arising from the session or building on previous homework.
- **Or absence of skill** or an **inappropriate performance** in one or more of the following areas:
  - Therapist made little or no attempt to facilitate the patient's understanding of the purpose of homework (e.g. failed to develop a rationale for importance / potential benefits).
  - If the patient did not understand, was sceptical about the rationale for homework or asked questions, these were ignored or disregarded **or** therapist responded in a negative manner (e.g. defensive, hostile).

#### 2. Basic

**Major substantive problems** in one or more of the following areas:

- Therapist facilitated the patient's understanding of the purpose of homework with limited skill (e.g. developed a limited or confusing rationale for importance / potential benefits).
- If the patient did not understand, was sceptical about the rationale for homework or asked questions, therapist gave these limited consideration (e.g. acknowledging a question but failing to answer it).

#### 3. Good

**Good degree of skill** in the following areas, with only **minor problems or inconsistencies**:

- Therapist facilitated the patient's understanding of the purpose of homework with some degree of skill (e.g. developed a rationale for importance / potential benefits) but some minor problems were evident (e.g. did not relate rationale to the patient's presenting problems / treatment goals / formulation, conveyed the rationale with limited clarity).
- If the patient did not understand, was sceptical about the rationale for homework or asked questions, these were acknowledged and therapist made some attempt to discuss and resolve the issues.

#### 4. Advanced

**Consistently high level of skill** in the following areas:

- Therapist skilfully facilitated the patient's understanding of the purpose of homework (e.g. worked with the patient to develop a clear and succinct rationale for the importance and potential benefits which aligned with the patient's presenting problems / treatment goals / formulation).
- If the patient did not understand, was sceptical about the rationale for homework or asked questions, therapist responded openly, fully discussed the issues and (where possible) resolved the issues (e.g. clarified any ambiguities).

#### 4.4. Planning Homework

Ability to work with the patient to ensure they have a clear and detailed understanding of the homework task(s).

##### 1. Limited

- Therapist failed to plan further homework arising from the session or building on previous homework.
- Or absence of skill** or an **inappropriate performance** in one or more of the following areas:
- Content or practicalities for homework were vague or unclear (e.g. experiment with going out).
  - Therapist made little or no attempt to identify potential obstacles. **Or** if the patient raised potential obstacles, these were ignored or disregarded.

##### 2. Basic

**Major substantive problems** in one or more of the following areas:

- Content and practicalities of homework were poorly specified (e.g. go into a specific situation and see if I get anxious).
- Therapist attempted to identify potential obstacles, with limited skill (e.g. asked complicated or vague questions such as “do you think you could complete the task?”). **Or** if the patient raised potential obstacles, therapist gave these limited consideration (e.g. acknowledging an obstacle but failing to address it).

##### 3. Good

**Good degree of skill** in the following areas, with only **minor problems or inconsistencies**:

- Content and practicalities of homework were outlined, though some specific details were lacking (e.g. exactly what, where, when, how, outcome evaluation).
- Therapist made some attempt to prepare the patient for how to complete homework (e.g. talked through a homework example, made sure the task was written down).
- Therapist identified potential obstacles (e.g. asked relevant questions such as “What might get in the way of completing this task?”). **And** made some attempt to discuss ways to overcome these obstacles (e.g. asked “how might we overcome that?”).

##### 4. Advanced

**Consistently high level of skill** in the following areas:

- Therapist skilfully worked with the patient to agree a clear and detailed plan of exactly what homework involved (e.g. what, how, where, when, frequency, duration, outcome measurement).
- Therapist thoroughly prepared the patient for how to complete homework (e.g. worked through a homework example together in-session, used guided imagery techniques).
- Therapist worked with the patient to identify any potential obstacles, fully discussed these obstacles **and** (where possible) identified ways to overcome them (e.g. using problem solving to break homework into smaller tasks if the patient felt overwhelmed, discussing advantages and disadvantages of homework).

## Domain 5 - Assessing Change

A range of methods can usefully be employed to assess change, these include standardised questionnaires **and/or** informal idiosyncratic measures (e.g. diaries, frequency counts, ratings of duration of event or experience, self-ratings of emotions and cognitions etc.). These methods should be employed **across treatment** to measure change in symptoms and movement towards goals over the course of treatment as a whole. However, these methods should also be employed **within treatment sessions** to measure the impact of cognitive-behavioural interventions completed within session and for homework (e.g. belief ratings pre/post intervention).

**NB**

In addition to viewing session recording, it is necessary to review any relevant written materials in order to make an informed rating on this item (e.g. completed questionnaires, diaries, belief ratings, treatment goals, etc.).

### 5.1. Choosing Suitable Measures

Ability to select appropriate, clinically relevant standardised **and/or** idiosyncratic methods for measuring change in symptoms and associated features (beliefs, behaviours, feelings) and movement towards goals.

#### 1. Limited

- Therapist neglected to measure change in symptoms, associated features or movement towards goals.
- Or absence of skill** or an **inappropriate performance** in one or more of the following areas:
- Therapist selected standardised measures with inadequate reliability, validity or usability, despite the availability of better measures<sup>1</sup> **and/or** created inadequate idiosyncratic measures with poor usability (e.g. too complicated for the patient to complete), completely unsuitable response scales (e.g. yes / no to measure symptom change), or undefined targets (e.g. rate your 'feelings').
  - Measures were irrelevant and of no clinical use (e.g. depression questionnaire for patient with anxiety, belief ratings of irrelevant cognitions, frequency of irrelevant behaviours).

#### 2. Basic

- Major substantive problems** in one or more of the following areas:
- Therapist selected standardised measures with poor validity, reliability or usability, despite availability of better measures **and/or** created idiosyncratic measures which were difficult to use, had inappropriate response scales, or had poorly defined targets.
  - Measures were of limited relevance and clinical use (e.g. general anxiety questionnaire for patient with panic disorder, belief ratings of peripheral cognitions).

#### 3. Good

- Good degree of skill** in the following areas, with only **minor problems or inconsistencies**:
- Therapist selected standardised measures with adequate reliability, validity and usability, though better measures were available **and/or** created usable idiosyncratic measures with relevant response scales and outlined targets (e.g. 0 to 100 emotional intensity ratings, 0 to 8 or 0 to 10 problem severity ratings).
  - Measures were relevant and served a clinical purpose (e.g. panic cognitions questionnaire for patient with panic disorder, belief ratings for related cognitions, rating severity of relevant problem).

#### 4. Advanced

- Consistently high level of skill** in the following areas:
- Therapist selected the most reliable, valid and usable standardised measures which were available **and/or** created idiosyncratic measures with clearly defined targets and highly appropriate response scales (e.g. 0 to 100 rating of clearly specified behaviour).
  - Measures were highly relevant and served an important clinical function (e.g. belief ratings for key cognitions, diary provided useful insight into relationship between different aspects of the patient's problems).

<sup>1</sup>Therapists should select the most reliable, valid and usable standard measures which were *available* to them. Thus therapists should *not* be penalised if they were unable to access 'gold standard' questionnaire measures (e.g. due to service constraints, cost).

## 5.2. Implementing Measures

Ability to administer measures at suitable time points across and within session and to skilfully review, interpret and respond to the information gleaned.

### 1. Limited

- Therapist neglected to measure change in symptoms, associated features or movement towards goals.
- Or absence of skill** or an **inappropriate performance** in one or more of the following areas:
- Monitoring schedule was random, haphazard, inappropriate or not clinically useful (e.g. no baseline function to measure change against [e.g. thought record without pre-intervention belief rating], patient overly burdened by completing measures too frequently, progress not regularly checked).
  - Therapist failed to review or conducted an extremely brief or cursory review of completed measures which did not provide useful clinical information (e.g. didn't compare post-intervention scores with pre-intervention scores, lack of understanding of completed measures).
  - If relevant, therapist made little or no attempt to identify or explore barriers (e.g. difficulty understanding or completing measures, doubts about the purpose of monitoring) or responded to barriers in an unhelpful or negative manner (e.g. scolded patient for incorrectly completing measure).

### 2. Basic

**Major substantive problems** in one or more of the following areas:

- Monitoring schedule was unsuitable or of limited clinical use (e.g. measures not used regularly enough or used more frequently than necessary, measures implemented at inappropriate time points).
- Therapist conducted a rushed or superficial review of completed measures which provided little useful clinical information (e.g. therapist showed a limited ability to interpret completed measures).
- If relevant, therapist made some attempt to identify barriers to monitoring and responded to these in an understanding manner. However, therapist made little or no attempt to explore or overcome barriers.

### 3. Good

**Good degree of skill** in the following areas, with only **minor problems or inconsistencies**:

- Monitoring schedule was appropriate (e.g. at the beginning, middle and end of treatment, pre/post interventions) and served a useful clinical purpose (e.g. provided insight into changes in patient's symptoms or impact of interventions).
- Therapist adequately reviewed completed measures and attempted to use this information for clinical purposes but some minor problems were evident (e.g. struggled to relate the results to the individual patient).
- If relevant, therapist identified barriers to monitoring, responded in a supportive manner and made some attempt to explore or overcome them.

### 4. Advanced

**Consistently high level of skill** in the following areas:

- Monitoring schedule was systematic, appropriate and served an important clinical function (e.g. provided clear and relevant information as to effectiveness of interventions or treatment progress).
- Therapist comprehensively reviewed completed measures and used information gleaned for relevant clinical purposes (e.g. exploring improvements or deteriorations to better understand maintaining factors, highlighting progress to encourage motivation, making decisions about where best to focus therapeutic efforts).
- If relevant, therapist thoroughly identified and explored barriers to monitoring. Where possible therapist worked with the patient to resolve issues (e.g. working through measure with the patient, modifying or simplifying measures).

## Domain 6 - Effective Use of Time

### 6.1. Pace

Ability to pace the session in a manner which is well suited to the therapeutic context and patient's capacity for learning.

#### 1. Limited

**Absence of skill** or an **inappropriate performance**:

- Pace consistently much too fast or slow for therapeutic context <sup>1</sup> or patient's optimal learning (e.g. therapist repeatedly belaboured a point long after the patient had grasped the message, important issues were rushed- making it difficult for the patient to grasp or retain key concepts, therapist switched from topic to topic far too rapidly).

#### 2. Basic

**Major substantive problems**:

- There were a number of times when the pace was too quick or slow for the therapeutic context or patient's optimal learning (e.g. therapist slightly overstressed a point, moved on from emotionally difficult topics too quickly, switched topics before conclusions had been drawn, spoke too rapidly or too slowly).

#### 3. Good

**Good degree of skill**, with only **minor problems or inconsistencies**:

- For most of the session therapist set a pace which was appropriate given the therapeutic context and patient's learning capacity. However, there were one or two occasions when the pace was a little too quick or slow to be optimally effective (e.g. therapist failed to slow the pace suitably where cognitive difficulties arose, moved the patient along before they had fully understood concepts).

#### 4. Advanced

**Consistently high level of skill**:

- Therapist was responsive to and consistently matched the pace of the session to the therapeutic context and patient's learning capacity (e.g. gave more time and attention to issues where cognitive difficulties arose, allowed the patient to experience emotions rather than rushing onto an intervention / another topic).

<sup>1</sup> Therapeutic context = patient's presenting problems, goals, stage of treatment, formulation, presentation etc.

## 6.2. Time Management

Ability to manage time within the session in a balanced and efficient manner.

### 1. Limited

**Absence of skill** or an **inappropriate performance** in one or more of the following areas:

- Inefficient, unbalanced allocation of time meant a number of important issues were not covered at all (e.g. not enough time left to plan homework, summarise session content, exchange feedback etc.).
- Omitted issues were given limited or no acknowledgement.
- Session ran very significantly over **or** under scheduled time without clinical justification <sup>1</sup> (e.g. 50 minute session lasted 70 minutes or ended after 30 minutes with no clinical justification).
- Overly rigid adherence to a schedule was unhelpful to the patient (e.g. comments such as “We said we’d move on after 10 minutes so we need to move on now”).

### 2. Basic

**Major substantive problems** in one or more of the following areas:

- Less than optimal use of time meant some important issues were not covered **or** were inadequately covered (e.g. insufficient time to review learning from an intervention or to plan how to take the work forward).
- Omitted issues were acknowledged but were not rescheduled.
- Session ran a little over **or** under scheduled time without sufficient clinical justification (e.g. 50 minute session lasted for 60 minutes or ended after 40 minutes).

### 3. Good

**Good degree of skill** in the following areas, with only **minor problems or inconsistencies**:

- Therapist’s use of time was generally well balanced and efficient, meaning most important issues were adequately covered. However, to make optimal use of time, it would have been necessary to spend a little less or a little more time on some issues (e.g. not quite enough time left at end of session to plan homework thoroughly).
- If issues were not covered, this was somewhat appropriate given the therapeutic context (e.g. focusing the entire session on one agenda item which was more distressing / significant than anticipated).
- Omitted issues were rescheduled for a different time or format (e.g. next session, homework).
- Length of session was largely as scheduled **or** there was some clinical justification for deviating from planned schedule.

### 4. Advanced

**Consistently high level of skill** in the following areas:

- Consistently balanced and efficient allocation of time meant all important issues were thoroughly covered. **Or** if issues were not covered, this was necessary given the therapeutic context and this decision was made openly and explicitly with the patient.
- Omitted issues were rescheduled for a different time or format (e.g. next session, homework).
- Length of session was as scheduled **or** there was clear clinical justification for deviating from planned schedule.

<sup>1</sup> Examples of clinical justification for running over / under time = significant patient distress, expression of risk etc.

### 6.3. Maintained Focus

Ability to maintain focus on important issues, whilst demonstrating appropriate flexibility in response to unanticipated issues.

#### 1. Limited

**Absence of skill** or an **inappropriate performance**:

- Session lacked any clear focus and appeared aimless (e.g. patient dominated session completely and therapist simply followed the patient's lead- making little or no attempt to focus session back to appropriate topics, general unstructured 'chat' which did not appear to have any specified aims or reach any particular conclusions).
- **Or** overly rigid focus was unhelpful to the patient (e.g. therapist dismissed potentially important issues raised by the patient or disregarded patient's distress because it did not relate to the agenda / fit with the session plan).

#### 2. Basic

**Major substantive problems**:

- Therapist showed limited skill in maintaining focus on appropriate topics, resulting in frequent repetitions, unproductive digressions or unjustified discussions of peripheral issues (e.g. therapist frequently switched topics without clear justification, was slow to respond to digressions, was abrupt or tactless when re-directing discussion to appropriate topics).
- **Or** therapist focused on established priorities in a rigid, inflexible or mechanistic manner (e.g. failed to acknowledge or respond to unanticipated issues).

#### 3. Good

**Good degree of skill**, with only **minor problems or inconsistencies** in the following areas:

- Therapist largely maintained focus on session priorities (i.e. agenda items). However, if repetitions, unproductive digressions or unnecessary discussions of peripheral issues arose, these were re-directed back to an appropriate topic in a timely manner and with some degree of sensitivity.
- **And/or** if unanticipated issues arose, therapist acknowledged these and showed appropriate flexibility (e.g. allowing the session to diverge from planned topics to make maximum therapeutic progress or maintain client engagement / therapeutic relationship).

#### 4. Advanced

**Consistently high level of skill** in the following areas:

- Therapist consistently maintained focus on session priorities (i.e. agenda items). However, if repetitions, unproductive digressions or unnecessary discussions of peripheral issues arose, these were quickly acknowledged, sensitively evaluated and skilfully steered back to an appropriate topic (e.g. "We seem to be straying from our plan for the session- is this something that it is important that we focus on? Or would it be more useful to return to [planned focus]?").
- **And** if unanticipated issues arose, therapist acknowledged these and showed appropriate flexibility. Any decisions to change focus were negotiated openly and explicitly with the patient.

## Domain 7 - Fostering Therapeutic Relationship

### 7.1. Interpersonal style

Ability to embody a positive interpersonal style which is congruent with the therapeutic context.

#### 1. Limited

##### **Absence of skill or an inappropriate performance:**

- Therapist consistently demonstrated a negative interpersonal style (e.g. impatient, aloof, insincere, patronising, distant, distracted, cold, uncaring, intimidating, reprimanding, hostile, demeaning etc.).
- **Or** therapist's interpersonal style was poorly suited to the patient's therapeutic context <sup>1</sup> (e.g. therapist praised patient excessively, demonstrated high level of warmth to a highly avoidant / socially anxious patient thus making them feel uncomfortable).

#### 2. Basic

##### **Major substantive problems:**

- Therapist generally demonstrated a reasonable interpersonal style (e.g. was friendly, positive, constructive etc.) which was appropriate given the patient's therapeutic context. However, at times therapist showed limited flexibility in adapting their interpersonal style in response to therapeutic context (e.g. insensitive use of humour which invalidated the patient's feelings, inappropriate self-disclosure, inappropriate disclosure of ideas about the patient's problems [e.g. told patient with eating disorder idea for final weight too early in treatment]).

#### 3. Good

##### **Good degree of skill, with only minor problems or inconsistencies:**

- Therapist generally demonstrated a positive interpersonal style (e.g. open, warm, respectful, genuine etc.) which was suited to individual patient's therapeutic context (e.g. friendly but not overly familiar, optimistic without being excessively positive).

#### 4. Advanced

##### **Consistently high level of skill:**

- Therapist consistently demonstrated a positive interpersonal style (e.g. embodied and effectively communicated sincerity, open-minded curiosity, genuineness, honesty, sensitive concern, optimism, professionalism, encouragement, unconditional positive regard etc.) **and** seamlessly adapted their interpersonal style so that it was congruent with the therapeutic context (e.g. optimal levels of warmth, concern etc. given the individual patient's current needs).

<sup>1</sup> Therapeutic context = patient's interpersonal style, presenting problems, history, stage of treatment, formulation & presentation.



## 7.2. Empathic Understanding

Ability to accurately grasp the content and emotional tone of the patient's viewpoint (i.e. their understanding of themselves and the world around them) and to sensitively and appropriately conveying this understanding.

### 1. Limited

**Absence of skill** or an **inappropriate performance** in one or more of the following areas:

- Therapist frequently projected their own attitudes, conventional attitudes, or attitudes derived from particular theoretical systems onto the patient.
- Therapist repeatedly ignored or completely misinterpreted obvious elements of the patient's viewpoint.
- Therapist negated, undermined or was critical of the patient's viewpoint (e.g. appeared disapproving, disparaging or judgemental) or over-identified with patient's perspective (i.e. was not objective).
- Therapist seemed unwilling or unable to revise their understanding of the patient's viewpoint in response to new clinical information or in-session changes.

### 2. Basic

**Major substantive problems** in one or more of the following areas:

- Therapist accurately reflected more obvious, verbal cues (i.e. what patient explicitly said), but repeatedly ignored or completely misinterpreted more subtle emotional or nonverbal cues (e.g. tone of voice, body language etc.) **and/or** responded inappropriately (e.g. excessive empathy).
- Therapist found it difficult or seemed reluctant to revise their understanding of the patient's viewpoint in response to new clinical information or in-session changes.

### 3. Good

**Good degree of skill** in the following areas, with only **minor problems or inconsistencies**:

- Therapist picked up on most verbal and more subtle emotional or nonverbal cues to gain an understanding of the patient's viewpoint but at times therapist slightly misinterpreted patient or focused on peripheral aspects of what patient said.
- Therapist attempted to convey their understanding of the patient's viewpoint but with limited skill (e.g. restating patient's words unnecessarily, overly long summaries, unsuitable tone of voice, intellectualising issues).

### 4. Advanced

**Consistently high level of skill** in the following areas:

- Therapist consistently picked up on verbal, emotional and nonverbal cues to gain an accurate and intimate understanding of the patient's viewpoint.
- Therapist consistently used appropriate verbal (e.g. paraphrasing, summarising, reflecting) and non-verbal responses (e.g. tone of voice, facial expression) to convey their understanding of the patient's viewpoint. This helped the patient feel listened to and understood on an emotional and cognitive level throughout the session (e.g. therapist conveyed the importance of working on issues which were important to the patient when prioritising agenda items, acknowledged participants bravery in undertaking anxiety provoking tasks etc.)

### 7.3. Collaboration

Ability to encourage the patient to take an active role in and to share responsibility for all aspects of the session in a manner suited to the stage of therapy and patient's presentation.

#### 1. Limited

##### **Absence of skill or an inappropriate performance:**

- Therapist repeatedly made very little or no attempt to work with or involve the patient (e.g. therapist appeared to come to the session with pre-planned ideas that were not open to discussion, focused on issues that were not a priority for the patient, told the patient what to do without requesting any input, ignored or disregarded issues raised by the patient, did not elicit or value the patient's ideas, did not share information with the patient, tried to control or dominate the patient, seemed to be 'cross-examining' or arguing with the patient).
- **Or** therapist was frequently too passive and offered the patient too much responsibility (e.g. provided no input where the patient was not able to do so independently, inappropriately followed the patient's lead).

#### 2. Basic

##### **Major substantive problems:**

- Therapist made some attempt to involve and work with the patient. However, on a number of occasions, the therapist offered the patient too much or too little responsibility given the stage of therapy or patient's presentation <sup>1</sup> (e.g. therapist expected the patient to take the lead in very early sessions, did not give the patient enough choice, paid minimal attention to the patient's ideas, did not give the patient sufficient space and time to think, used overly complicated or vague questions such as "What shall we talk about today?" or "What next?", lectured the patient, debated with or tried to persuade the patient).

#### 3. Good

##### **Good degree of skill, with only minor problems or inconsistencies:**

- For most of the session, the therapist worked effectively with the patient and helped them to share responsibility in a manner appropriate to the stage of therapy and patient's presentation (e.g. therapist offered the patient choices, paid attention to the patient's ideas, gave the patient some time and space to think, asked relevant questions such as "What do you think the most important things are for us to cover today?", "How might we test that out?"). However, there were one or two occasions when the therapist and patient did not appear to be working as a team (e.g. therapist was too instructive or passive).

#### 4. Advanced

##### **Consistently high level of skill:**

- Therapist consistently encouraged the patient to take an active role in and to share responsibility for all aspects of the session in a manner suited to the stage of therapy and patient's presentation (e.g. therapist offered the patient appropriate choices, used skilful questioning to elicit and incorporated the patient's ideas, gave the patient plenty of time and space to think, asked skilful questions such as "How might you take this forward next week?", "What's the most important thing you need to do to keep the progress going?", "You have mentioned X, Y and Z. What do you think is most important to cover today, given that we are nearing the end of therapy?").

<sup>1</sup> NB it may be appropriate for therapists to take more responsibility in initial sessions, but responsibility should be increasingly transferred to the patient as therapy progresses, depending on patient's presentation.

## Domain 8 - Effective Two-way Communication

### 8.1. Patient Feedback

Ability to elicit, explore and respond to feedback about the patient's understanding of and reaction to all aspects of session.

#### 1. Limited

**Absence of skill** or an **inappropriate performance** in one or more of the following areas:

- Therapist made little or no attempt to check the patient's understanding of and reaction to the session **or** discouraged the patient from giving feedback.
- Therapist repeatedly ignored or disregarded patient feedback **or** responded in a negative manner (e.g. became defensive or argumentative).

#### 2. Basic

**Major substantive problems** in one or more of the following areas:

- Therapist inconsistently checked the patient's understanding of and reaction to the session, meaning that feedback was not elicited for a number of important aspects of the session (e.g. formulation, homework, interventions etc.).
- Therapist used overly complicated or vague questions to elicit patient feedback (e.g. asked "Is that OK?", "Does everything seem to be going well?").
- Therapist failed to ask for patient feedback about any negative reactions to session, despite clear need to do so (e.g. patient's comments indicated potential concerns).
- Therapist acknowledged patient feedback but made little or no attempt to discuss or respond to it.

#### 3. Good

**Good degree of skill** in the following areas, with only **minor problems or inconsistencies**:

- Therapist regularly checked the patient's understanding of and reaction to the session. However, feedback was not elicited for one or two important aspects of the session (e.g. formulation, homework, interventions etc.).
- Therapist used some appropriate questions to elicit patient feedback (e.g. asked "How do you think the session is going so far", "Does this homework seem manageable?", "Is the homework clear?", "How does the idea of doing X strike you?", "How do you feel about attempting X?").
- Therapist made some attempt to elicit potentially negative reactions to session (e.g. doubts, scepticism or concerns) as well as positive reactions (e.g. asked "Do you have any concerns about X", "You seem a little uncertain, is there anything you feel unsure about?").
- Therapist discussed patient feedback and made some attempt to respond to patient's feedback (e.g. answered questions, revised focus in response to patient's concerns).

#### 4. Advanced

**Consistently high level of skill** in the following areas:

- Therapist consistently checked the patient's understanding of and reaction to all aspects of session (e.g. formulation, homework, interventions, agenda, measuring change, patient's response to therapist etc.).
- Therapist consistently used skilful questions to elicit patient feedback (e.g. asked "From your point of view, why is it important to do X?", "What might you learn from doing X?").
- Therapist actively encouraged the patient to express positive and negative reactions to all aspects of session in a warm and friendly manner which invited exploration (e.g. asked "What has been least helpful today?", "Is there anything I've said that didn't make sense?").
- Therapist thoroughly and openly discussed patient feedback in a non-judgemental, supportive and sensitive manner. **And** therapist responded appropriately to patient's feedback (e.g. adapted interventions, adjusted their own behaviour, clearly and fully answered questions).
- If relevant, therapist picked up on subtle cues (e.g. tone of voice, hesitation etc.) to identify difficulties giving authentic feedback (e.g. patient responded in accordance with what they thought therapist wished to hear) and openly discussed these with the patient.

## 8.2. Reflective Summaries

Ability to work with the patient to reflect upon and summarise salient session content in order to facilitate joint understanding of crucial therapeutic material and consolidate key learning.

### 1. Limited

**Absence of skill** or an **inappropriate performance** in one or more of the following areas:

- Therapist made little or no attempt to encourage the patient to review and reflect on session content.
- Therapist made little or no attempt to summarise important information or provided very minimal, highly inappropriate or inaccurate summaries.

### 2. Basic

**Major substantive problems** in one or more of the following areas:

- Therapist prompted the patient to review and reflect on session content **and/or** provided summaries either too rarely (e.g. only once or twice) **or** too frequently (e.g. continually providing summaries or asking the patient to reflect on session content).
- Reflective summaries were of limited therapeutic benefit as they were superficial **and/or** focused on irrelevant information or peripheral learning points.

### 3. Good

**Good degree of skill** in the following areas, with only **minor problems or inconsistencies**:

- At the beginning and end of session, and a number of times within session, therapist prompted the patient to review and reflect on session content (e.g. asked relevant questions such as “what’s the main thing you’d like to remember about this session”) **and** provided accurate capsule summaries (e.g. “so to recap, at the beginning of the session we discussed X and the impact it had on your mood. Then we talked about Y etc.”).
- Reflective summaries focused on relevant information and learning points and thus were of some use in helping to reinforce understanding of important therapeutic material and consolidate key learning.

### 4. Advanced

**Consistently high level of skill** in the following areas:

- At the beginning and end of session, and at appropriately regular intervals within session, therapist used skilful questioning to elicit in-depth patient reflections on and summaries of session content **and** provided clear, succinct and meaningful capsule summaries.
- Reflective summaries skilfully drew together salient information and key learning points in a way which helped to reinforce and facilitate joint understanding of crucial therapeutic material, consolidate key learning and enabled the patient to gain new insights and make therapeutic shifts.

## Global Performance Rating

How would you rate the therapist’s overall performance within this session?

- 1. Limited**

  - Therapist demonstrates a significant absence of skill or an inappropriate performance which is likely to have negative therapeutic consequences.
- 2. Basic**

  - Therapist’s performance is somewhat appropriate with some degree of skill evident.
  - However, major substantive problems are evident.
- 3. Good**

  - Therapist demonstrates a good degree of skill with no major problems.
  - However, minor problems or inconsistencies are evident in the therapist’s performance.
- 4. Advanced**

  - Therapist consistently demonstrates a high level of skill with only very few and very minor problems.

## Patient Complexity Rating

How complex do you feel the patient was to work with? Issues that may influence complexity include level of patient motivation, level of engagement, the presence of social or environmental problems, the number of problems, the severity of problems, and suitability for CBT.

- |                                    |                            |
|------------------------------------|----------------------------|
| <b>1. Very straightforward</b>     | <b>3. Somewhat Complex</b> |
| <b>2. Somewhat Straightforward</b> | <b>4. Verv Complex</b>     |

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