Experts in the assessment and treatment of complex mental health disorders

Workshop

The supervisor perspective: Therapist behaviours that have the biggest impact on therapy outcome

Matthew Smout

Saturday 1 July 2017
9.30am - 1pm

#2017Clinical
THE SUPERVISOR PERSPECTIVE: THERAPIST BEHAVIOURS THAT HAVE THE BIGGEST IMPACT ON THERAPY OUTCOME

Dr Matthew Smout, University of South Australia

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* To vote in surveys...

Text MATTHEWSMOUT107 to +61 427 541 357 once to join
MY CURRENT CASELOAD — *COMPLETE BEFORE WORKSHOP*

Write down the initials of 5 people on your current (or most recent) case load. If applicable, include some clients that are not making as much progress as others, or who are struggling.

<table>
<thead>
<tr>
<th>Name (Initials)</th>
<th>3 strengths</th>
<th>3 main barriers to them making progress toward their goals</th>
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</table>
[1] MAKING TIME TO REVIEW SESSION VIDEO/AUDIO

List barriers and possible solutions to reviewing sessions more often.

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<thead>
<tr>
<th>Barrier</th>
<th>Potential Solutions</th>
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Plan:

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[2a] EDUCATE CLIENTS ABOUT THERAPY

Homework: If you don’t already have one, write a script to provide an overview or introduction to therapy, considering the following questions:

- What can clients expect from you in therapy?
  - In session?
  - Outside of session?
- What will be expected of them?
  - In session?
  - Outside of session?
- How do your expectations fit with their expectation of therapy? What will the balance of talk time between you look like? Balance between talk and other activities? What will the balance between therapist-directed v client-discovered solutions look like?
- How will the approach you plan to take, work? How will the client change if therapy is successful?
- According to research, how effective is the approach you plan to take with the kind of problem(s) the client is presenting with, given the kind of person the client is? What chance of recovery does the client have on average? What kind of improvement in functioning and quality of life can s/he expect following successful therapy?
• How long and how often should you meet and what kind of changes are needed in order for the client to reach his/her goal? If you don’t have that long, what could be reasonably achieved in the time you have available? What can the client do after that?

[2b] GOALS FOR THERAPY

1. Next to each case, state the goal of treatment as best you can.

2. For each goal, indicate whether this is best conceptualised as a:
   i) short-term goal (achievable in 2-4 sessions)
   ii) medium term goal (achievable by the end of therapy)
   iii) long-term goal (achievable in the next few years)

3. Rate its “SMARTness” (Specific Measurable Achievable Relevant, within a Timeframe) by checking each SMART dimension the goal statement meets.

**Top 3 most responsive cases**

<table>
<thead>
<tr>
<th>Name (Initials)</th>
<th>Goal Statement</th>
<th>S/M/L</th>
<th>S</th>
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<th>A</th>
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[3a] EXERCISE: FORMULATE CLIENT ATTITUDE TO THERAPY (AS WELL AS PRESENTING PROBLEM)

1. Refer to p.2 and choose a client who is not progressing as well as others.
2. Identify the top 3 behaviours that are part of his/her reason for coming to therapy.
3. Identify the top 3 behaviours that interfere with therapy (look through checklist of therapy-interfering behaviours below if needed to stimulate hypotheses).
4. For at least one problem and one therapy-interfering behaviour, list the 3 most important factors that keep the problem/behaviour going. These may be beliefs, strong classically conditioned urges to key stimuli, social, physical, emotional or financial consequences for the behaviour. Whatever you think is maintaining the problem or behaviour.

<table>
<thead>
<tr>
<th>Therapy-interfering behaviour^ (tick if present)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Does not acknowledge having a problem</td>
</tr>
<tr>
<td>☐ Does not adequately or consistently acknowledge the problem’s severity or its impact on others.</td>
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<tr>
<td>☐ Frequently complains about problems or blames others for his/her problems.</td>
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<tr>
<td>☐ The client wants another person to change.</td>
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<tr>
<td>☐ Does not identify clear goals for treatment or contribute to the agenda</td>
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<tr>
<td>☐ Argues with, repeatedly questions, or otherwise dismisses the therapist’s presentation of the nature of the problem or the treatment plan.</td>
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<td>☐ Insists s/he cannot change or that therapy cannot help him/her.</td>
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<td>☐ Attempts to change the focus of sessions to issues not on the treatment plan</td>
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<td>☐ Presents too many problems or jumps from crisis to crisis</td>
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<td>☐ Has difficulty explaining the treatment plan or the rationale behind it.</td>
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<td>☐ Has difficulty answering questions in a timely fashion (e.g., provides information not relevant to the question, provides too much detail).</td>
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<td>☐ Is frequently late or does not show up for treatment sessions</td>
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<tr>
<td>☐ Has difficulty following the treatment plan (e.g., does not complete therapy assignments, doesn’t take medication as prescribed) even when accompanied by therapist</td>
</tr>
<tr>
<td>☐ Has difficulty following the treatment plan (e.g., does not complete therapy assignments, doesn’t take medication as prescribed) when not accompanied by therapist</td>
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<tr>
<td>☐ Provides information to the treatment team that is inaccurate, misleading, or inconsistent (e.g., does not adequately report difficulties, reports different things to different clinicians, leaves out critical details).</td>
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<tr>
<td>☐ Engages in, threatens to engage in, or hints at engaging in self-destructive acts</td>
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<td>☐ Speaks or acts in a way that makes others feel physically threatened</td>
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<td>☐ Demands entitlements</td>
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<td>☐ Becomes angry, upset, critical or nonresponsive</td>
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<tr>
<td>☐ Is inattentive or frequently interrupts the therapist</td>
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<tr>
<td>☐ Repeatedly contacts the therapist between sessions in crisis</td>
</tr>
<tr>
<td>☐ Other:</td>
</tr>
</tbody>
</table>

^ Compiled from van Dyke And Pollard (2005) and J.Beck (2005)
<table>
<thead>
<tr>
<th>Top 3 clinical problems</th>
<th>Top 3 maintaining factors (hypotheses)</th>
<th>Behavioural experiment/experiential exercise</th>
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<table>
<thead>
<tr>
<th>Top 3 therapy-interfering behaviours</th>
<th>Top 3 maintaining factors (hypotheses)</th>
<th>Behavioural experiment/experiential exercise</th>
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**[4a] REVIEW WORKING ALLIANCE**

**BRIEF ALLIANCE INVENTORY (BAI) – Therapist version**

In the next set of items are sentences that describe different ways a person might think or feel about his or her client. Remember, there are no right or wrong answers. We realize that your thoughts or feelings may undergo changes over a period of time, but we would like to know your views or feelings as of right now. Please use the following response scale:

<table>
<thead>
<tr>
<th>Positive</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly disagree</td>
<td>Disagree</td>
<td>Neutral</td>
<td>Agree</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>Reversed</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
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</tbody>
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<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>T/G</th>
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<tbody>
<tr>
<td>1.</td>
<td>I feel I really understand my client</td>
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<td>2.</td>
<td>We have established a good understanding between us of the kind of changes that would be good for my client</td>
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<td>3.</td>
<td>I appreciate my client as a person</td>
<td></td>
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<tr>
<td>4.</td>
<td>I believe the time my client and I are spending together is not spent efficiently – <em>use reversed</em></td>
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<td>5.</td>
<td>I believe my client likes me</td>
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<td>6.</td>
<td>My client and I both feel confident about the usefulness of our current activity in therapy</td>
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<td>7.</td>
<td>I respect my client even when s/he does things that I do not approve of</td>
<td></td>
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<tr>
<td>8.</td>
<td>I have doubts about what we are trying to accomplish in therapy – <em>use reversed</em></td>
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<td>9.</td>
<td>I am confident in my ability to help my client</td>
<td></td>
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<td>10.</td>
<td>I feel confident that the things we do in therapy will help my client to accomplish the changes that s/he desires</td>
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<tr>
<td>11.</td>
<td>My client and I have built a mutual trust</td>
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<td>12.</td>
<td>I have some disagreements with my client about the goals of these sessions – <em>use reversed</em></td>
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<td>13.</td>
<td>I am genuinely concerned for my client’s welfare</td>
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<td>14.</td>
<td>We agree on what is important for my client to work on</td>
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<tr>
<td>15.</td>
<td>My client and I respect each other</td>
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<tr>
<td>16.</td>
<td>The things we are doing in therapy don’t make much sense to my client – <em>use reversed</em></td>
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**Total:**

**Mean (Divide by 8):**

*Adapted from the Brief Alliance Inventory client version.*


Instructions: Choose one of the clients from your caseload and think about your last session with him/her. Tick the behaviours you engaged in. You could write “N/A” if you thought the behaviour wasn’t applicable for this client at this time. Positive behaviours you didn’t tick, that aren’t ‘N/A’ may be behaviours worth experimenting with in your next session. Negative behaviours you ticked are behaviours worth trying to decrease next session.

Engagement

☐ I explained how therapy works
☐ I asked the client what s/he wants to talk about in session
☐ I encouraged the client to articulate his/her goals for therapy
☐ I asked the client what s/he wants to talk about in session
☐ I asked the client whether s/he is willing to do a specific in-session task
☐ I asked the client whether s/he is willing to follow a specific suggestion or do a specific homework assignment
☐ I asked the client whether s/he is willing to do a specific in-session task
☐ I asked the client about the impact or value of a prior homework assignment
☐ I expressed optimism or noted that a positive change had taken place or can take place
☐ I ‘pulled in’ my client when s/he was quiet, by:
  ☐ deliberately leaning forward
  ☐ calling the client by name

Add others...

☐ I asked if the client had any questions
☐ I praised the client for expressing motivation to change

Promoting Disengagement

I defined the therapeutic goals or imposed tasks or procedures without asking the client for their collaboration

☐ I argued with the client about the nature, purpose, or value of therapy
☐ I shamed or criticized how the client did (or did not do) a prior homework assignment

Emotional Connections

☐ I shared a light-hearted moment or joke with the client
☐ I expressed confidence, trust, or belief in the client
☐ I explained how therapy works
☐ I expressed interest in the client apart from the therapeutic discussion at hand
☐ I expressed caring
☐ I disclosed my personal reactions or feelings toward the client or situation
☐ I disclosed some facts about my personal life
☐ I remarked on or described how my values or experiences are similar to the clients’
☐ I expressed empathy for the client’s struggle (e.g., “I know this is hard”, “I feel your pain”, crying with the client)
☐ I normalized the client’s emotional vulnerability (e.g., crying, hurt feelings)

Promoting emotional disconnection

I had hostile, sarcastic or critical interactions with the client

☐ I didn’t respond to the client’s expression of personal interest or caring for me

Cont...
THERAPIST CONTRIBUTIONS TO WORKING ALLIANCE CHECKLIST continued

Safety within the therapeutic system
- I acknowledged that therapy involves taking risks or discussing private matters
- I provided structure and guidelines for safety and confidentiality
- I invited discussion about intimidating elements in the therapy context (e.g., recording equipment, reports to third parties, questionnaire collection etc)
- I asked the client how I could help him/her feel more comfortable talking about his/her concerns

Promoting mistrust and insecurity
- I did not attend to overt expressions of client vulnerability (e.g., crying, defensiveness, fear)

Therapeutic relationship (bond)
- I talked about how the client thought our relationship was going
- I asked the client for feedback about my approach
- I checked the client felt I had listened to and understood them

Promoting ruptures in the therapeutic relationship
- There was a rupture in the alliance and I avoided talking about it

Tasks and goals
- I talked about the progress the client was making toward his/her goals
- I checked with the client to ensure we were talking about the right topics for the client to meet his/her goals


My plan for enhancing the alliance with this client:

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[3B] EXERCISE Pt I: NOTICING ALLIANCE RUPTURES (THERAPIST REACTIONS)

Take a moment to visualise a session with one of your clients who is not progressing as well as others (“who do I wish would cancel his/her session today?” [J Beck, 2005]). Write out any thoughts and feelings you notice.

Emotions:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Thoughts:

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__________________________________________________________________________

Sensations:

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Action urges:

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Now, see if you can identify the specific client behaviours (verbal and/or non-verbal) that elicit the above reactions in you:

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[4] REPAIRING RUPTURES IN THE ALLIANCE

Ruptures can happen at any time in therapy. They vary in intensity or significance from barely noticeable to major conflicts. Similarly, repair attempts should vary proportionally. If interpersonal problems are either the focus of treatment or if the client’s style of interpersonal interaction is a significant impediment to getting their needs met (including benefiting from treatment), then ruptures offer opportunities to conceptualise and address problems in relating. In the following exercise, consider whether you and your client have agreed to address problems relating to others and have the time to examine and address these patterns. In which case, your repair might aim to highlight a theme in the way the client relates to others. Otherwise, consider “rolling with resistance” and adopting a collaborative, problem-solving approach to resolving the rupture.
Examples of responding to ruptures when time is limited, interpersonal problems not focal (J Beck, 2005)

- Empathise: ask questions to understand how the client is perceiving your behaviour; check out this understanding
- Validate what’s valid (e.g., “You’re right. It is unfair that I have a family and you don’t”)
- Clarify misperceptions (e.g., “What did you hear me say?”, “No wonder you felt angry if that’s what you thought I said. I want you to notice though, I didn’t say ‘you should just suck it up’. Do you remember what I actually said?”)
- Thank the client for disclosing concerns about you or the therapy (“It’s good you told me that”)
- If you’ve made a mistake, apologise (e.g., “I’m sorry — I moved too quickly into problem-solving, no wonder you felt like I didn’t understand you”)
- Problem solve with client; be flexible enough to meet client’s present needs/capabilities. (e.g., “Perhaps we could spend the first 15 minutes of each session where we just let you talk and get things off your chest without me interrupting, but then we focus the rest of the session on working out what to try differently the next week?”; “Maybe we could spend the first half of each session on your anxiety, and the second half on your drinking?”)
- Elicit motivation to remain in treatment: instil hope; ask for time to test out beliefs

Examples of metaphors describing relationship during alliance ruptures

Metaphors are useful for lowering the intensity of the metacommunication about the therapeutic relationship. They’re also useful for describing the shared roles in the pattern of interaction to diminish the sense that the client is being blamed.

- “This may just be me, but at the moment I feel like, you’re on a stage and I’m in the audience, and my job is just to watch and listen to you, but it’s not really ok for me to join in. Do you have any sense of that?”
- “I’m just noticing that we seem to have fallen into a pattern at the moment, almost like we’re at baseball practice, where I just lob up a suggestion, one after the other, and you kind of swipe them away and then get ready to pace the next pitch. Does it feel like that to you at all?”
- “Could we pause for a moment here. I have this image coming to mind as I kind of step back and watch what’s going on between us. It reminds me of the kid that’s in trouble at school and has gone to the principal’s office. It looks like you can’t wait for this to be over and I sound like I’m interrogating you and telling you what you should do — is that how I’m coming across to you?”

When ruptures exemplify a clinically significant pattern of relating to others

1. Formulate: share hypothesis & invite client feedback
2. Validate the protective function of the coping strategy
3. Elicit disadvantages of coping strategy
4. (If needed) Highlight the adverse impact on therapy (& optionally, on therapist)
5. Invite the client to collaboratively solve this problem (as behavioural experiment)
### Examples of Empathic Confrontation

<table>
<thead>
<tr>
<th></th>
<th>Client appears detached, disengaged</th>
<th>Client engages in regular, prolonged bouts of detached complaining</th>
<th>Client has rigid routines and standards for performance limiting openness to new learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>“Sometimes even though people deep down want help, they’re so used to having their guard up that they keep that guard up even in therapy. I’m wondering if that’s happening between us right now?”</td>
<td>“I’m not sure if you realise it, but each time you’ve come in here you’ve told me about all of your injuries in a lot of detail. When you do this, I feel like it would be insensitive of me to talk about anything else, so I feel a pressure to keep quiet. What do you feel as I tell you this?”</td>
<td>“I get the sense that there are limits to what you’re open to doing in therapy. I wonder whether when I start to suggest anything outside your comfort zone, that you seem to close off and start trying to convince me that the routines and habits you have are necessary – the right way and the best way - to do things and you don’t show as much interest in what I have to say about these areas of your life. Have you noticed this too?”</td>
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<tr>
<td>2.</td>
<td>“If you remember times in the past when you felt overwhelmed by your emotions, it makes sense that you would get good at keeping a lid on them. And right now, you don’t know me that well, you don’t know what I might ask about, so it makes sense that you’d try and keep your feelings down.”</td>
<td>“You do have a lot of real problems that other people don’t have. You do deserve sympathy and help. I wonder whether this sense of being ‘shut down’ I’m having, also functions to help protect you from feeling overwhelmed by any demands you think I might make of you? What do you think?”</td>
<td>“It sounds like when you were growing up, you were always expecting to be criticised or punished for not doing things the way your mum expected. It makes total sense that in this environment you would work very hard to get good at doing everything in a predictable, precise way. That way you might avoid punishment or at the very least, get a chance to do things your way and feel a sense of mastery and control. It’s a basic human need to feel autonomous. I get that your routines and habits were the only way you got to experience autonomy.”</td>
</tr>
<tr>
<td>3.</td>
<td>“Can you think of any downsides to keeping your guard up all the time, with everybody? What about in therapy?”</td>
<td>“Could there be any disadvantages to repeatedly listing your injuries to people?”</td>
<td>“Are there any not-so-good parts about keeping up these strict rules and routines?”</td>
</tr>
<tr>
<td>4.</td>
<td>“My concern is that I can’t help you learn to live better with your thoughts and emotions if you don’t allow us to see what they are. If you keep your guard up like this all the time, I can’t help you.”</td>
<td>“I do care about you and I do want to help. I think others may too. But when you kind of, “get on a roll”, you don’t some across as someone who’s soft and needs to be cared for. When you rant, I actually feel shut down, and I’d bet others do too”</td>
<td>“I’m concerned this strategy might be making your current life worse. I see how exhausted you get from trying to keep this level of perfection up. I can imagine how draining and frustrating this might be for those around you too. Right now, I’m worried it’s getting in the way of our work together. This coping strategy isn’t letting you and I try out new things to see if life can be better”</td>
</tr>
<tr>
<td>5.</td>
<td>“What could we do about this? Is there something I could do differently that would make”</td>
<td>“So how could I do a better job of helping you here? If you actually want me to back off, could we try”</td>
<td>“What rule would you be willing to bend – even if it’s the smallest step possible – so you and I can”</td>
</tr>
<tr>
<td>Letting your guard down easier? Could we agree that when I ask you what you’re feeling you have to give me at least one emotion word?”</td>
<td>You saying so to me? Would it work better if we rescheduled, instead of going ahead with sessions when your pain is so intense?”</td>
<td>Find out what happens when you try something new?”</td>
<td></td>
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</tbody>
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[5] **EXERCISE Pt II: SCRIPTING RESPONSES TO HIGHLIGHT RUPTURE AND INVITE FORMULATION AND/OR PROBLEM-SOLVING**

Script some ways of addressing client therapy-interfering behaviours or behaviours that elicit therapy-interfering thoughts or feelings in you.

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________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
[6] COGNITIVE THERAPY SESSION STRUCTURE SIMPLE CHECKLIST

INITIAL PART OF SESSION
1. Do a mood check. 
2. Set the agenda. 
3. Obtain an update. 
4. Review homework. 
5. Prioritize the agenda. 

MIDDLE PART OF SESSION
6. Work on a specific problem and teach cognitive behavior therapy skills in that context. 
7. Follow-up discussion with relevant, collaboratively set homework assignment(s). 
8. Work on second problem. 

END OF SESSION
9. Provide or elicit a summary. 
10. Review new homework assignments. 
11. Elicit feedback. 

COGNITIVE THERAPY SESSION COMPREHENSIVE CHECKLIST

REGULAR SESSION

MOOD CHECK
☐ I reviewed questionnaires I had given the client

☐ I asked the client to tell me in 1-2 sentences how s/he had felt for most of the week

☐ There was a discrepancy between questionnaires and verbal report
  (If yes) ☐ I asked the client to explain the discrepancy

☐ I compared questionnaire scores this session to previous sessions and checked with the client that these reflect his/her experience

☐ I confirmed that the questionnaire represents the previous week not just that day

☐ There was some mood improvement
  (If yes) ☐ I asked what the client attributed mood improvement to
  ☐ I praised the client for changes s/he made that improved his/her mood
    ☐ The client was unsure why his/her mood had improved
      (if yes) ☐ I asked him/her if s/he had noticed any changes in thinking or behaviour
    ☐ The client attributed mood improvements to external factors
      (if yes) ☐ I validated the attribution AND asked him/her if s/he had ALSO noticed any changes in his/her thinking or behaviour

☐ There was some mood deterioration
  (If yes) ☐ I asked what the client attributed mood deterioration to and checked whether his/her thinking or behaviour could have contributed (to reinforce the cognitive model)

AGENDA-SETTING
☐ I asked the client what problems s/he wanted my help in solving today and to just tell the names of problems (to socialise to agenda-setting)

POTENTIALLY THERAPY-INTERFERING BEHAVIOUR
  (If applicable)

☐ The client began discussing a problem before completing agenda setting
  If yes... ☐ I gently interrupted

OBTAINING AN UPDATE
☐ I asked the client what has happened since last appointment that is important for me to know

☐ I established whether these events needed to be discussed

---

I postponed discussing the less important events my client talked about
I asked whether any positive events or moments of improved mood occurred

HOMEWORK REVIEW
I asked the client to read aloud the assignments from their homework list
I asked the client to rate how much they believed the adaptive statements/responses to automatic thoughts/beliefs identified in previous sessions
I asked the client what s/he had learnt from his/her behavioural assignments

PRIORITISING THE AGENDA
I asked the client to prioritise agenda items, including the top 1-2 most important
   □ I asked the client to hypothetically imagine one problem was solved: how much relief do they feel?

POTENTIALLY THERAPY-INTERFERING BEHAVIOUR
(If applicable)
□ The client began discussing a different problem not on the agenda

If yes...□ I gently interrupted, highlighted the topic change and asked the client whether s/he wanted to return to the agenda or to continue talking about this new topic

FIRST THIRD OF SESSION COMPLETE WITHIN FIRST 15 MINUTES

MIDDLE OF SESSION
□ I asked the client which problem to start with
□ I asked the client permission to start with a problem/goal I thought was particularly important

□ WE CHOSE TO FOCUS ON SOLVING THE PROBLEM SITUATION
□ WE CHOSE TO FOCUS ON EVALUATING THOUGHTS OR BELIEFS
   □ I gave the client one or more question prompts to use to evaluate thoughts (or thought record/worksheet) to practice between sessions
      □ I first made sure the client understood that evaluating his/her thinking can help them feel better
      □ I first made sure the client believed s/he would be able to use these questions effectively at home

□ WE CHOSE TO REDUCE THE CLIENT’S IMMEDIATE DISTRESS
□ WE CHOSE TO FOCUS ON MAKING BEHAVIOURAL CHANGES
□ Other ____________________________________________________________

LAST THIRD OF SESSION BEGUN BY 35-MINUTE MARK

HOMEWORK SETTING
□ I asked the client what the most important thing for them to remember this week is
□ I went over the homework tasks and...
☐ Checked the client understood and agreed with the rationale for the assignment
☐ The only complex assignments set had been explicitly taught and rehearsed in session
☐ Checked how long each would take
☐ Checked that client was 90-100% confident could complete or made “optional”
☐ Checked how the client would remember to do each task, trouble-shooting if needed
☐ Checked that all agreed homework assignments were written down for client

FEEDBACK
☐ I asked the client what they thought of the session and explicitly asked if I got anything wrong or did anything that bothered them
☐ I gave the client the Therapy Report to complete in the waiting room

THROUGHOUT WHOLE SESSION
Rate the following on this scale:

<table>
<thead>
<tr>
<th></th>
<th>n/a</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>never</td>
<td>Sometimes</td>
<td>Usually</td>
<td>Always</td>
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</table>

ATTENTION TO CLIENT MENTAL STATE IN SESSION
___ I noticed affect shifts (e.g., changes in facial expression, tightening of muscles, shifts in postures, hand gestures, tone, pitch, volume or pace)
___ I asked “what went through your mind?” (when I noticed affect shifts)

GUIDED DISCOVERY TECHNIQUE
___ I first asked “what went through your mind?” to elicit automatic thoughts
    ____ The client couldn’t answer, so I...
    _____ Asked them how they were feeling & where in their body they felt the emotion
    _____ Elicited a detailed description of the problem situation
    _____ Asked the client to visualise the distressing situation
    _____ Asked the client to role play the situation with me
    _____ Elicited an image
    _____ Supplied thoughts opposite to the ones I hypothesized actually went through their mind
    _____ Asked for the meaning of the situation
    _____ Phrased the question differently (e.g., “were you making a prediction?”)
    ____ If the client still couldn’t answer, I...
    _____ Changed the subject to:
    ☐ Avoid the client feeling like s/he was being interrogated
    ☐ reduce the chance of the client feeling like a failure
I guided the client to state the actual words or images that went through his/her mind, rather than interpretations.

I guided the client to rephrase automatic thoughts in question/incomplete forms into statements.

CHOICE OF THOUGHTS TO FOCUS ON

I determined at which point in a situation the client was most distressed: before, during or after.

I asked clients to rate the degree of intensity of emotions and the degree of conviction in beliefs.

I contrasted emotional intensity and belief conviction: then v no v later.

I focused on thoughts that were most distressing and likely to recur.

TEACHING THE COGNITIVE MODEL

I helped the client correctly categorise thoughts, emotions (and other model components).

I questioned further when the client reported an emotion that seemed incongruent with the situation.

Rate how well you did each of the following items using this scale:

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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tbody>
<tr>
<td>Poorly</td>
<td>Barely</td>
<td>Adequately</td>
<td>Mediocrely</td>
<td>Satisfactorily</td>
<td>Well</td>
<td>Very Well</td>
<td>Excellently</td>
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</table>

I regularly checked the client understood what I was saying.

I summarised the client’s problems in terms of the cognitive model, using the client’s own words.

I asked the client to summarise after evaluating a thought/belief (or asked them what was most important to remember).

I provided a summary when a section of the session had been completed.

I said “I’m glad you told me that” when the client gave me negative feedback.

I understood the client’s “internal reality”.

I was warm.

I showed concern.

I showed confidence.

I demonstrated professionalism.

I encouraged the client as much as possible to take an active role in session so we could function as a “team”.

I gave clear rationales for session activities including homework.

I used time efficiently by tactfully limiting peripheral and unproductive discussion and pacing the session as rapidly as appropriate for the client.

I avoided debating, persuading, or “lecturing”. I didn’t cross-examine the client or put my client on the “defensive”.

I used questioning to guide client discovery (examining evidence, considering alternatives, weighing advantages and disadvantages).

I was conscious of how to help the client feel better by the end of the session and how to help them have a better week.

I focused on identifying the key thoughts, assumptions, beliefs and behaviours most relevant to the problem and that offered the most potential for progress.

When the client reacted negatively to something in session I conceptualised this in the cognitive model and helped solve the problem.
[7] GUIDED DISCOVERY (SOCRATIC QUESTIONING)

(Optional) Workshop exercise (pairs): Identify two points you’d like to teach a client. First, explain this to them didactically, as if giving a lecture to a class. Obtain your partner’s feedback. Next, use Socratic questioning to help your partner understand your second point. Obtain your partner’s feedback. Swap roles.

What was your experience like in the client role? Compare with your partner.

Homework task: Video- or audio-record a therapy session with a client. Make predictions about the ratio of questions: statements. Watch session recording and count the number of questions & number of statements (where you provide new information not contained in the client’s previous statements, so don’t count simple reflections & paraphrases). Bonus task: count summaries. What did you learn?

[9] MANAGE AROUSAL TO ENABLE LEARNING

Managing dissociation

- Use a 0-10 scale (or similar) of anxious arousal where 10=completely dissociated. Use the scale to check in regularly with the client and monitor their arousal level.

- Grounding:
  - The 5-4-3-2-1 intervention is easy for clients to learn
    - 5 things you can see
    - 4 things you can hear
    - 3 things you can touch
    - 2 things you can smell
    - 1 thing you can taste
  - Ensure environment well-lit
  - Call client by name, identify yourself, tell her where she is & what month, day, year
  - Use reassuring tone but avoid hypnotic tones (overly soft, soothing, prosodic): calm, firm, normal pitch and volume.
  - Aim to maintain eye contact, otherwise have client name objects in physical environment & look at other parts of therapist that are less threatening (e.g., legs, shirt).
  - Comforting objects: e.g., soft blankets, toys, pictures
  - Grounding smells: e.g., coffee, mint, potpourri, fragrant soaps.

Arousal-reduction techniques

Ideally, these would be taught and practiced in states of lower arousal, to later be available as ways to lower higher levels of arousal.

- Safe place imagery (example scripts in (Gilbert & Choden, 2014; Young, Klosko, & Weishaar, 2003))
- Slow-paced breathing – e.g., (Barlow & Craske, 2006)
- Mindfulness of breath – e.g., (Kabat-Zinn, 2005)
- Progressive muscle relaxation – e.g. (Bernstein, Borkovec, & Hazlett-Stevens, 2000)
### IDENTIFY & REDUCE AVOIDANCE

Choose one of your clients who is not progressing as you would like. Complete the following:

<table>
<thead>
<tr>
<th>My client’s avoidance behaviours</th>
<th>How I currently respond</th>
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<table>
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<tr>
<th>My avoidance behaviours</th>
<th>How I plan to respond from now on</th>
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20
1. Review client homework assignments.

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<th>Client Initials</th>
<th>Current homework assignment</th>
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2. Choose a client who does not have a task assigned (or one whose task is unsatisfactory).

3. Identify a desirable behaviour for the client to introduce between sessions (one that would take him/her closer to his/her goal for therapy).


5. Develop an experiment the client could try for homework. At a minimum try an alternating behaviours experiment: the client will alternate between status-quo behaviour and new behaviour. Identify a belief, emotion or outcome to measure to test the advantages & disadvantages of status-quo v new behaviour.
1. Conceptualise your hooks.

<table>
<thead>
<tr>
<th>Triggers</th>
<th>Therapist “hook” (therapy-interfering belief)</th>
<th>Emotional Behavioural consequences</th>
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2. Intervention plan to address therapist “hooks” (e.g., cognitive restructuring, defusion etc).

OTHER PROFESSIONAL DEVELOPMENT PLANS:
REFERENCES


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