

Assessment ***The Mindfulness-
Based Cognitive
Therapy
Adherence Scale:
Inter-rater
Reliability,
Adherence to
Protocol and
Treatment
Distinctiveness***

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The development of the Mindfulness-Based Cognitive Therapy Adherence Scale (MBCT-AS) is described. This 17-item scale measures therapist adherence to the treatment protocol for Mindfulness-Based Cognitive Therapy (MBCT), a treatment for the prevention of recurrence in Major Depressive Disorder. The MBCT-AS assesses therapist behaviours specific to (MBCT) as well as therapy practices that MBCT shares with Cognitive Behaviour Therapy (CBT). To determine the utility of this scale, we compared delivery of group MBCT against group CBT, with independent ratings of taped sessions provided to measure adherence to MBCT and CBT for therapists in

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both groups. The results showed that: (a) raters can reliably use the MBCT-AS; (b) MBCT therapists demonstrated adherence to the treatment protocol, as measured by the MBCT-AS; and (c) MBCT is distinguishable from CBT on both the MBCT-AS and a scale measuring adherence to CBT (CBT-AS). These findings indicate that the MBCT-AS may be a useful tool for ensuring the proper delivery of MBCT in future research, and may be helpful in determining the elements of MBCT that are unique to that treatment. Copyright © 2002 John Wiley & Sons, Ltd.

INTRODUCTION

Mindfulness-based cognitive therapy (MBCT; Teasdale *et al.*, 2000) is a recently developed psychological treatment designed to reduce relapse/recurrence in individuals who have recovered from unipolar major depression. This integrative 8-week group treatment features the core elements of mindfulness-based stress reduction as developed by Kabat-Zinn (Kabat-Zinn, 1990), in combination with standard cognitive behaviour therapy (CBT) interventions. The theoretical rationale behind this approach is that skills in attentional deployment acquired through the practice of mindfulness would facilitate earlier detection of dysphoric moods and negative thinking, leaving formerly depressed persons with greater options for responding to these precursors to a depressive episode, including CBT. The results of a recently completed randomized trial of MBCT support its efficacy as a prophylactic intervention, as patients receiving this treatment had a significantly longer time to relapse compared to patients receiving treatment as usual (Teasdale *et al.*, 2000).

While efficacy data are central to the development and evaluation of any new treatment, it is also important to be able to measure the degree to which the intervention as described in its treatment manual is actually being administered. For psychosocial interventions, these measures usually involve evaluating how well therapists adhere to the treatment protocol. Whereas treatment manuals serve to specify how a treatment is to be carried out, adherence measures offer a way of quantifying how faithfully the intervention has been provided (Shaw *et al.*, 1999). Without measuring adherence, it is difficult for studies of comparative outcomes to verify whether the independent variable of interest, namely treatment, has been successfully manipulated.

In addition, by specifying those interventions that are necessary to the overall treatment, it becomes

possible to use adherence measures to distinguish between treatments that possess similarities or have a common developmental history. Waltz, Addis, Koerner and Jacobson (1993) note that adherence scales can be helpful in examining unique and common elements in different treatments, especially through the inclusion of items measuring features of the treatment of interest that are 'unique and essential' and those that are 'essential but not unique'. By looking at procedures that are only present for a specific treatment, and those that may be more generic and shared between treatments, it is possible to characterize more fully the definitive features of a treatment of interest.

Considerations of treatment distinctiveness are especially important in the present case, as MBCT borrows heavily from aspects of cognitive behaviour therapy, as well as possesses features that are unique to it. An MBCT adherence measure would not only allow determination of appropriate therapy delivery based on the procedures outlined in the treatment manual (Segal, Williams, & Teasdale, 2002), but would also assist in quantifying those aspects of the intervention which are specific to MBCT, and those which it shares with CBT.

The present study reports on a rater-scored measure constructed to assess therapist adherence in the delivery of MBCT. Delivery of group MBCT was compared against group CBT, with independent ratings of taped sessions provided to measure adherence to MBCT and CBT for therapists in both groups. We addressed four main questions. First, can raters reliably use the developed MBCT Adherence Scale (MBCT-AS)? To examine this issue, we measured the inter-rater reliability of MBCT-AS adherence ratings on a subset of the audiotaped MBCT sessions. Second, do MBCT therapists demonstrate adherence to the protocol, as measured by the MBCT-AS? This question was looked at through a comparison of the mean adherence ratings. Third, is MBCT distinguishable from CBT on the MBCT-AS and

CBT Adherence Scale (CBT-AS)? To address the distinctiveness of the two therapies, ratings for both of the treatments were compared on each of their respective measures of adherence. Finally, what are the unique components of MBCT, as identified by the MBCT-AS? To answer this question, we performed a multidimensional scaling analysis of the MBCT-AS to identify separable dimensions.

METHODS

Therapies

MBCT

Mindfulness-based cognitive therapy (MBCT) is an 8-week group-treatment that combines elements of mindfulness practice with techniques drawn from cognitive therapy to produce a comprehensive treatment system specifically designed to give formerly depressed individuals training in skills relevant to the prevention of depressive recurrence (Segal *et al.*, 2002). The treatment programme was adapted from the Stress Reduction and Relaxation Program of the University of Massachusetts Medical Center (Kabat-Zinn, 1990), and has as its goal increasing patients' awareness of present, moment-to-moment experience. Patients receive extensive practice in centring their attention on the present, using a focus on the breath as an anchor, whenever they observe that attention has been diverted to streams of thoughts, worries, or general lack of awareness. It is assumed that the development of such a detached, decentred relationship to depression-related thoughts and feelings is a core skill that patients acquire, and that its utilization helps prevent the escalation of negative thinking patterns at times of potential relapse (Teasdale, 1997; Teasdale, Segal, & Williams, 1995). In contrast to cognitive behaviour therapy, there is relatively little emphasis in MBCT on changing the content or specific meanings of negative automatic thoughts. Instead, the training in MBCT uses everyday experience as the object of training, thereby allowing this work to proceed during remission, when negative automatic thoughts may be less marked.

All patients receiving MBCT had been diagnosed as suffering from major depression in the past but were no longer in episode. Remission status was confirmed by a SCID-based interview (First, Spitzer, Gibbon, & Williams, 1996) and Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960) score below the cut-off of 9. Patients participated in the previously mentioned outcome study

of MBCT (Teasdale *et al.*, 2000) and MBCT was delivered by the authors of the treatment manual.

CBT

Cognitive Behaviour Therapy is a short-term (16 weekly sessions) intervention for depressive disorders. The therapy format followed was that based on the manual by Beck, Rush, Shaw and Emery (1979), delivered in this case in a group setting. Both behavioural (e.g. role playing, self-reinforcement) and cognitive strategies (e.g. meaning inquiry, thought monitoring) were utilized in the therapy.

The patients receiving CBT were diagnosed as suffering from Major Depressive Disorder, as confirmed by SCID-based interview and an HRSD score of 16 or greater.

Cognitive Behaviour Therapy was administered by a registered clinical psychologist with 5 years of training in CBT and 3 years of group experience.

Both of the treatments were administered at the Cognitive Behaviour Therapy Unit, an outpatient treatment clinic within the Mood and Anxiety Disorders Division of the Centre for Addiction and Mental Health in Toronto.

Measures

MBCT Adherence Scale (MBCT-AS)

The MBCT-AS is composed of 17 items, each of which is rated on a 0 to 2 point scale (0 = no evidence for item, 1 = slight evidence, 2 = definite evidence). The MBCT-AS has two subscales. Nine MBCT-AS items assess therapist behaviours specific to MBCT (e.g. movement-based awareness exercises), and form the Mindfulness (M) subscale, and eight of the therapy practices that MBCT shares with CBT (e.g. linking thoughts with feelings) make up the Cognitive Therapy (CT) subscale. The items of the scale are presented in Appendix 1.

CBT Adherence Scale (CBT-AS)

The CBT-AS is a 26-item scale, with the items taken from the Collaborative Study Psychotherapy Rating Scale (Hollon *et al.*, unpublished data). The items used addressed various areas of CBT: cognitive rationale, cognitive processes, evaluating and changing behavioural focus, homework, etc. As for the MBCT-AS, all items were rated on a 3-point scale (0 = no evidence for item, 1 = slight evidence, 2 = definite evidence). The items of the scale are presented in Appendix 2.

Raters

As Waltz *et al.* (1993) suggest, graduate student raters are appropriate when a behaviourally-anchored rating scale is used to assess therapist adherence. The present study employed three doctoral-level clinical psychology students to rate adherence. All of the raters were previously familiar with CBT, and had received training in that therapy at the Cognitive Behaviour Therapy Unit. For MBCT, raters first received a general orientation to the theoretical and clinical background to MBCT from one of the developers of the intervention, Dr. Zindel Segal. Raters then received approximately 10 h of training in the use of the MBCT-AS and scoring its individual items. The focus of this training was to be able to identify the presence or absence of the specific MBCT-AS-listed behaviours in an audiotaped therapy session.

Procedures

Sixteen audiotapes¹ of group treatment were assessed by each rater. Eight sessions of both MBCT and CBT were randomly selected with the session numbers being identical for treatment. The raters were given all 16 audiotapes and were not informed which audiotapes were of which therapy type. Raters listened to the audiotapes and completed the MBCT-AS and CBT-AS individually. As in other adherence studies (Shapiro & Startup, 1992; Startup & Shapiro, 1993), to prevent rater drift all the raters met on occasion to review the behavioural criteria for each of the scale items.

RESULTS

Inter-rater Reliability

The reliability of the ratings obtained from the three raters was examined by calculating intraclass correlation coefficients (ICC), treating the raters as random effects (Strout & Fleiss, 1979, Model 2). The reliability for the MBCT-AS was very high, $ICC(2, 1) = 0.820$, and the CBT-AS also demonstrated good reliability, $ICC(2, 1) = 0.762$.

The two subscales of the MBCT-AS, the Mindfulness (M) and Cognitive Therapy (CT) subscales,

were also examined for reliability. The M subscale ratings were extremely reliable, $ICC(2, 1) = 0.971$, whereas lower rater consistency was found for the CT subscale, $ICC(2, 1) = 0.595$.

MBCT-AS Internal Consistency

To determine whether the MBCT-AS scale items were consistent with each other, we calculated the average measure intraclass correlation coefficient for the scale. The alpha for the full scale was 0.557. We then looked separately at the nine items that are unique to MBCT, those items on the M subscale. The alpha for these items was much higher, 0.886. The remaining eight items, those common to MBCT and CBT (the CT subscale), had a relatively low alpha of 0.415. Only the M subscale seemed to have sufficient internal consistency. The differences in internal consistency between these two subscales may also be reflected in the differences in the inter-rater reliability of these two subscales.

To better characterize the two subscales, we also examined the degree of association of each subscale with the total scale score, as well as the association between the subscales themselves, for ratings of the MBCT tapes. The M subscale correlated 0.51 ($p < 0.05$) with the total scale score, and the C subscale correlated 0.72 ($p < 0.01$) with the total scale score. The correlation between the two subscales was -0.24 and not statistically significant, suggesting that the two subscales are not redundant and assess distinct features of the treatment.

Structure of MBCT-AS

In order to explore the underlying structure of the MBCT-AS, we performed a multidimensional scaling analysis of the 24 (8 tapes \times 3 raters) MBCT-AS ratings for the MBCT sessions. For the purposes of this analysis, the 3-point scale was converted into a binary presence/absence measure by coding 'No evidence for item' as 'Missing', and 'Slight evidence' and 'Definite evidence' as 'Present', and binary Euclidean distance was calculated.

The stress value for the one-dimensional solution was 0.120, with a large improvement in stress, to 0.081, for the two-dimensional solution, and relatively little improvement at higher dimensions (0.075 for three dimensions, 0.073 for four dimensions). We therefore chose to examine more closely the two-dimensional solution.

The configuration plot for the two-dimensional solution is presented in Figure 1. As can be seen

¹ When treatments are being rated for adherence, and not competence, and when the rated behaviours would all be obvious auditorially, it is generally agreed that audiotapes are sufficient for this purpose (Waltz *et al.*, 1993).

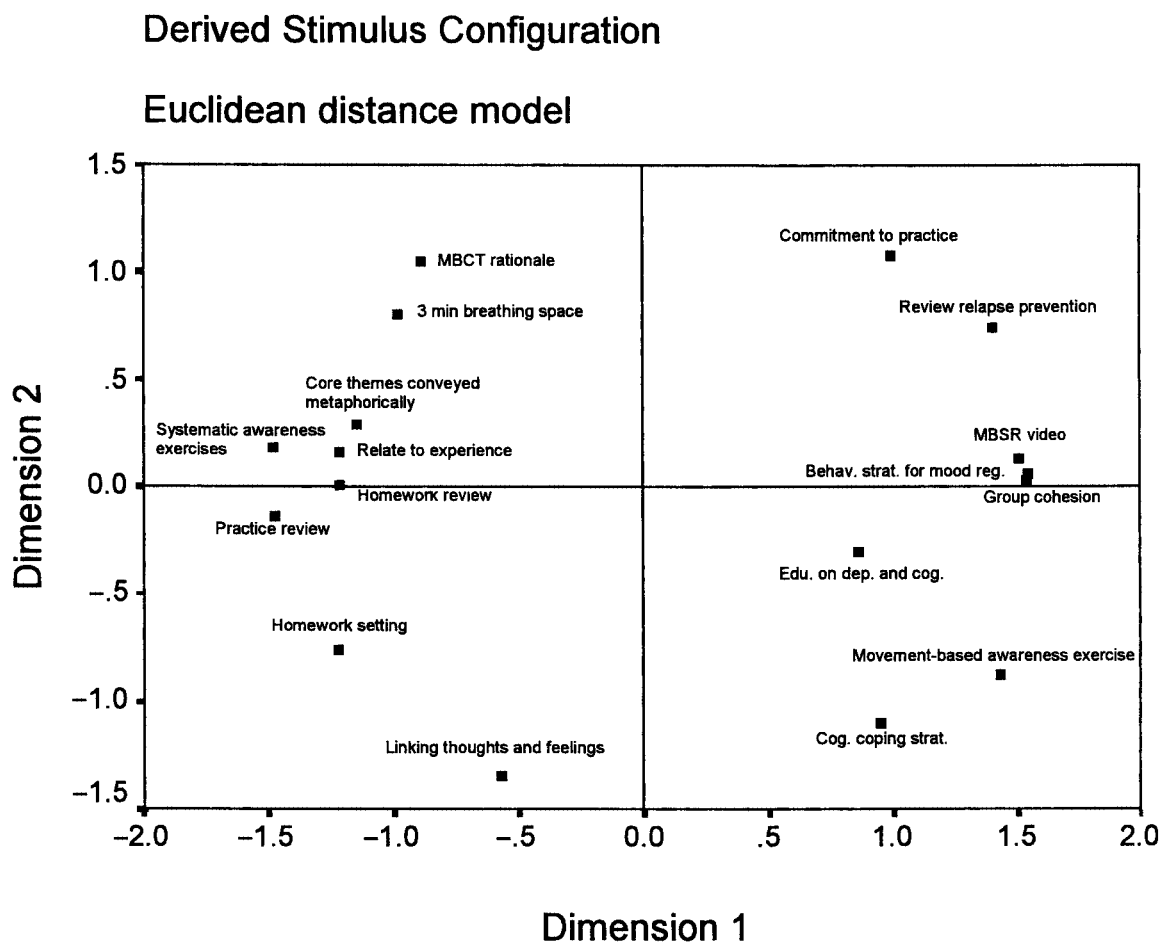


Figure 1. Configuration plot for multidimensional scaling of MBCT-AS

from the figure, dimension 1 seems to capture the distinction between the elements of MBCT that are active and experiential as opposed to those that are more didactic, with the former items on the negative end of this dimension and the latter on the positive end. The role of dimension 2 is less clear, and the overall figure suggests a clustering of items, rather than a smooth two-dimensional structure.

Treatment Differences

The mean scores for each treatment group on the MBCT-AS and CBT-AS, as well as the two MBCT-AS subscales, are presented in Table 1. As this table shows, adherence ratings of the MBCT treatment sessions were higher on the MBCT-AS, and lower on the CBT-AS, relative to the CBT group. A similar pattern was observed for the two MBCT-AS

subscales, with the M subscale score higher for the MBCT group, and the CT score lower, compared to the CBT group. All of these group differences were statistically reliable ($p < 0.001$).

DISCUSSION

The present study is an important step in the ongoing development of MBCT. Through the construction of the MBCT-AS and its examination in this work, we have shown that delivery of MBCT can be reliably assessed, with a quantifiable measure of adherence to treatment protocol. These findings are important in that they provide future trials of MBCT with an instrument to assess treatment integrity, the assurance of which is a foundational necessity for comparative treatment

Table 1. Mean ratings for MBCT and CBT

Scale	MBCT		CBT		<i>t</i>
	Mean	SD	Mean	SD	
MBCT-AS-total scale	15.7	2.9	8.5	2.4	9.45
Mindfulness subscale (item mean)	1.1	0.22	0.0	0.0	25.03
CBT subscale (item mean)	0.7	0.32	1.1	0.30	3.41
CBT-AS	8.4	4.1	17.7	5.8	6.46

All comparisons $p < 0.001$.

research. The fact that such reliable measures were obtained from assessors who were previously unfamiliar with the therapy and who received a relatively short training period suggests that the scale is easy to use even for those who are not already providing this relatively new form of therapy, making independent ratings of adherence relatively simple to obtain.

Furthermore, this work also shows that MBCT can be distinguished from its most relevant comparator, CBT. Although MBCT utilizes some elements of CBT in its interventions, this result indicates that MBCT is more than just those borrowed interventions, and contains elements that are unique to it. By understanding the common and unique elements of this treatment, it may be possible to have a clearer picture of how the treatment obtains its effectiveness.

Although the MBCT-AS scale has clear utility, the present work points out one potential weakness of the measure. Our attempts to examine the dimensional structure of the scale were only partially successful, suggesting that further refining of the measure may be necessary to produce clearly distinguishable dimensions.

MBCT is a very promising treatment that targets one of the most troubling aspects of major depression, recurrence. The development of a measure of adherence provides an important step in the further elucidation of this therapy.

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APPENDIX 1. MBCT-AS ITEMS

1. GROUP COHESION: To what extent did the therapist's actions facilitate the cohesiveness and shared identity of the treatment group?
2. PROVISION OF MBCT RATIONALE: To what extent does the therapist provide patients with an explanation for why the performance of MBCT tasks will help them learn to prevent depression from re-occurring?
3. EXTENDED SYSTEMATIC AWARENESS EXERCISES: To what extent does the therapist use extended systematic awareness exercises?
4. CONVEYS CORE THEMES METAPHORICALLY: To what extent does the therapist use metaphors and narratively-oriented material to communicate the core themes of MBCT to patients?
5. HOMEWORK SETTING: To what extent does the therapist assign homework to group participants?
6. CONSISTENCY OF PRACTICE REVIEW: To what extent does the therapist review an awareness exercise or sitting once the group has finished it?
7. HOMEWORK REVIEW: To what extent does the therapist review homework that was assigned to the group?
8. THOUGHTS AND FEELING LINKAGE: To what extent does the therapist convey the link between thinking and feeling?
9. MOVEMENT-BASED AWARENESS EXERCISES: To what extent does the therapist use awareness exercises that are based on movement rather than sitting?
10. 3-MIN BREATHING SPACE: To what extent does the therapist use 3-min breathing spaces during the group session?
11. USE OF VIDEO MATERIAL ABOUT MBSR: To what extent does the therapist use the videotapes of the MBSR programme during group sessions 4 and 5?
12. EDUCATION ABOUT DEPRESSION AND THE COGNITIVE MODEL: To what extent does the therapist try to educate participants about depression and the cognitive model?
13. RELATE TO EXPERIENCE THROUGH ACCEPTANCE-AVERSION: To what extent does the therapist introduce the differences between relating to one's experiences from a standpoint of acceptance as opposed to aversion?
14. COGNITIVE COPING STRATEGIES: To what extent does the therapist describe different cognitive therapy strategies for responding to negative thoughts?
15. BEHAVIOURAL STRATEGIES FOR MOOD REGULATION: To what extent does the therapist describe different behavioural strategies for mood regulation?
16. REVIEW ASPECTS OF RELAPSE PREVENTION: To what extent does the therapist discuss specific things that group members could do if they find themselves starting to relapse?
17. COMMITMENT TO PRACTICE AND RELAPSE PREVENTION: To what extent does the therapist address the relevance of group members' commitment to practice as a way of preventing depressive relapse?

APPENDIX 2. CBT-AS ITEMS

1. RELATIONSHIP OF THOUGHTS AND FEELINGS: Did the therapist encourage the client to relate affective states that the client had experienced (OR will experience in the future) to the client's ongoing thoughts?
2. CBT RATIONALE: Did the therapist provide a rationale which emphasized the importance of evaluating the accuracy of the client's beliefs and changing inaccurate beliefs in order to alleviate the client's depression?
3. RELATE IMPROVEMENT TO CHANGE: Did the therapist relate improvement that has occurred in the client's depressive symptoms or related problems to changes in the client's beliefs?
4. REPORTING COGNITIONS: Did the therapist ask the client to report specific thoughts (as verbatim as possible) that the client experienced either in the session OR in a situation which occurred prior to the session?

5. EXPLORED PERSONAL MEANING: Did the therapist probe for beliefs related to a thought the client reported in order to explore the personal meaning associated with the client's initial thought?
6. EXPLORED ASSUMPTIONS: Did the therapist explore with the client a general belief that underlies many of the client's specific negative thoughts and beliefs?
7. DISTANCING OF BELIEFS: Did the therapist encourage the client to view her/his thoughts as beliefs which may or may not be true rather than as established facts?
8. EXAMINE EVIDENCE: Did the therapist help the client to use the currently available evidence or information (including the client's prior experiences) to test the validity of the client's beliefs?
9. TESTING BELIEFS: Did the therapist encourage the client to (1) engage in specific behaviours for the purpose of testing the validity of her/his beliefs OR (2) make explicit predictions about external events so that the outcomes of those events could serve as tests of those predictions OR (3) review the outcome of previously devised prospective tests?
10. ALTERNATE EXPLANATIONS: Did the therapist help the client to consider alternative explanations for events besides the client's initial explanations for those events?
11. REALISTIC CONSEQUENCE: Did the therapist work with the client to determine what the realistic consequences would be if the client's beliefs proved to be true?
12. ADAPTIVE VALUE OF BELIEFS: Did the therapist guide the client to consider whether or not maintaining a specific belief is adaptive for the client (regardless of whether or not it is accurate)?
13. DIDACTIC PERSUASION: Did the therapist use didactic persuasion to urge the client to change her/his belief(s)? (scoring reversed)
14. SUBSTITUTING POSITIVE THOUGHTS: Did the therapist encourage the client to substitute a more positive belief for another (whether or not the substitute belief was more accurate or realistic), solely because the client would feel better if she/he thought that way? (scoring reversed)
15. PRACTICING 'RATIONAL RESPONSES': Did the therapist and client practice possible rational responses to the client's negative thoughts or beliefs?
16. ALTERNATIVE BEHAVIOURS: Did the therapist work with the client to plan OR to practice alternative overt behaviours for the client to utilize outside of therapy?
17. SKILLS TRAINING: Did the therapist attempt to teach the client skills (e.g. assertiveness, social skills, task relevant skills) in the session?
18. HOMEWORK ASSIGNED: Did the therapist or client develop one or more specific assignments for the client to engage in between sessions?
19. PLEASURE AND MASTERY: Did the therapist encourage the client to engage in activities which would be pleasurable to the client from which the client would obtain a sense of accomplishment?
20. SCHEDULING ACTIVITIES: Did the therapist work with the client to schedule OR structure one or more specific activities for the purpose of increasing the likelihood that the client will initiate OR follow through on those activities?
21. SELF-MONITORING: Did the therapist encourage the client to record feelings, activities, or events between sessions OR review the client's record of feelings, activities, or events?
22. RECORDING THOUGHTS: Did the therapist encourage the client to record thoughts between sessions OR review the client's records of her/his thoughts?
23. MANIPULATING BEHAVIOUR VIA CUES: Did the therapist help the client to arrange for cues (i.e. stimulus control) OR consequences (i.e. reinforcement or punishment) for the client's specific thoughts or behaviours in order to manipulate the occurrence of those behaviours?
24. NEGOTIATING THERAPY CONTENT: Did the therapist negotiate with the client assignments, changes in direction, or major emphases of the session in a way that gave the client opportunity to have input?
25. EXPLANATION FOR THERAPIST'S DIRECTION: Did the therapist explain to the client the therapist's reasons for pursuing a particular topic in the session?
26. SUMMARIZING: Did the therapist summarize OR encourage the client to summarize key issues discussed either in a previous session or in the current session?