THE USE OF A COGNITIVE-BEHAVIOURAL HOMEWORK ENHANCEMENT PROTOCOL

Submitted by

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Abstract

The positive relationship between homework compliance and treatment outcome, and homework’s causal effects on improved treatment outcomes, has been well established empirically. However, a better understanding of how homework leads to therapeutic change is needed to optimise therapeutic outcomes. The aim of the present research was to examine methods for enhancing homework compliance, with a particular focus on therapist behaviour. Methods outlined in a cognitive-behavioural homework protocol were examined (Kazantzis, MacEwan, & Dattilio, 2005). Study 1 investigated the extent to which psychologists reported use of a systematic approach to homework integration in their clinical practice. One hundred and sixteen Australian practising psychologists completed an online survey regarding their use of homework. The majority of respondents (97%) reported the use of homework, with 52% classified as using a systematic approach to homework according to their self-report of at least occasional use of behaviourally and cognitively focused strategies within the homework protocol. The use of an integrative conceptual framework to define systematic use is proposed.

Study 2 provided an initial experimental test of the cognitive-behavioural homework enhancement protocol on homework compliance, using a standardised homework assignment with a non-clinical sample, in an analogue study design. Sixty-seven participants were randomly assigned to either receive homework administered according to the protocol (experimental condition) or according to the procedures practitioners reportedly use in clinical practice (control condition), incorporating both objective and subjective measures of homework compliance. The results showed no significant differences between the experimental and control groups on all measures of homework.
compliance. A high rate of homework compliance was observed in both groups.

Therefore, no support was found for the use of the homework protocol in Study 2. The implications of the findings and future research directions are discussed.
Statement of Authorship

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis submitted for the award of any other degree or diploma.

No other person’s work has been used without due acknowledgement in the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

The principal supervisor of this thesis, Dr. Nikolaos Kazantzis made important contributions to conceptual and theoretical aspects, research design, data interpretation and thesis revisions. I worked collaboratively with Dr. Kazantzis in the conception and design of this research and for the most part I conducted data collection, analysed and interpreted data, and completed the written work.

All research procedures reported in this thesis were approved by the La Trobe University Human Ethics Committee (Study 1: FHEC 10/R52; Study 2: FHEC 10/R49).

Signature and Date............................................................................................................................................
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FOREWORD

With the need to provide efficient and effective treatments in the provision of mental health services today, the cognitive-behavioural therapy (CBT) approach to psychotherapy has gained prominence (D. Dobson & Dobson, 2009). A key component of CBT is the use of between-session therapeutic tasks or “homework” (A. T. Beck, Rush, Shaw, & Emery, 1979). The use of homework assignments has emerged from this theoretical tradition, and thus homework has largely been defined and empirically studied from this therapeutic approach. The positive relationship between homework compliance and treatment outcome, and homework’s causal effects on improved treatment outcomes, has been well established empirically.

A factor that has been found to influence client homework engagement is therapist behaviour. Different practitioner models for homework enhancement have been proposed in the literature, some that are behaviourally focused and others that integrate behavioural and cognitive theoretical determinants of homework compliance. From a theoretical and empirical standpoint, it has been suggested that therapists integrate homework into treatment in a carefully planned and thought through manner (i.e., use a “systematic” approach) to enhance homework engagement. However, few empirical studies have examined therapists’ use of a systematic approach to homework in clinical practice and the effects of therapist behaviour on client homework engagement. The aim of this dissertation is to examine methods for enhancing homework compliance, with a particular focus on therapist behaviour. The use of a cognitive-behavioural homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005) will be examined.
In this dissertation, an overview of the use of homework in therapy is provided. This is followed by a discussion of key theories that help explain the determinants of client homework engagement in CBT. The theories reviewed provide valuable insights into how homework produces its effects in therapy, for which there is limited discussion in the literature. The empirical literature related to the use of homework assignments is next presented. Following this, a range of recommendations and models proposed to enhance homework engagement are critically reviewed. Next, empirical research on therapist homework behaviour is presented. The results of a practitioner survey that investigates therapists’ use of a systematic approach to homework integration in clinical practice are presented next (Study 1). Following this, the results of an experimental test of a cognitive-behavioural homework enhancement protocol on homework engagement, using a self-monitoring task with a non-clinical sample, in an analogue study design, are presented (Study 2). The two studies in the present research were parallel studies, conducted concurrently. The findings of Study 1 thus were not available and consequently did not inform the design of Study 2. Finally, a general discussion of the main findings of the present research is provided, as well as a discussion of the implications of the findings and future research directions.
CHAPTER 1

AN INTRODUCTION TO HOMEWORK IN PSYCHOTHERAPY

Introduction to Homework

A prominent evidence-based therapeutic approach utilised for the treatment of a wide range of clinical disorders is cognitive-behavioural therapy (CBT; A. T. Beck & Dozois, 2011). CBT is a term used to classify therapies that are based on the propositions that thoughts affect behaviour, thoughts can be monitored and changed, and that behaviour modification can be achieved by changing thoughts (K. S. Dobson & Dozois, 2001). The CBT approach is based on the central tenet of Aaron T. Beck's (1976) theory of psychopathology which emphasises the role of cognitions as predisposing and perpetuating factors of emotional distress and maladaptive behaviour (A. T. Beck, 1976; K. S. Dobson & Dozois; Mahoney, 1974). A key component of CBT is the use of between-session therapeutic tasks or “homework” (A. T. Beck et al., 1979). Homework is used to facilitate cognitive change in CBT. However, the use of homework is not limited to this theoretical orientation (Nelson, Castonguay, & Barwick, 2007), with its use integral to behavioural and systemic approaches (Kazantzis & Ronan, 2006a). In contrast, other therapeutic approaches such as interpersonal therapy (Young & Mufson, 2007), emotion-focused therapy (Ellison & Greenberg, 2007), and psychodynamic therapy (Stricker, 2007), tend to view homework as an adjunct intervention. Due to the limited scope of this thesis, the use of homework as utilised in the CBT approach will be examined.
**Homework Definition**

In cognitive-behavioural therapy, the term homework refers to any between-session activities that are collaboratively agreed upon between therapist and client, and carried out by the client with the goal of enhancing therapeutic outcomes (Kazantzis, Petrik, & Cummins, 2012). Whilst the definition is made explicit by some authors (e.g., Kazantzis, 2005; Scheel, Hanson, & Razzhavaikina, 2004), the meaning is generally implied and tends to refer to therapeutic activities that a client engages in between sessions. Debate exists between models of psychotherapy about whether to include client-initiated activities that are not explicitly negotiated in-session in the definition (Nelson et al., 2007). Some therapeutic approaches, such as client-centred therapy, recognise the value of client-initiated between-session activities, and view recommended (i.e., prescribed) homework as detrimental to clients (e.g., undermines a client’s personal autonomy; Nelson et al., 2007). In client-centred therapy, a broad range of tasks may be requested by clients (Brodley, 2006). As the focus of the present research is to examine methods for enhancing homework compliance, in particular, the use of a cognitive-behavioural homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005), homework as defined in CBT is adopted for present purposes.

The term “homework” tends to have some negative connotations associated with it, and is considered problematic to both clients (Kazantzis, MacEwan, & Dattilio, 2005) and therapists (Fehm & Kazantzis, 2004). Clients may feel as though they need to “comply” with homework “assigned” by the therapist and may have concerns about being graded on tasks on a pass/fail basis (Kazantzis & L’Abate, 2007). Clients may have developed negative perceptions as a result of their educational experiences, may
associate homework with negative evaluation, or have concerns about perfection (Hudson & Kendall, 2002). Consequently, in clinical practice, the use of the term homework is generally avoided and replaced with other more neutral labels such as “between-session assignments”, “home-practice activities”, “tasks”, “experiments”, “self-help assignments” (Kazantzis & Lampropoulos, 2002), or age appropriate labels such as “show that I can” for children and adolescents (Hudson & Kendall, 2002). On the other hand, the terms “behavioural practice”, “extratherapy”, “extratreatment”, “home practice”, “homework”, and “self-help assignments” are often used in the research literature (Kazantzis, Whittington, & Dattilio, 2010). In this thesis, the term homework will mostly be used to remain consistent with the term commonly used in the research literature.

Use of Homework to Facilitate the Change Process in Different Models of Psychotherapy

Models of psychotherapy differ in the use of homework, ranging from those that consider it to be an additional therapeutic intervention (e.g., interpersonal therapy, emotion-focused, psychodynamic, client-centred) to those that consider it to be a fundamental component of the psychotherapeutic process to facilitate theorised change processes (e.g., behaviour therapy, cognitive-behavioural therapy). Although homework is a defining characteristic of particular psychotherapies, it may also be considered a “common factor” (Kazantzis & Ronan, 2006a; Lambert, Harmon, & Slade, 2007), that is, a therapeutic change agent present either explicitly or implicitly in almost all therapies (Horvath, 2011; Kazantzis & Ronan, 2006a; Weinberger, 1995).
The extent to which homework is integrated into a therapeutic approach is largely guided by its theorised model of change. For instance, in client-centred therapy, where the goal of therapy is to support the client to arrive at their own solutions for their problems (Mearns & Thorne, 1999), homework will only be discussed if suggested by the client (Witty, 2007). Surveys of practitioners’ attitudes toward homework indicates that CBT practitioners hold more positive attitudes toward homework compared to psychoanalytic practitioners (Fehm & Kazantzis, 2004; Kazantzis, Lampropoulos, & Deane, 2005).

Behavioural and cognitive-behavioural therapies consider homework to be a crucial and defining feature of the therapeutic process for the purpose of enhancing treatment gains (A. T. Beck et al., 1979; Ledley & Huppert, 2007). These therapies are generally time-limited, action-oriented, and collaborative in nature. The therapist and client work together in treatment, with most of the therapeutic work occurring out-of-session in the client’s everyday life (J. S. Beck, 1995; Ledley & Huppert, 2007). Out-of-session work is viewed as integral to these therapies because it allows for: (i) the client’s problem to be treated in the environment in which it is occurring; (ii) the client to learn to transfer skills learnt in therapy into their everyday life, and (iii) increases the likelihood that skills learnt in therapy will be applied when therapy has ended (Neimeyer & Fexias, 1990; Neimeyer, Kazantzis, Kassler, Baker, & Fletcher, 2008).

In behaviour therapy, an individual’s behaviour is explained to occur in terms of a relationship that exists between incoming stimuli and outgoing responses, referred to as a stimulus-response relationship, with cognitive mediating factors considered irrelevant (K. S. Dobson & Dozois, 2001; Mahoney, 1974). From this perspective,
psychopathology is postulated to occur and be maintained by learned associations between stimuli and responses. The goal of behaviour therapy is to achieve behavioural change, which generally results in shifts in cognition and affect (Ledley & Huppert, 2007). Engaging in activities, rather than talking about problems, is central to behaviourally based treatments (Martell, Dimidjian, & Herman-Dunn, 2010), with most of the therapeutic “work” occurring between sessions (Dimidjian, Martell, Addis, & Herman-Dunn, 2008). Thus, homework is considered central to treatment. Homework assignments are utilised to help the client develop new and more adaptive stimuli-response associations, whilst attenuating maladaptive responses (Ledley & Huppert, 2007). Examples of behavioural assignments include scheduling pleasant activities, self-monitoring, performing relaxation exercises, or exposure to anxiety provoking stimuli.

In contrast, cognitive-behavioural therapies emphasise the role of cognitions in mediating an individual’s response to the environment (i.e., the mediational model; K. S. Dobson & Dozois, 2001; Mahoney, 1974) such as beliefs and expectancies. The theory of pathology according to the cognitive approach, initially developed by Aaron T. Beck (1976), is that thoughts (i.e., content and processes) are considered to be predisposing or perpetuating factors in psychopathology. The focus of treatment is therefore to achieve cognitive change. According to the cognitive approach, the therapist facilitates change to take place both in- and out-of-session. Homework is used as a vehicle or means by which cognitive change is facilitated beyond the therapy session, with a range of interventions used. For example, homework may comprise of activities designed for clients to educate themselves (e.g., psychoeducation), collect data (e.g., monitor thoughts, feelings, and behaviour), test out thoughts and beliefs, modify
thinking, develop new skills, and conduct behavioural experiments (J. S. Beck, 1995). Examples of homework tasks in CBT include the use of thought records, self-monitoring, pleasant activities scheduling, exposure, and anxiety management techniques (J. S. Beck, 1995; Leahy, 2002). All of these different types of homework activities, regardless of their emphasis, aim to promote cognitive change.

**Use of homework in CBT.**

In line with the theoretical assertions of CBT, empirical work indicates that homework is an integral component of the CBT treatment approach (Blagys & Hilsenroth, 2002). A review of the psychotherapy process literature found that the use of homework distinguished cognitive-behavioural therapy from psychodynamic–interpersonal therapy (Blagys & Hilsenroth, 2002). Findings from practitioner surveys indicate that homework is used by psychotherapy practitioners (Deane, Glaser, Oades, & Kazantzis, 2005; Kazantzis & Deane, 1999) and other mental health professionals such as counselors, nurses and social workers (Kazantzis, Busch, Ronan, & Merrick, 2006), and case managers (Kelly, Deane, Kazantzis, Crowe, & Oades, 2006). However, cognitive-behavioural therapy practitioners on average report using more homework assignments compared to therapists from other theoretical orientations (Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kazantzis, Lampropoulos, & Deane, 2005).

Homework is utilised in CBT for the treatment of a wide range of clinical disorders including depression (Burns & Spangler, 2000; K. S. Dobson, 1989), generalised anxiety disorder (Westra, Arkowitz, & Dozois, 2009), panic disorder (D. M. Clark et al., 1994; Schmidt & Woolaway-Bickel, 2000), agoraphobia (Edelman &
Chambless, 1993), obsessive-compulsive disorder (D. A. Clark, 2007; Franklin, Huppert, & Ledley, 2005), substance dependence disorders (Carroll, Nich, & Ball, 2005), psychosis (Chadwick, Birchwood, & Trower, 1996; McLeod & Nelson, 2005), borderline personality disorder (Freeman & Fusco, 2005), social phobia (Emmelkamp, Mersch, Vissia, & Van der Helm, 1985; Heimberg, Salzman, Holt, & Blendell, 1993), and eating disorders (Wilson & Fairburn, 1993). Therapists may select homework assignments based on clinical experience, subjective judgment, theory (Kazantzis & L’Abate, 2007), or disorder-specific treatment models.

**Homework Compliance**

In psychotherapy, client homework noncompliance is a common problem (Helbig & Fehm, 2004; Tompkins, 2002). Homework compliance may be defined as the extent to which a client engages in the discussed homework assignment between sessions (Kazantzis, Deane, & Ronan, 2005; Scheel et al., 2004). Although clients’ have been found to generally hold positive attitudes towards homework (Fehm & Mrose, 2008), empirical work examining clients’ attitudes towards homework has been scarce. As homework is utilised as a vehicle to facilitate therapeutic change, it is likely to present a challenge for clients to engage in the change process. The study of patient compliance to healthcare recommendations has emerged from the field of medical healthcare. Improving patient adherence to medical therapies, such as medication taking, has been extensively studied in this field (e.g., Haynes, 2001; Ley, Jain, & Skilbeck, 1977; Lowe & Lutzker, 1979). Since engagement in homework activity leads to the achievement of better therapeutic outcomes (Kazantzis et al., 2000; Kazantzis et al., 2010; Mausbach, Moore, Roesch, Cardenas, & Patterson, 2010), enhancing compliance
is considered important. However, the “compliance” construct is problematic in many ways.

To define homework compliance according to the extent of task completion alone, with more completion assumed to be more beneficial, is narrow as it does not take into account the range of functions homework serves in cognitive-behavioural therapy. The manner in which a client engages in homework activity provides valuable data that the therapist can utilise to inform case conceptualisation and treatment in CBT. For example, if a client completes considerably more homework than discussed, this may indicate perfectionistic or overachieving tendencies. Homework noncompletion and partial completion (i.e., client completes less) may also provide therapists with useful information to aid in conceptualisation and treatment (Kazantzis et al., 2004), as well as be beneficial to the client. For example, a client who was only able to complete the first three columns of a thought record for homework (i.e., situation, moods, automatic thoughts, or images), due to not knowing how to complete the rest, is likely to have further developed an understanding of the thought-feeling connection and identified their maladaptive thoughts. In this instance, the therapist may realise that further work is required to help the client identify evidence for their thoughts and generate adaptive thoughts. If homework noncompletion is due to client avoidance of unpleasant emotions associated with task completion, this data is also therapeutically useful.

On the other hand, if a client engages in homework activity different to what was discussed, this too may be beneficial. Although this behaviour may viewed as “noncompliance”, it may indicate that generalisation has occurred and that the client was able to apply the knowledge gained in therapy in a meaningful way (see Chapter 2
for a further discussion on generalisation). Therefore, to define homework compliance primarily based on task completion is a failure to recognise that homework serves as an important mechanism for change in therapy.

The term “compliance” tends to have some negative connotations associated with it such as implying a sense of subordination of the patient to the therapist and the notion of being reprimanded for noncompliance (Haynes, 2001). An alternate term like “adherence” does not carry such negative connotations. As the term compliance is commonly used in the research literature and clinical settings (Openshaw, 1998; Tompkins, 2002), both the terms compliance and adherence will be used interchangeably in this thesis.

**Motivation.**

Homework compliance is viewed as a key indicator of client commitment, motivation, and involvement in the change process (Addis & Jacobson, 2000; Scheel et al., 2004). Alternately, noncompliance is considered an expression of resistance to change, low motivation, or ambivalence about change (Huppert, Ledley, & Foa, 2006; Newman, 1994). Readiness, confidence, and importance are proposed as three critical conditions for change (Miller & Rollnick, 2002). The element of readiness refers to the extent to which an individual is ready to engage in the change process. Confidence refers to the extent to which an individual feels that they are able to change. The perceived importance of change is another element of motivation. Assessing these elements in the context of homework may help predict whether a person will engage with homework and subsequently lead to the use of motivation enhancing strategies. For instance, whilst a client may consider themselves as able to complete a homework
activity, they may not consider change as important, and therefore not be ready to engage in the activity. As the interpersonal context is proposed to influence motivation, the therapist may therefore use strategies to facilitate change (e.g., explore ambivalence about change; Miller & Rollnick, 2002).

**Summary**

Homework is a vehicle used to facilitate therapeutic change, utilised in almost all therapies. However, models of psychotherapy differ in the emphasis afforded to homework in treatment. The extent to which homework is integrated into a therapeutic approach is largely guided by its theorised model of change. In behavioural and cognitive-behavioural therapies, homework is considered to be an integral component of treatment. Although client homework compliance is associated with enhanced treatment outcomes, difficulties with client homework engagement are often encountered in clinical practice. The “compliance” construct is problematic in many ways. It is important to define homework compliance beyond task completion alone and recognise that homework serves an important role as a mechanism of change in therapy. To help promote client homework compliance and thus optimise treatment outcomes, an understanding of the determinants of compliance is needed.
CHAPTER 2

THEORETICAL DETERMINANTS OF HOMEWORK COMPLIANCE

Introduction

In order to facilitate client engagement with homework assignments, an understanding of the determinants of compliance is needed. Key behavioural and cognitive theories provide a firm theoretical basis for understanding the determinants of client engagement with homework assignments (Kazantzis & L’Abate, 2005). The research on homework has largely proceeded without consideration of the theoretical determinants of compliance. Although the importance of homework is emphasised in CBT literature, explanations of how homework produces its effects are sparse (A. T. Beck, 1976; A. T. Beck et al., 1979; J. S. Beck, 1995). Attending to theories is integral to the scientific method. Theories provide a framework for explaining scientific observations and how observed phenomena work, and can potentially lead to the development of solutions or interventions (Evans & Rooney, 2008). Theories serve as a platform upon which predictions can be generated and empirically evaluated. A full discussion of all the theories relevant to explaining the determinants of client homework compliance is beyond the scope of this thesis. Therefore, a selective review of relevant theories will be discussed.

Behavioural Theory

According to behavioural theory, problematic behaviour is proposed to occur as the result of a learned association between a stimulus and response (i.e., stimulus-response model; Ledley & Huppert, 2007). The behavioural theories of classical and
Operant conditioning explain how antecedents (e.g., obstacles) and consequences (e.g., pleasure) associated with homework activity can determine compliance.

**Classical Conditioning**

Classical conditioning refers to the learning that takes place from the impact that antecedent events have on behaviour. The principles of classical conditioning may be applied to the context of homework to help explain engagement. A variety of situational antecedents can trigger a client’s decision to engage in a therapeutic task between sessions (Kazantzis & Daniel, 2009). Triggers can be environmental stimuli (e.g., exposure to a feared social situation) or thoughts (e.g., “I feel helpless”). From a radical behavioural framework, thoughts are treated as behaviours, that is, they are considered “private behaviours” (G. Martin & Pear, 1996). Identifying potential antecedents to homework engagement can be helpful in homework planning, as well as help a client recognise which events lead to homework engagement (Kazantzis, Dattilio, Cummins, & Clayton, in press).

**Operant Conditioning**

Operant conditioning refers to the learning that takes place from the impact that consequences have on behaviour. The theory contends that behaviours that are reinforced are likely to be repeated (G. Martin & Pear, 1996). When applied to the context of homework, a client’s engagement in a task is proposed to be determined by the consequences of engagement. The costs and benefits (i.e., reinforcement and punishment contingencies) of task engagement may serve as motivational variables for homework engagement (Kazantzis & L’Abate, 2005). For example, a client who receives therapist praise for engaging in homework, is likely to engage in homework
activities in future (i.e., positive reinforcement). If a client experiences a reduction in anxiety after having engaged in controlled breathing in-session with the therapist (i.e., negative reinforcement), the client is likely to repeat this behaviour for homework. On the other hand, if a client experiences discomfort or a negative event (i.e., punishment), such as feeling like a failure because they experienced difficulty completing the homework assignment, homework engagement is likely to decrease. Clients will differ with regards to what they experience as reinforcing or punitive (Kazantzis et al., in press). It is therefore important to elicit client feedback about the consequences of homework engagement (Kazantzis et al., in press). As illustrated, the nature of behavioural contingences may determine homework compliance.

**Generalisation**

It is important that the skills learnt in therapy can be extended to new settings, for these skills to be maintained, and for new skills that have not been specifically trained to develop, that is, for generalisation to occur (A. T. Beck & Emery, 1985; G. Martin & Pear, 1996). Homework thus provides a means by which therapists can check if skill acquisition has occurred beyond the therapy session and into the client’s everyday life, rather than assuming that the process of generalisation has taken place (Kazantzis & L’Abate, 2005).

Homework generalisation may occur at different levels (Kazantzis & Daniel, 2009). Accordingly, an individual’s homework behaviour may be influenced by the level at which generalisation occurs. Simple generalisation occurs when the client completes the homework task as discussed in-session. For example, as discussed with the therapist, the client keeps a gratitude diary and writes down three good things that
went well at the end of each day. Complex reasoning occurs when the client understands the essence of the activity and is able to extend and apply the activity in a variety of ways. An aim of homework is for complex reasoning to occur. A homework activity may be generalised in a way that is similar or different to the task discussed in-session, with the latter requiring more complex reasoning. For example, a client may report that they completed the gratitude diary exercise each time they experienced a low mood rather than at the end of each day. In this instance, the client demonstrated the ability to apply the knowledge they gained in a meaningful way. However, it is important to note that when generalisation takes place using complex reasoning, a client’s behaviour may traditionally be labelled as “non-compliant”. Thus, an understanding of the different levels of generalisation may help therapists better recognise meaningful homework engagement.

**Cognitive Theory**

Cognitive theories propose that behavioural antecedents and consequences are moderated by cognitions (Mahoney, 1974). Although cognitive theories acknowledge the role that overt reinforcement contingencies have on behaviour, they tend to emphasise the role of cognitions in behaviour change (K. S. Dobson & Dozois, 2001). Cognitive theory suggests that clients form beliefs about the homework task which determine adherence. As homework is used to facilitate cognitive change in CBT, the suggested homework activity is likely to pose a challenge for the client to engage in the change process for which a range of beliefs may be activated. When a therapist suggests homework, the client’s beliefs about themselves, others, the world or future, their problems, or ability to cope, may be activated (A. T. Beck et al., 1979). For example, a
client who considers themselves to be defective in some way may not want to engage in homework as they expect their performance will be substandard. Clients may also have beliefs about task difficulty, the costs and benefits of engaging in a task, and the value of a task, that may determine homework compliance (Kazantzis & L’Abate, 2005). These beliefs may be influenced by factors such as therapist behaviour (e.g., providing task rationale) or client variables (e.g., past therapy experiences).

Social Psychology Cognitive Theories and Models

Social psychology cognitive theories and models are used extensively to explain health behaviours (Curtis, 2000). They help to explain underlying motivational variables that may influence a client’s health action or behaviour. As homework may be considered a form of health behaviour, social psychology theories and models may be aptly applied in this context to understand the determinants of homework compliance.

Social cognitive theories.

Social learning theories focus on the role that cognitions have on learning within a social context. Bandura (1986), a leading proponent of social learning theory, renamed it “social cognitive theory”. This theory contends that individuals learn by observing others, with the environment, behaviour, and cognition being key factors that influence an individual’s behaviour (Bandura, 1986). Through observational learning or modeling (i.e., observing an individual who serves as an example) an individual can learn new responses, learn which behaviours to carry out, and which to avoid depending on the consequences of another’s actions (T. L. Rosenthal & Zimmerman, 1978). Further, an individual may form self-efficacy beliefs as a result of the experience (Kazantzis & L’Abate, 2005). Self-efficacy refers to the belief in one's ability to perform a particular
behaviour (Bandura, 1989). In applying social cognitive theory to the context of homework, a therapist can help a client learn a new behaviour through modeling. A therapist may also assign homework tasks that the client can complete and achieve success with, and provide encouragement, in order to build the client’s sense of self-efficacy. An individual’s sense of self-efficacy is likely to affect their motivation to engage in homework activities (Bandura, 1989).

**The health belief model.**

The “health belief model”, a social cognitive model that explains health related behaviour, can also be applied to the context of homework. It emphasises the role of client beliefs as determinants of engagement in recommended health action. The model asserts that an individual will engage in a health behaviour if they believe that a negative outcome can be avoided, and have the expectation that the action taken will prevent a negative outcome from occurring (Rosenstock, 1974). For example, if a client believes that anxiety can be reduced, and that deep breathing exercises will lead to a reduction in anxiety, then they are more likely to engage in the activity. The model contends that four primary variables affect engagement in health related behaviour: (i) perceived vulnerability to developing an illness; (ii) perceived severity of an illness; (iii) perceived barriers to engagement in health behaviour, and (iv) perceived benefits to engagement in health behaviour (Becker & Rosenstock, 1984). According to this framework, client homework engagement may be determined by factors related to a client’s beliefs about their presenting problem, and associated costs and benefits of task engagement.
The stages of change model.

The “transtheoretical model” (TTM), also known as the “stages of change model” (Prochaska & DiClemente, 1982), is a prominent health behaviour change model. The model proposes that intentional behaviour change is a process rather than a single event, and occurs in a series of stages over time. These stages, as applied to homework engagement include precontemplation (i.e., not thinking about engaging in the homework task), contemplation (i.e., thinking about engaging in homework), preparation (i.e., getting ready to engage in homework), action (i.e., engaging in the activity) and maintenance (i.e., continued engagement in the activity; Kazantzis & L’Abate, 2005; Prochaska & DiClemente, 1982). However, clients may also be at different stages of change for different homework tasks (Figure 1). For instance, in Session 1, a client may be in the preparation stage to complete a self-monitoring task for homework. By Session 2, the client has completed the self-monitoring task and is in the action stage for that task. However, in Session 3, the client has some hesitations about scheduling in pleasant events, and is in the contemplation stage for this homework activity. Different tasks present different challenges for clients such as the costs and benefits of engagement, and self-efficacy beliefs. Therefore, according to this framework, therapists cannot assume that a client’s compliance with one homework activity will necessarily occur for another.
<table>
<thead>
<tr>
<th>Session</th>
<th>Homework Task</th>
<th>Stage of Change</th>
<th>Compliant Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Self-monitoring</td>
<td>Preparation</td>
<td>n/a</td>
</tr>
<tr>
<td>2 - 3</td>
<td>Self-monitoring</td>
<td>Action</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Pleasant events scheduling</td>
<td>Contemplation</td>
<td>No</td>
</tr>
<tr>
<td>4-6</td>
<td>Thought monitoring</td>
<td>Action</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Thought evaluation</td>
<td>Precontemplation</td>
<td>No</td>
</tr>
<tr>
<td>7</td>
<td>Thought evaluation</td>
<td>Preparation &amp; Action</td>
<td>Partially complete</td>
</tr>
</tbody>
</table>

*Figure 1.* The stages of change model (Prochaska & DiClemente, 1982) as applied to a client’s homework engagement with different therapeutic homework tasks.

Successful behaviour change is assumed to occur when an individual has engaged in each stage of the stages of change model (Prochaska & DiClemente, 1982). The model proposes that individuals tend to move backwards and forwards between the stages, with relapse viewed a form of backward movement rather than a distinct stage (Prochaska, 1995). Relapse is considered a part of the change process. It is regarded an indicator of inadequate learning rather than of failure or that an individual cannot change (DiClemente, 2005).

The TTM has been critiqued on several levels. It has been criticised for being too reductionistic in its conceptualisation of the change process (Adams & White, 2005; Brug et al., 2005; Littell & Girvin, 2002). The stages of change are considered not representative of qualitatively distinct categories, with individuals able to be in multiple
stages at once (Littell & Girvin, 2002; Sullivan & Terris, 2001; Wilson & Schlam 2004). It is argued that the change process is better viewed as existing on a continuum rather than comprising of a series of stages (Littell & Girvin, 2002). Further, it has been argued that the empirical evidence for the model is weak (Adams & White, 2005; Herzog, 2010; Littell & Girvin, 2002). Whilst controversy surrounds the TTM, the model provides a useful framework for exploring and understanding the process of health behaviour change.

**Theory of planned behaviour.**

The theory of planned behaviour (Ajzen, 1985, 1988), an extension of the theory of reasoned action (Ajzen & Fishbein, 1977), is a conceptual framework that seeks to explain why individuals engage in particular behaviours. It emphasises the role of intentions, with actions considered to be controlled by intentions. The theory proposes three conceptually independent determinants of intention: (i) attitude toward the behaviour; (ii) subjective norm which refers to an individual’s perception of whether significant others think the behaviour should be performed, and (iii) perceived behavioural control.

When applied to the context of homework, the theory would predict that a client who believes that homework is beneficial (i.e., positive attitude) will most likely form an intention to engage in homework activity. If the client believes that their partner thinks that they should engage in homework, it is also predicted that the client will intend to perform the task. Similarly, if the client perceives the homework task to be easy, believes that they have the resources and opportunities to perform the task, and anticipates minimal obstacles (i.e., perceived behavioural control), the theory suggests
that they will more likely form an intention to engage in the task. It is predicted that the client’s intention in each instance will lead to action. In contrast, if the client believes that they will not have opportunities to complete the homework task due to a busy schedule, it is predicted that they will unlikely form strong behavioural intentions to engage in the task, despite having a positive attitude toward it or believing that their partner approves of them undertaking the task.

The theory of planned behaviour contends that having an intention to perform a behaviour does not always lead to action. This is likely to occur when the individual is unaware of factors that may hinder goal attainment (Gollwitzer, 1999; Gollwitzer & Sheeran, 2006). For example, if a client has a high level of perceived behavioural control, however a poor understanding of how to complete the homework task, and has not anticipated the limited opportunities that they will have to complete the task, it is predicted that task completion is less likely to occur. In this instance, the client’s perceptions of behavioural control did not correspond well with their actual control over the task (Ajzen, 1988). Empirical work indicates a small-to-medium effect size ($d = 0.36$; Cohen, 1992) for the effect of goal intention strength on goal achievement (Webb & Sheeran, 2006). It is clear that other factors contribute to successful goal attainment. Planning has been found to facilitate and further strengthen the intention-behaviour relation, specifically plans referred to as *implementation intentions* (Gollwitzer & Sheeran, 2006).

*Implementation intentions.*

Whilst intentions refer to specifying a desired end state (e.g., “I intend to achieve X”), that is, what an individual seeks to achieve (Gollwitzer & Sheeran, 2006),
implementation intentions are if-then plans that refer to specifying *when*, *where*, and *how* an individual intends to pursue a goal (e.g., “If situation Y occurs, I will engage in behaviour Z”; Gollwitzer & Oettingen, 2011). Gollwitzer and Sheeran (2006) conducted a meta-analysis including a sample of more than 8,000 participants across 94 studies, to examine the impact of implementation intention formation on goal attainment. The findings indicated a medium-to-large effect size ($d = 0.65$; Cohen, 1992) of implementation intention formation on goal attainment, on top of the effects of goal intentions. This finding suggests that forming implementation intentions enhances goal achievement beyond the effect of intentions alone. Further, findings from this meta-analysis indicated that implementation intentions help to ensure that individuals: (i) remember to act; (ii) seize opportunities to act; (iii) are not derailed by short-term considerations; (iv) are shielded by unwanted influences, and (v) attend to critical cues to either initiate action or anticipate obstacles to goal attainment.

Therefore, based on the literature on implementation intentions, clients are likely to benefit from developing a plan that specifies when, where, and how they intend to complete a homework activity. An implementation intention creates a strong link between a situational cue (e.g., meal time) and behavioural response (e.g., complete thought diary; Gollwitzer & Oettingen, 2011). Consequently, the initiation of homework engagement is likely to become automatic (Gollwitzer & Sheeran, 2006; Oettingen, Honig, & Gollwitzer, 2000; Webb & Sheeran, 2004).

**Elaboration likelihood model.**

Another social cognitive model relevant to homework is the elaboration likelihood model (ELM; Petty & Cacioppo, 1986), a general theory of attitude change.
The model proposes that a continuum of message elaboration exists from no thought about issue-relevant information presented to complete thought of the message content. Attitude formation and change is suggested to occur via two distinct routes: (i) central, and (ii) peripheral. The central route involves processing persuasive message content in a careful and thoughtful manner to determine the merits of the issue relevant information presented. Alternately, peripheral route processes do not involve scrutiny of the merits of information presented, rather rely on simple cues in the persuasion context to determine attitude change (e.g., therapist credibility and trustworthiness). The theory contends that an individual’s motivation to process the message, and ability to critically evaluate the content, will determine the route of processing chosen.

Thus, according to the ELM, a client who is motivated for change is more likely to put forth effort to evaluate a homework assignment to decide if it will be beneficial and worth undertaking (i.e., central route). By contrast, it is predicted that if a client has low motivation for change they will less likely engage in extensive cognitive processing of the therapist’s messages about homework (i.e., peripheral route). According to the model, attitude formation toward homework that occurred in the first scenario, via the central route, is more likely to be enduring, whereas attitude change that occurred in the latter scenario, via the peripheral route, is likely to be short term.

**Self-regulation theory of illness cognition.**

Self-regulation theory of illness cognition is another social cognitive model that can be utilised to understand the range of factors that determine health behaviour (Leventhal, Nerenz, & Steele, 1984). A feature of the model is its inclusion of emotional reactions as a determinant of health related behaviour. The model suggests that when
faced with a health threat, individuals will create a definition or representation of both the health threat and emotional response to the threat. These responses will be followed by the development and execution of a plan for coping. The model proposes that an individual will evaluate their coping strategies which may subsequently lead to modifications to their illness representations or coping strategies. When applied to homework, the model suggests that therapists need to consider the client’s conceptualisation of their disorder in order to facilitate change. Additionally, to enhance homework compliance the therapist will need to suggest homework tasks that treat the client’s disorder and reduce emotional distress.

**Synthesis of Cognitive and Behavioural Theories to the Process of Homework**

**Integration**

A synthesis of the cognitive and behavioural theories as applied to the three broad processes of homework design (i.e., selecting tasks), assign (i.e., planning tasks), and review (i.e., reviewing homework engagement) in-session, is presented in Figure 2 (Kazantzis, Deane, & Ronan, 2005). As presented in Figure 2, the use of a homework task or generalisation of a task in CBT is proposed to be triggered by emotional, psychological, or cognitive triggers in a given situation (Kazantzis & L’Abate, 2005). A client’s intention or confidence to engage in homework activity will be determined by obstacles and client beliefs about the task. When selecting (homework design) and planning (homework assign) tasks in-session, a range of client beliefs may be activated such as beliefs about task difficulty, the value of the task, and the costs and benefits of engagement. If a client believes that they have the ability to complete the task, that the task is relevant and will be beneficial, then task engagement is likely. However,
practical obstacles may hinder engagement. Intentions may not lead to action if unanticipated obstacles arise (e.g., busyness, failing to remember, poor task comprehension). Forming a specific plan for task accomplishment is likely to increase the likelihood of goal attainment.

Desired behavioural or cognitive change is likely to occur if a client engages in tasks that they can achieve success in (i.e., build self-efficacy [social learning theory]), through a process of successive approximations. The consequences of task engagement, including costs (e.g., difficulty) and benefits (e.g., pleasure), will determine whether a particular behaviour or skill is maintained. Following task engagement (homework review), the client reflects on their experience drawing conclusions about the relevance (i.e., match with therapy goals), and benefits (i.e., pleasure, mastery, progress) of the homework task (Kazantzis & L’Abate, 2005).

This summary and synthesis of the theoretical determinants of client homework engagement in CBT for the design, assign, and review phases of homework integration, has clinical implications for therapist behaviour in each phase. These theories provide a foundation upon which therapist strategies to enhance client homework engagement may be developed and selected. It is important to note that in therapy, therapist homework enhancement strategies are utilised together with other basic general counselling and CBT specific skills (i.e., case conceptualisation, collaboration; Kazantzis, MacEwan, & Dattilio, 2005).

Summary

In summary, several relevant theories have been reviewed that help explain the determinants of client homework engagement in CBT. Behavioural, cognitive, and social cognitive theories, all offer a firm theoretical basis for understanding factors that underpin homework compliance. This understanding helps inform the development of strategies to enhance compliance. The theories reviewed provide valuable insights into
how homework produces its effects in therapy, for which there is limited discussion in the current literature. A theoretical discussion is considered necessary in order to further develop and refine understanding in the field regarding the complexities of homework behaviour, and thus guide research efforts.
CHAPTER 3

EMPIRICAL RESEARCH ON THE EFFECTS OF HOMEWORK

The Effects of Homework

The positive relationship between homework compliance and treatment outcome, and homework’s causal effects on improved treatment outcomes, has been well established empirically. Results from four meta-analytic reviews conducted indicate a small positive relationship between homework compliance and treatment outcomes (Beutler et al., 2004; Kazantzis, Deane, & Ronan, 2000; Kazantzis & Lampropoulos, 2002; Kazantzis et al., 2010; Mausbach et al., 2010). It is important to note that when interpreting correlational relationships, the possibility that a third variable is causing a correlation between the use of homework in therapy and outcome cannot be ruled out.

Kazantzis et al. (2000) conducted a meta-analysis in an attempt to examine the relationship between homework compliance and outcome in CBT. This meta-analysis was conducted in order to clarify concerns regarding the inconsistent findings in the literature. Previous empirical work had consistently shown a positive homework compliance-outcome relationship, with an effect size in the small-to-medium range (e.g., Edelman & Chambless, 1993; Hoelscher, Lichstein, & Rosenthal, 1984; Startup & Edmonds, 1994). However, findings were inconsistent regarding the causal effects of homework (i.e., the effects of treatments with and without homework assignments on treatment outcome; e.g., Blanchard et al., 1991; Neimeyer & Fexias, 1990), an issue that was likely related to investigations lacking statistical power to detect effects (Kazantzis, 2000). In addition, past reviews of the effects of homework (Burns & Auerbach, 1992;
Primakoff, Epstein, & Covi, 1986; Shelton & Levy, 1981) were considered problematic, as both correlational and experimental studies were examined together, with different research questions addressed by each methodology.

Kazantzis et al.’s (2000) meta-analysis comprised of a sample of 1,327 participants across 27 studies. Results indicated a small association between homework compliance and outcome ($r = .22$), with greater compliance associated with better outcomes. The findings indicated a weighted mean effect size ($r$) of .36 of the causal effects of homework assignments on treatment outcome. Thus, homework was found to have a medium-to-large effect ($d = 0.77$; Cohen, 1988) on outcome. Using R. Rosenthal and Rubin’s (1982) binominal effect size display, the causal effect ($r = .36$) may be further interpreted to suggest that 68% of clients would be expected to improve in treatment that involved homework compared to 32% in treatment without homework (Figure 3; Kazantzis & Lampropoulos, 2002).
Figure 3. Client improvement in therapy with and without homework. Data from meta-analyses conducted on the effects of homework in cognitive-behavioural therapy (Kazantzis, Deane, & Ronan, 2000; Kazantzis, Whittington, & Dattilio, 2010). Percentages represent expected client improvement in treatment that involved homework compared to treatment without homework, using R. Rosenthal and Rubin’s (1982) binominal effect size display to interpret experimental effects.

In a smaller meta-analytic review conducted by Beutler et al. (2004), comprising of a sample of 326 participants across 5 studies, a small correlation between homework compliance and treatment outcome was found ($r = .10$). In another review, Mausbach et al. (2010) replicated part of Kazantzis et al.’s (2000) meta-analysis examining only the association between homework compliance and treatment outcome. Consistent with previous findings, the results indicated a small significant positive ($r = .26$) relationship between homework compliance and treatment outcome. However, as most of the empirical studies examined in Kazantzis et al.’s (2000) and Mausbach et al.’s (2010) meta-analyses were largely based on samples of participants with anxiety and
depression, the findings cannot be generalised to clinical populations where comorbid presentations are prevalent. Other limitations of these meta-analytic studies include: (i) not including an estimate of effect size for control therapy conditions (i.e., therapy without homework); (ii) use of the correlation coefficient $r$ as the effect size index whereas Cohen’s $d$ standardized mean difference (Cohen, 1988) has subsequently become a more widely used index for interpretations, and (iii) not including data from some compliance-outcome studies that were essentially an ‘experimental’ condition along with data that examined homework’s causal effects. These limitations were subsequently addressed in a recent meta-analysis conducted by Kazantzis et al. (2010) which was a replication and extension of the earlier meta-analysis (Kazantzis et. al., 2000). Results from Kazantzis et al.’s (2010) meta-analysis supported previous findings that CBT with homework produces enhanced therapeutic outcomes compared to therapy without it (Figure 3).

Data from the above mentioned meta-analytic studies on the effects of homework in therapy indicate large differences in comparison group studies between homework and no homework conditions (Kazantzis et al., 2000; Kazantzis et al., 2010). However, a small positive relationship between homework compliance and outcome has been consistently found by various research groups publishing reviews (Beutler et al., 2004; Kazantzis et al., 2000; Kazantzis et al., 2010; Mausbach et al., 2010). The small relationship between compliance and outcome suggests that it is important to consider other factors that contribute to homework engagement. As compliance is not the most important factor, all the theoretically suggested factors that lead to compliance (as reviewed in Chapter 2) are potentially important, and are in part determined by therapist
behaviour (e.g., praise homework efforts, consider potential obstacles, build self-efficacy).

In psychotherapy process research, it is important to acknowledge the complex and interdependent relationship that exists between treatment methods and the therapeutic relationship (Norcross & Lambert, 2011). Although aspects of treatment methods and the relationship may be examined separately in research, both influence each other and are inseparable in practice (Norcross & Lambert, 2011). The collaborative and affective bond between therapist and client is referred to as the therapeutic alliance (Luborsky, 1984) and is a variable that has been extensively examined in psychotherapy process research. It is a variable present in both individual and group therapy contexts. However, most cognitive therapy outcome research has been conducted in individual therapy contexts. Findings from meta-analytic reviews indicate a moderate relationship between the therapeutic alliance and treatment outcomes in cognitive therapy (D. J. Martin, Garske, & Davis, 2000; Shirk & Karver, 2003). Thus, a moderate relationship between the therapeutic alliance and client homework compliance may also be proposed, however, empirical work examining this association has been scarce (Dunn, Morrison, & Bentall, 2006). A limitation of previous cognitive therapy outcome research is that the measures of therapeutic alliance employed have often failed to capture key aspects of the therapeutic relationship that are important in CBT (e.g., collaborative empiricism; Tee & Kazantzis, 2011). Therefore, the effect that the therapeutic relationship has on homework compliance remains unclear.
In summary, it is clear that the use of homework in therapy is associated with enhanced therapeutic outcomes. Client homework noncompliance, however, is a common problem in clinical practice (Helbig & Fehm, 2004; Tompkins, 2002). In order to help promote client homework engagement and consequently optimise therapeutic outcomes, further empirical work investigating the determinants of homework engagement is needed.

**Measurement of Client Homework Compliance**

The methods utilised to assess homework compliance in the empirical literature varies across studies. In some studies only homework *quantity* (i.e., extent of task completion) is measured (e.g., Bryant, Simons, & Thase, 1999; Neimeyer & Fexias, 1990), whilst in others both *quantity* and *quality* are measured (e.g., Funk, Zvolensky, & Schmidt, 2011; Schmidt & Woolaway-Bickel, 2000). Quality of homework compliance refers to the extent to which homework assignments are carried out correctly (Primakoff et al., 1986). In a past review conducted on the methods used to assess homework compliance across 32 studies (Kazantzis, Deane, & Ronan, 2004), all studies were found to have assessed the *quantity* of homework compliance with the exception of one that also assessed *quality*. However, over the last decade, empirical work assessing homework quality has increased (Funk et al., 2011; Neimeyer et al., 2008; Rees, McEvoy, & Nathan, 2005; Schmidt & Woolaway-Bickel, 2000; Woods, Chambless, & Steketee, 2002). To assess compliance meaningfully, the quality of compliance needs to be considered. Simply attending to whether or not a client has completed a task (i.e., quantity) is inadequate for assessing the extent of learning that has taken place or competence of effort (i.e., quality; Kazantzis et al., in press; Primakoff et al., 1986).
Inconsistent findings exist in the literature regarding the predictive ability of homework quantity and quality on treatment outcome. In empirical work conducted by Funk et al. (2011), and Kelly and Deane (2009), the findings indicated that both homework quantity and quality predicted outcome. Alternatively, Neimeyer et al. (2008) found that only homework quality in combination with a client’s willingness to complete homework assignments was associated with positive treatment outcomes. Schmidt and Woolaway-Bickel (2000) found that homework quality was a better predictor of outcome than quantity. On the other hand, Rees et al. (2005) found quantity was a better predictor of treatment outcome than quality. Further, the findings of Woods et al.’s (2002) study indicate that treatment outcome was not associated with either the quantity or quality of client homework completion. These inconsistencies across studies may possibly be attributed to differences in patient population, types of homework tasks assigned, or a third variable such as readiness for change (Funk et al., 2011; Woods et al., 2002). It is clear that further research assessing both homework quantity and quality is needed. Therefore, both quantity and quality of homework compliance will be assessed in the present research.

A further methodological difference across studies examining homework compliance is the diversity of measures employed to assess homework compliance. For example, measures of homework compliance have included assessing clients’ self-report of adherence (e.g., Cox, Tisdelle, & Culbert, 1988), assessing client kept record forms of practice (e.g., Funk et al., 2011; Hoelscher et al., 1984), therapist ratings of homework practice forms (e.g., Schmidt & Woolaway-Bickel, 2000), and use of a homework
compliance scale (e.g., Bryant et al., 1999; Westra, 2011). Thus, it is difficult to make comparisons between studies.

Further, empirical studies have assessed homework compliance using either subjective or objectives measures, or both. Objective measures of homework compliance and measures of client motivation have been found to be superior to self-report data (Hoelscher et al., 1984, 1986; Schmidt & Woolaway-Bickel, 2000; Taylor, Agras, Schneider, & Allen, 1983; Westra, 2011). For instance, hidden electronic monitoring devices in tape players were utilised in empirical work to investigate objective (i.e., the amount of relaxation practice recorded by the devices) versus subjective (i.e., client kept record forms of practice) measurements of homework compliance (Hoelscher et al., 1984, 1986; Taylor et al., 1983). The findings of these studies revealed that self-reported practice markedly exceeded actual practice, with average overestimations ranging from 82% to 126% (Hoelscher et al., 1984, 1986; Taylor et al., 1983). Similarly, objective measures of homework compliance (Hoelscher et al., 1984, 1986; Schmidt & Woolaway-Bickel, 2000) and client motivation (e.g., Westra, 2011) have been found to more reliably predict treatment outcomes. In contrast, Taylor et al. (1983) found no significant correlation between either objective or subjective measures of practice on treatment outcomes. It has been suggested that these divergent findings may possibly be related to an insufficient amount of relaxation practice undertaken by the participants in Taylor et al.’s study to reduce blood pressure (Hoelscher et al., 1986). Poor reliability of self-report indices may be attributed to reporting bias, memory fallibility, or related to the different constructs being assessed by objective and subjective measures (Schmidt & Woolaway-Bickel, 2000). Therefore,
both objective and subjective measures of homework compliance will be utilised in the present research.

The methodological limitations associated with the measurement of homework compliance may preclude clear interpretation of findings across studies. To improve the measurement of homework compliance, Kazantzis et al. (2004) developed the Homework Rating Scale (HRS), a 12-item, client self-report questionnaire. The HRS was later revised and replaced by the HRS-II (Kazantzis, Deane, & Ronan, 2005; Figure 4).

The HRS-II may be a more valid and reliable measure of assessing homework compliance as it measures homework quantity and quality, as well as theoretically significant factors that affect client engagement such as client beliefs, obstacles, and behavioural consequences (Kazantzis, Deane, & Ronan, 2005). Based on an understanding of the theoretical determinants of client homework engagement (see discussion in Chapter 2), Kazantzis, Deane, and Ronan (2005) argue that rather than measuring client “compliance” with assignments, it may be more clinically useful to examine perceived relevant homework completion that leads to learning and skill acquisition. Therefore, in considering homework compliance there is a need to step away from single-item measures (i.e., quantity of homework completion) to measures that more comprehensively capture the determinants of homework compliance (Kazantzis, Deane, & Ronan, 2005). Thus, the HRS-II measure will be utilised in the present research.
### Homework Rating Scale II Client Version

**Instructions:** Many people find ways to engage in activities between therapy sessions in a way that suits them. This may differ from the way in which the activity was discussed with their therapist. This questionnaire asks about your activities from last session. Below are some ways in which people have said that they have engaged and learned from their activities. Please read each question carefully, and for each of the statements, circle the response that best applies to you.

<table>
<thead>
<tr>
<th>1. Quantity</th>
<th>7. Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was able to do the activity</td>
<td>I had an active role in planning the activity</td>
</tr>
<tr>
<td>0</td>
<td>not at all</td>
</tr>
<tr>
<td>1</td>
<td>a little</td>
</tr>
<tr>
<td>2</td>
<td>some</td>
</tr>
<tr>
<td>3</td>
<td>a lot</td>
</tr>
<tr>
<td>4</td>
<td>completely</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Quality</th>
<th>8. Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was able to do the activity well</td>
<td>The guidelines for how to carry out the activity were specific</td>
</tr>
<tr>
<td>0</td>
<td>not at all</td>
</tr>
<tr>
<td>1</td>
<td>somewhat</td>
</tr>
<tr>
<td>2</td>
<td>moderately</td>
</tr>
<tr>
<td>3</td>
<td>very</td>
</tr>
<tr>
<td>4</td>
<td>extremely</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Difficulty</th>
<th>9. Match with Therapy Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>The activity was difficult for me</td>
<td>The activity matched with my goals for therapy</td>
</tr>
<tr>
<td>0</td>
<td>not at all</td>
</tr>
<tr>
<td>1</td>
<td>somewhat</td>
</tr>
<tr>
<td>2</td>
<td>moderately</td>
</tr>
<tr>
<td>3</td>
<td>very</td>
</tr>
<tr>
<td>4</td>
<td>extremely</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Obstacles</th>
<th>10. Pleasure</th>
</tr>
</thead>
<tbody>
<tr>
<td>I experienced obstacles in doing the activity</td>
<td>I enjoyed the activity</td>
</tr>
<tr>
<td>0</td>
<td>not at all</td>
</tr>
<tr>
<td>1</td>
<td>a little</td>
</tr>
<tr>
<td>2</td>
<td>some</td>
</tr>
<tr>
<td>3</td>
<td>a lot</td>
</tr>
<tr>
<td>4</td>
<td>extensive</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Comprehension</th>
<th>11. Mastery</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understood what to do for the activity</td>
<td>I gained a sense of control over my problems</td>
</tr>
<tr>
<td>0</td>
<td>not at all</td>
</tr>
<tr>
<td>1</td>
<td>a little</td>
</tr>
<tr>
<td>2</td>
<td>somewhat</td>
</tr>
<tr>
<td>3</td>
<td>a lot</td>
</tr>
<tr>
<td>4</td>
<td>completely</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Rationale</th>
<th>12. Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>The reason for doing the activity was clear to me</td>
<td>The activity helped with my progress in therapy</td>
</tr>
<tr>
<td>0</td>
<td>not at all</td>
</tr>
<tr>
<td>1</td>
<td>somewhat</td>
</tr>
<tr>
<td>2</td>
<td>moderately</td>
</tr>
<tr>
<td>3</td>
<td>very</td>
</tr>
<tr>
<td>4</td>
<td>extremely</td>
</tr>
</tbody>
</table>

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An important variable to consider when measuring homework compliance is motivation. Reduced levels of resistance to change have been found to be associated with increased client engagement in cognitive-behavioural therapy (Aviram & Westra, 2011; Westra, 2011; Westra et al., 2009). In a recent study conducted by Westra (2011), the predictive capacity of observed in-session resistance compared to self-reported motivation for change in cognitive-behavioural therapy were examined. The sample comprised of 38 participants receiving CBT for generalised anxiety disorder. The results indicated that observed in-session resistance was a better predictor than self-reported motivation of: (i) homework compliance; (ii) short and long-term treatment outcome, and (iii) it reliably differentiated participants who received motivational interviewing prior to CBT from those who did not. Self-reported measures of motivation were inconsistent and weaker predictors of each index compared to observed resistance. Observed resistance in Session 1 was found to be the most consistent and strongest predictor of homework compliance and treatment outcome. Higher client resistance predicted lower homework compliance and reduced treatment outcomes. These findings suggest that clients who are more engaged in the change process are more likely to engage in treatment (e.g., homework).

The mechanism through which motivational interviewing added to CBT (i.e., MI-CBT) produces its effects was examined by Aviram and Westra (2011). The sample comprised of participants receiving CBT for generalised anxiety disorder with \( n = 18 \) or without \( n = 17 \) motivational interviewing pretreatment. Client observed in-session resistance was measured using the Client Resistance Code (CRC; Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984), a measure that assesses any behaviour
which opposes, blocks, diverts, or detracts from the direction set by the therapist (e.g., not responding, talking over the therapist). The findings from a path analysis indicated that observed in-session resistance, not homework compliance, strongly and directly mediated the relationship between the treatment group (i.e., MI-CBT) and worry reduction. Lower early observed in-session resistance was associated with higher levels of subsequent homework compliance, as well as improved worry reduction. These findings suggest that motivational interviewing helps to reduce resistance to change and treatment which facilitates client engagement in treatment (e.g., homework).

In summary, the methodological limitations of the assessment of homework compliance in the empirical literature impedes meaningful interpretation of findings across studies. It is clear that the adequate measurement of the compliance construct needs to include both quantity and quality of completion, as well as capture other theoretically meaningful determinants of engagement (e.g., self-efficacy beliefs, costs and benefits of task engagement). To best understand homework compliance, it is important to recognise the range of functions that homework serves in CBT. Further, when examining the relationship between homework compliance and outcomes, it is necessary to consider mediating factors such as motivation.

Summary

It has been well established empirically that the use of homework in therapy leads to better treatment outcomes. Results from meta-analytic studies indicate a small positive relationship between homework compliance and treatment outcome, with client improvement in therapy with homework expected to be greater than therapy without homework. The need to examine strategies for enhancing client homework compliance
is thus warranted. A review of the literature indicates that a diversity of measures have been utilised to assess homework compliance, consequently making comparisons between studies difficult. Although over the last decade there has been a shift toward assessing homework compliance more meaningfully, further empirical work that utilises valid and reliable measures to assess the theoretical determinants of client homework engagement is needed.
CHAPTER 4

RECOMMENDATIONS FOR ENHANCING HOMEWORK COMPLIANCE

With out-of-session work viewed as integral to behavioural and cognitive-behavioural therapies (A. T. Beck et al., 1979; Kazantzis & L’Abate, 2005; Shelton & Levy, 1981), homework assignments tend to be regularly integrated into treatment in a carefully planned and thought through manner referred to as a “systematic” approach, rather than with little or no preparation or “off the cuff” (Shelton & Levy, 1981). A systematic approach comprises of therapist behaviours such as designing assignments to achieve therapeutic goals, following up assignment completion and taking steps to enhance compliance (Shelton & Levy, 1981). From a theoretical standpoint, it is proposed that better therapeutic outcomes are achieved as the level of specificity and use of a systematic approach increases (Kazantzis & Deane, 1999). This is consistent with empirical research on patient adherence to medical therapies which shows that clearer prescriptions lead to enhanced medication compliance (e.g., Haynes, 2001; Ley et al., 1977; Lowe & Lutzker, 1979). A range of recommendations and models to enhance homework adherence have been proposed in the literature (e.g., A. T. Beck et al., 1979; J. S. Beck, 1995; Conoley, Padula, Payton, & Daniels, 1994; Detweiler & Whisman, 1999; D. Dobson & Dobson, 2009; Kazantzis, MacEwan, & Dattilio, 2005; Malouff & Schutte, 2004; Robinson, 2008; Scheel et al., 2004; Shelton & Levy, 1981; Tompkins, 2002). Due to the limited scope of this thesis, only a select number of recommendations will be discussed.

Various recommendations for enhancing homework compliance in clinical practice exist in the CBT literature. The need for therapists to use a systematic approach
to integrate homework into cognitive therapy was initially emphasised by A. T. Beck et al. (1979). A. T. Beck et al. provide a set of clear guidelines describing processes to follow for the integration of homework in clinical practice. It is recommended that homework activities are integrated into sessions at both the beginning and end. A. T. Beck et al. contend that the way in which homework is delivered critically influences therapeutic collaboration. The recommendations offered for how to deliver homework include tailoring tasks to client’s goals, anticipating obstacles, identifying negative attitudes toward homework, and being clear and specific in planning how tasks will be carried out. Collaboration between the client and therapist (i.e., a team approach; A. T. Beck et al., 1979) with homework is expected to strengthen the therapeutic relationship by using strategies such as explaining the goal and rationale for the task, obtaining client feedback about the task, and viewing tasks as “experiments” (e.g., Eisenthal, Koopman, & Lazare, 1983; Tee & Kazantzis, 2011).

Based primarily on behavioural theories, Shelton and Levy (1981) proposed a systematic model for integrating behavioural assignments into therapy. The Shelton and Levy model was largely informed by empirical work conducted on medication compliance enhancement (e.g., Davis, 1971; Lowe & Lutzker, 1979) and an earlier systematic homework model (Shelton & Ackerman, 1974). Eleven detailed propositions are provided (Table 1), along with relevant empirical support for each. Shelton and Levy (1981) suggested that therapists should ensure specificity is attained regarding the response and stimulus elements of the behaviour to be performed. They suggested that therapists need to work collaboratively with clients to achieve specificity regarding the frequency, duration and location of task practice, and ensure the client has a written
summary of the task. This proposition has generally been the basis for defining a systematic approach in the literature (i.e., Deane et al., 2005; Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kelly et al., 2006).

Table 1

Shelton and Levy’s (1981) Model for Enhancing Compliance with Behavioural Assignments

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The therapist should be sure assignments contain specific detail regarding response and stimulus elements relevant to the desired behaviour.</td>
</tr>
<tr>
<td>2. The therapist should give direct skill training when necessary.</td>
</tr>
<tr>
<td>3. Compliance should be reinforced.</td>
</tr>
<tr>
<td>4. The therapist should begin with small homework requests and gradually increase assignments.</td>
</tr>
<tr>
<td>5. The therapist should use cuing.</td>
</tr>
<tr>
<td>6. The therapist should have the client make a public commitment to comply.</td>
</tr>
<tr>
<td>7. The therapist should help the client develop a private commitment to comply.</td>
</tr>
<tr>
<td>8. The therapist should use cognitive rehearsal strategies to improve success with assignments.</td>
</tr>
<tr>
<td>9. The therapist should try to anticipate and reduce the negative effects of compliance.</td>
</tr>
<tr>
<td>10. The therapist should closely monitor compliance with as many sources as possible.</td>
</tr>
<tr>
<td>11. The therapist should use paradoxical strategies when necessary.</td>
</tr>
</tbody>
</table>

Consistent with A. T. Beck et al.’s (1979) model, Shelton and Levy (1981) suggested the need to be clear and specific when planning homework, to provide a rationale, anticipate obstacles, and integrate homework at both the beginning and end of sessions. In contrast, behavioural theory underpins many of Shelton and Levy’s propositions. For instance, the need for the therapist to provide direct skills training, reinforce compliance, begin with small homework requests, and gradually increase assignments. Further, direct empirical support for the use of Shelton and Levy’s entire model is not provided.

A review of the literature indicates that homework enhancement recommendations are largely derived from CBT literature and practice. Based primarily on the earlier work of A. T. Beck et al. (1979), and Shelton and Levy (1981), Kazantzis and Deane (1999) proposed a set of recommendations for enhancing homework in psychotherapy. These recommendations accounted for important cognitive and behavioural theory determinants of homework engagement. In a subsequent review of the homework research literature, Scheel et al. (2004) proposed a set of recommendations for homework enhancement, however, it is important to note, that Scheel et al.’s recommendations are predominantly a summary of Kazantzis and Deane’s earlier recommendations.

There is great overlap amongst the various recommendations for homework enhancement in the literature (e.g., J. S. Beck, 1995; D. Dobson & Dobson, 2009; Robinson, 2008) which are largely based on the earlier work of A. T. Beck et al. (1979), not markedly extending the literature. J. S. Beck (1995) provides detailed guidelines for increasing the likelihood of successful homework completion. Step-by-step procedures
are provided by Robinson (2008), which are predominantly based on theory and clinical experience. D. Dobson and Dobson (2009) provide a list of tips of how to successfully integrate homework into therapy, with a reference text provided for the reader to consult regarding the theoretical and empirical foundations. The recent models that have emerged in the CBT literature (i.e., D. Dobson & Dobson, 2009; Robinson, 2008) tend to vary in structure (i.e., tips, step-by-step procedures) and do not build upon previous models. The recommendations differ in the level of specificity and degree of theoretical and empirical foundations. Consequently, no one set of recommendations has emerged as a unified guideline for practice.

Detweiler and Whisman (1999) proposed a heuristic for understanding the factors that may determine client engagement in homework. The heuristic was developed based on a review of the existing empirical literature on the determinants of homework compliance in CBT. The heuristic extended previous work by combining the components identified to influence a client’s decision to engage in homework assignments. The heuristic suggests that client, therapist, and task characteristics, and the interrelationship of these characteristics, are important determinants of homework compliance. The description of the task, client-therapist relationship, and match between the client and the task, are also proposed to determine compliance. For instance, client beliefs about task difficulty may be shaped by how the therapist describes the task or provides opportunities for in-session practice.

It is important to acknowledge the complex and interdependent relationships that exist between client, therapist, and task characteristics. Whilst these variables may be examined separately in research, they are inseparable in clinical practice (Norcross &
Lambert, 2011). Nevertheless, Detweiler and Whisman’s (1999) heuristic provides a useful framework for understanding the influence that separable client, therapist, and task factors have on homework compliance. The heuristic is helpful as it encourages practitioners to consider other factors that may determine homework non-engagement (e.g., task difficulty) rather than attributing blame to the client. Consequently, methods for enhancing homework adherence can be developed from the heuristic. However, specific recommendations for integrating homework into therapy are not provided. Another limitation of the heuristic is its lack of theoretical foundations (see Chapter 2).

By reviewing the recommendations for enhancing homework compliance that exist in the literature, it is evident that there are strengths and limitations of each. Some recommendations have a firm empirical basis (e.g., D. Dobson & Dobson, 2009; Shelton & Levy, 1981) whilst others do not (e.g., Robinson, 2008). Some recommendations are clearly linked to behavioural theory (e.g., Shelton & Levy, 1981) or cognitive theory (e.g., A. T. Beck et al., 1979). The degree of specificity of the recommendations varies. Further, whilst some models (e.g., A. T. Beck et al., 1979; J. S. Beck, 1995; Robinson, 2008) advocate the use of a systematic approach for integrating homework into therapy, apart from Shelton and Levy (1981), a definition for a systematic approach is not provided.

In order for therapists to systematically integrate homework into therapy, it would be useful to have a model that incorporates previous recommendations, as well as overcomes the limitations. To a large extent this has been achieved by a ‘guiding model for practice’ for homework in CBT, also referred to as a homework enhancement protocol, developed by Kazantzis, MacEwan, and Dattilio (2005). This homework
protocol consolidates the numerous recommendations offered by previous models (i.e., A. T. Beck et al., 1979; Shelton & Ackerman, 1974; Shelton & Levy, 1981) and includes attention to the role of client cognition, an aspect of the therapeutic process not adequately addressed by previous models. Thus, both behavioural and cognitive theories underpin this protocol. This homework protocol is based on firm theoretical foundations, empirical support, and clinical experience.

A Cognitive-Behavioural Homework Enhancement Protocol

Kazantzis, MacEwan, and Dattilio’s (2005) cognitive-behavioural homework enhancement protocol outlines a three-step process to integrating homework into therapy, comprised of the design, assign, and review phases. Each phase is described with a high degree of specificity. Twenty therapist behaviours are outlined in a quick reference guide, aimed at making the process more explicit and the protocol easy to use for therapists. The recommendations are not to be used in a sequential fashion, rather, are to be used flexibly and integrated into the therapeutic dialogue (i.e., a flexible protocol to guide process). A comprehensive description of each recommendation is provided, including clinical case examples to help illustrate some recommendations (e.g., the use of guided imagery). A summary of the protocol is presented in Figure 5.

Compared to previous models, the homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005) elaborates further on aspects of the collaborative therapeutic relationship. Therapeutic collaboration is considered essential for the effective use of homework. The role of therapist qualities (e.g., genuineness, empathy, consistency), therapist beliefs (e.g., use of a structured therapy format), and therapist behaviours (e.g., forgetting to review homework) in the use of homework in CBT are discussed and represented in the protocol. Elements of motivational interviewing (MI), an approach designed to promote intrinsic motivation and resolve ambivalence about

<table>
<thead>
<tr>
<th>1. HOMEWORK REVIEW</th>
<th>2. HOMEWORK DESIGN</th>
<th>3. HOMEWORK ASSIGN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss Non-Completion and Quantity and Quality of Completion</td>
<td>Guided Discovery to Identify Coping Strategies and Beliefs</td>
<td>Ask Client to Summarize Rationale in Relation to Therapy Goals</td>
</tr>
<tr>
<td>Provide Verbal Reinforcement for any Portion Carried-Out</td>
<td>Use Disorder Specific Cognitive Model and Individualized Conceptualization</td>
<td>Collaborate to Specify How the Task Will be Practically Possible (i.e., when, where, how often, and how long it will take)</td>
</tr>
<tr>
<td>Situational Conceptualization to Identify Beliefs about the Consequences to Homework (i.e., synthesis of learning)</td>
<td>Collaboratively Select Tasks</td>
<td>Consider Potential Difficulties (i.e., link to obstacles identified during review)</td>
</tr>
<tr>
<td>Use Individualized Conceptualization to Make Sense of Non-Completion</td>
<td>Present a Rationale that Aligns with the Clients’ Treatment Goals</td>
<td>Emphasize Learning ‘Experiment’ Focus</td>
</tr>
<tr>
<td>Problem-Solve Obstacles</td>
<td>Ask about Client’s Ability and Perceived Task Difficulty</td>
<td>Ask Client to Summarize Task and Obtain Rating of Readiness, Importance, and Confidence (renegotiate if &lt; 70%)</td>
</tr>
<tr>
<td>Record Homework Completion in Session Notes</td>
<td>In-Session Practice of Task</td>
<td>Make a Written Note of the Homework for the Client (or use Homework Form)</td>
</tr>
</tbody>
</table>
change (Miller & Rollnick, 2002), are incorporated in the protocol (e.g., assessing client readiness and confidence, and task importance). MI strategies have been found to enhance treatment adherence (e.g., Hettema, Steele, & Miller, 2005; Westra et al., 2009). This protocol also extends further from previous recommendations by highlighting the need to tailor homework assignments to the client’s individualised cognitive conceptualisation and treatment goals at each stage of the homework administration process, so that homework is beneficial for the client. Whilst some of the recommendations in the protocol have empirical support (e.g., Bryant et al., 1999; Cox et al., 1988; Detweiler & Whisman, 1999; Mahrer, Gagnon, Fairweather, Boulet, & Herring, 1994), there is a need for focused evaluations of the protocol to evaluate the extent to which it can be followed by practitioners, and whether it leads to enhanced compliance and positive beliefs about therapeutic homework.

A model for practice that contains a high degree of specificity regarding the procedures to follow for homework delivery is likely to reduce the variability in which homework is delivered, and thus enhance treatment integrity (Drozd & Goldfried, 1996). Therapist treatment adherence is an aspect of treatment integrity that refers to the extent to which specified procedures are followed as intended (Perepletchikova, Hilt, Chereji, & Kazdin, 2009). In order that treatment integrity is not compromised, therapist adherence to a model of practice is considered necessary (Perepletchikova et al., 2009; Waltz, Addis, Koerner, & Jacobson, 1993).

**Summary**

In summary, it is recommended that therapists use a systematic approach to deliver homework into treatment. Different practitioner models for homework
enhancement have been proposed in the literature, some that are behaviourally focused and others that integrate behavioural and cognitive theoretical determinants of homework compliance. A review of existing homework recommendations and models highlights strengths and limitations of each. Kazantzis, MacEwan, and Dattilio’s (2005) CBT homework protocol which aptly consolidates the numerous recommendations from previous homework models, extends past work, and has firm theoretical and empirical foundations, will be examined in the present research.
CHAPTER 5

EMPIRICAL RESEARCH ON THERAPIST HOMEWORK BEHAVIOUR

Given that it has been well established empirically that the use of homework in therapy leads to better treatment outcomes (see Chapter 3), it is important to understand what factors determine client homework compliance. Therapist behaviour has been proposed to be an important determinant of client homework compliance (e.g., A. T. Beck et al., 1979; Detweiler & Whisman, 1999). In this chapter, research investigating the effects of therapist behaviour on homework compliance will be discussed. This review of the literature will highlight specific therapist behaviours found to be related to homework compliance. Following this, survey research examining therapist homework implementation behaviours in clinical practice will be discussed.

Therapist Behaviour

Although client homework compliance is proposed to be in part determined by therapist behaviour (e.g., A. T. Beck et al., 1979; Detweiler & Whisman, 1999), relatively little empirical work has been conducted to investigate the effects of therapist behaviour on homework compliance (Bryant et al., 1999; Conoley et al., 1994; Cox et al., 1988; Detweiler-Bedell & Whisman, 2005; Mahrer et al., 1994; Scheel, Seaman, Roach, Mullin, & Mahoney, 1999; Startup & Edmonds, 1994; Worthington, 1986).

A study by Conoley et al. (1994), examined whether particular variables used in the process of homework delivery predicted client implementation of counsellor suggested recommendations (i.e., homework). This research was conducted in the field of counselling psychology, thus the generalisability of results to CBT and other fields of therapy is limited. In the study, thirty-seven videotaped counselling sessions were rated.
Three predictor variables were analysed which included the matching of recommendations to the clients’ perception of their problem, difficulty of the recommendation, and the extent to which recommendations were built upon client’s strengths. All three variables were found to predict client implementation of recommendations. A limitation of the study was that all measures were based on rater observations of counsellor and client behaviour, and thus were based on the raters’ perspective rather than assessed directly from the counsellor and client. Ratings were also only conducted on early counselling sessions, thus it is possible that different variables may predict recommendation implementation in later sessions.

In another study conducted by Mahrer et al. (1994), 31 published and available transcripts of individual adult therapy sessions were analysed to examine therapist methods used to gain client commitment to engage in homework activities. Client commitment to engage in homework was examined rather than whether clients actually carried out the homework activity. A total of 241 transcripts were analysed by judges to identify client statements indicating commitment and resolve to carry out the postsession behaviours. A 70% agreement criterion for coding the transcripts was set, yielded a final sample of 22 usable transcripts. The sample of transcripts comprised of a range of theoretical orientations, including CBT (i.e., 32%). Several therapist methods were identified as being associated with client commitment to engage in homework which included: (i) working with client-initiated homework activity ideas; (ii) considering the client’s readiness and willingness; (iii) using a high degree of specificity in defining the task; (iv) providing a rationale, and (v) therapist encouragement. Of note, a limitation of the study was that client commitment was measured rather than actual
homework compliance. Clearly, having an intention to perform a behaviour does not always lead to action (Gollwitzer, 1999; Gollwitzer & Sheeran, 2006).

The use of a written copy of the homework assignment was examined by Cox et al. (1988). Thirty clients in behavioural medicine clinics were randomly assigned to either a condition where homework was administered verbally or a written copy of the homework assignment was provided. The use of a written reminder was found to lead to significantly better homework compliance. Another therapist behaviour found to be positively related to compliance was discussing barriers to homework completion (e.g., Detweiler-Bedell & Whisman, 2005).

Additionally, Startup and Edmonds (1994) examined therapist behaviours associated with compliance, using data drawn from 235 sessions of cognitive-behavioural therapy for depression received by 25 clients. The results indicated that homework compliance predicted improvement in depression scores at therapy termination. However, in contrast to previous research (e.g., Cox et al., 1988; Worthington, 1986) and theory (e.g., A. T. Beck et al., 1979), therapist behaviours (e.g., client collaboration, clarity of explanation, providing a rationale) were not found to predict homework compliance. The authors suggested that possibly the null statistical findings may be related to therapists’ changing strategies in response to client requirements. It is also possible that alternate associations may exist if the therapist behaviours were therapist or observer rated rather than client-rated.

In summary, the empirical work conducted to date has examined the effects of a limited range of therapist behaviours on homework compliance. This research has been predominantly correlational and conducted in different fields including counselling
psychology, CBT, and behavioural therapy. The findings indicate that specific therapist behaviours aptly predict client homework compliance, with some inconsistencies in findings reported.

**Therapist Competence**

When discussing therapist behaviour, it raises the important issue of treatment integrity (also known as treatment fidelity), which refers to implementing interventions as intended (Perepletchikova et al., 2009). Therapist treatment adherence and competence are key components of treatment integrity. Adherence refers to how often a therapist implements prescribed (i.e., recommended) treatment procedures and avoids those that are proscribed (i.e., not recommended; Perepletchikova et al., 2009). By contrast, therapist competence refers to a therapist’s level of skillfulness and judgment with which prescribed procedures are implemented (Perepletchikova et al., 2009). Measurements of the constructs of adherence and competence have been confounded to some extent, with high correlations observed between the constructs (Kazantzis, 2003). Despite this, empirical work indicates that the concept of competence does capture an important qualitative component not inherent in adherence (Barber, Crits-Christoph, & Luborsky, 1996; Shaw et al., 1999).

According to A. T. Beck and colleagues (A. T. Beck et al., 1979), therapist variables such as competence in integrating homework into therapy are proposed to be important determinants of both client compliance and treatment outcome. The limited empirical work to date supports these propositions in CBT (Bryant et al., 1999; Ryum, Stiles, Svartberg, & McCullough, 2010; Shaw et al., 1999). The effect of therapist competence on *homework compliance* was examined by Bryant et al. (1999). In the
study, data from 26 patients diagnosed with major depression, in a 20-session cognitive therapy protocol, were used to examine the predictive ability of patient and therapist variables on homework compliance. Homework compliance and therapist competence were assessed by raters who observed video or listened to audiotapes of sessions. A single rater, blind to client treatment outcomes, assessed therapist competence. Therapist competence was assessed using two observer-rated measures: (i) the Cognitive Therapy Scale (CTS; Young & Beck, 1980), and (ii) the Therapist Homework Assignment Competency Scale (THACS) developed by the first author. The CTS measures therapist competence in delivering CBT on two dimensions, one measuring general therapeutic skills (e.g., feedback, interpersonal effectiveness, collaboration) and the other CBT specific techniques (e.g., guided discovery, homework). The CTS comprises of 11 items, with items rated on a 7-point Likert scale ranging from 0 (poor) to 6 (excellent).

The THACS was developed to better capture the range of homework related therapist behaviours compared to the single homework item on the CTS. The THACS is a 4-item measure, with items rated on a 5-point Likert scale ranging from 0 (very poor or not done) to 4 (very well done). The findings indicated that therapist review of previous homework (i.e., THACS Item 1) and general therapeutic skills (i.e., CTS subscale) were the best predictors of subsequent client homework compliance. Patient variables were found to be largely unrelated to compliance (i.e., age, education, depression severity, learned resourcefulness), except for the number of previous depressive episodes which was negatively related.

In another study by Shaw et al. (1999), the effect of therapist competence on treatment outcome was examined. The sample comprised of 36 patients who completed
CBT treatment for depression of 20 sessions in 16 weeks. Therapist competence was assessed by raters using the CTS (Young & Beck, 1980). The findings indicated that greater therapist competence in being able to structure treatment (i.e., assign and review homework, set an agenda, pace sessions) significantly contributed to a reduction in depressive symptomology as measured by the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960). However, no significant effects were observed on the Beck Depression Inventory (BDI; A. T. Beck et al., 1979) measure of depression. The relationship between therapist competence and outcome was not as strong or consistent as expected. It was suggested that the weak effects observed may be attributed to the CTS measure of therapist competence not being comprehensive or specific enough.

Subsequent to this research, a revised version of the CTS has been developed to overcome these limitations (i.e., CTS-R; Blackburn et al., 2001).

More recently, Ryum et al. (2010) also examined the effect of therapist competence on treatment outcome. The study comprised of data from 25 patients with Cluster C personality disorders that received 40 sessions of cognitive therapy. Therapist competence was rated using the CTS (Young & Beck, 1980) items related to homework (i.e., ability to assign, monitor, and review homework) and agenda setting. These ratings were conducted early in treatment (mostly Session 6) by independent raters who observed videotapes of sessions. The findings indicated that higher ratings of therapist competence in assigning homework predicted better treatment outcomes at both mid- and posttreatment, as well as at termination. Improved treatment outcomes observed at mid- and posttreatment included a reduction in both psychological distress and interpersonal problems, whilst reduced Cluster C personality pathology was observed at
termination. Therapist competence in agenda setting did not predict outcomes. It is important to note that general therapist competence in cognitive therapy was not assessed, and thus its potential influence on the outcomes is unknown. Consistent with previous research (Shaw et al., 1999), the findings suggest that the quality of homework integration is an important determinant of treatment outcome. As the study lacked a measure of client homework compliance, the associations between homework compliance, therapist competence, and treatment outcome could not be examined.

In summary, therapist competence or skilfulness at integrating homework into therapy has been found to enhance both client homework compliance and treatment outcomes. However, the weak effects or null findings in the literature may possibly be related to inadequacies in defining and measuring the therapist competence construct in CBT. Further, this research has been correlational and thus causal inferences cannot be drawn.

Summary

It is clear that therapist behaviour is a predictor of client homework compliance. Recommendations for future empirical work in this field have emphasised the need for research efforts to be theoretically driven (Kazantzis et al., 2010; Lambert et al., 2007), and to examine the mechanisms by which homework produces its effects (Kazantzis, Deane, Ronan, & Lampropoulos, 2005; Kazantzis & L’Abate, 2007). Many of the predictors of compliance evaluated empirically tend to be consistent with the theory that explains how homework produces its effects, as discussed in Chapter 2. Therefore, in the present research, the effect of therapist behaviour on homework compliance will be examined. In particular, an experimental test of a homework protocol (i.e., “guiding
model for practice”; Kazantzis, MacEwan, & Dattilio, 2005) that outlines a range of therapist behaviours for promoting homework compliance will be examined.

**Practitioner Surveys**

Although a sound theoretical understanding of the use of homework in therapy exists and empirical work is increasing, limited research has been conducted on practitioners’ use of homework in clinical practice. Research conducted to date has mainly focused on examining practitioners’ general use of homework assignments and homework integration procedures (e.g., Deane et al., 2005; Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kelly et al., 2006), as well as attitudes toward homework (e.g., Fehm & Kazantzis, 2004; Kazantzis, Lampropoulos, & Deane, 2005).

Survey research on homework has generally found that a large majority of mental health professionals report using homework assignments in clinical practice. In a survey of New Zealand psychologists, 98% of the sample reported the use of homework in their clinical work (Kazantzis & Deane, 1999). Likewise, a survey of Australian psychologists found that 96% of the sample reported the use of homework in their clinical work (Deane et al., 2005). Similarly, a high rate of homework use has been reported by other mental health professionals including case managers, counsellors, nurses, psychotherapists, and social workers (83% of a predominantly New Zealand sample, Kazantzis, Busch, et al., 2006; 93% of an Australian sample, Kelly et al., 2006). It is important to consider the potential impact of socially desirable responding, self-selection, and the generalisability of data from practitioner surveys when interpreting the high rates of homework use reported in these studies. It is possible that distinct differences may exist between the practitioners who responded and those who did not
participate. Another limitation of some of these practitioner surveys (Deane et al., 2005; Kelly et al., 2006) is the moderate sample sizes which limit the generalisability of results. As it is rather impossible to attempt to sample a fully representative sample of psychotherapists (see discussion in Orlinsky, Botermans, & Ronnestad, 2001), researchers need to be cautious about generalising study findings to the population (Orlinsky et al., 2001; Westen, Stirman, & DeRubeis, 2006). It is important that sufficient data about the sample (e.g., ethnicity, workplace setting, social economic status) is reported to allow for the generalisability of findings to therapists with comparable characteristics (Lincoln & Guba, 1985; Orlinsky et al., 2001).

In the available studies that have been published, cognitive-behavioural therapy practitioners on average report using more homework assignments (Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kazantzis, Lampropoulos, & Deane, 2005) and having more positive attitudes towards homework (Kazantzis, Lampropoulos, & Deane, 2005) than therapists from other theoretical orientations. This finding is consistent with the CBT therapeutic framework in which homework is an essential part of therapy (A. T. Beck et al., 1979). Of note, in the Kazantzis and Deane (1999) study, there was an overrepresentation of cognitive-behavioural therapists in the sample, which limits the generalisability of findings.

On the other hand, a recent practitioner survey examined a wide range of routine therapy practices including homework (J. M. Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010). The sample comprised of North American psychotherapists. The results indicated that only 59% \( (n = 1,274) \) of practising psychotherapists surveyed used homework in at least half of their sessions, with 79% \( (n = 1,940) \) self-described as CBT practitioners.
In summary, the research conducted to date indicates the widespread use of homework among a range of mental health professionals, with higher rates of use generally reported among CBT practitioners. It is also well known that there is a small positive relationship between homework compliance and outcome (e.g., Kazantzis et al., 2010; Mausbach et al., 2010), and evidence for homework’s causal effects on improved treatment outcomes (Kazantzis et al., 2000; Kazantzis et al., 2010; see discussion in Chapter 3). With the effects of homework well established, and particular therapist behaviours found to enhance homework adherence (e.g., Bryant et al., 1999; Detweiler-Bedell & Whisman, 2005), it is important to know which homework procedures practitioners are implementing in clinical practice so that therapeutic change may be optimised. In particular, the extent to which practitioners are delivering homework into treatment in a carefully planned and thought through manner (i.e., using a “systematic approach).

**Practitioners’ Use of a Systematic Approach to Homework**

In the few studies that have been conducted (i.e., Deane et al., 2005; Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kelly et al., 2006), the findings indicate that practitioners are generally not being systematic in their approach to homework integration. In prior studies, a systematic approach was defined according to Shelton and Levy’s (1981) behaviourally focused model for practice, that is, practitioners almost always specified the frequency, duration and location of task practice, and ensured the client had a written summary of the task. Previous surveys have coded response items as systematic if they were greater than and equal to the second most extreme value on the scale. Findings ranged from 12% (Kazantzis, Busch, et al., 2006) to less than 25%
(Kazantzis & Deane, 1999) of practitioners that reported the use of a systematic approach. A difference in the degree to which practitioners are systematic is apparent amongst practitioners from different professional backgrounds. The use of a systematic approach was higher amongst psychologists surveyed (23%, Deane et al., 2005; 25%, Kazantzis & Deane, 1999) than samples comprised of a range of mental health professionals (12%, Kazantzis, Busch, et al., 2006; 15%, Kelly et al., 2006). Further, practitioners practising from a cognitive-behavioural orientation reportedly used a systematic approach to a slightly greater extent than those from other theoretical orientations (Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999).

A limitation of previous surveys (i.e., Deane et al., 2005; Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kelly et al., 2006) is that homework administration practices were defined as systematic based on Shelton and Levy’s (1981) model which is predominantly behaviourally focused and based on principles of behaviour change. This definition is considered inadequate as it does not include important cognitive and behavioural theory determinants of homework engagement (see discussion in Chapters 2 and 4). Although data regarding some of these other aspects of homework administration were examined in previous studies (e.g., provide a rationale, consider client ability), these data were not considered in the definition of systematic use. Therefore, to include strategies founded on both principles of cognitive and behaviour change the concept of “systematic” homework use requires re-conceptualisation. Systematic use will thus be re-conceptualised in the present research to include both cognitive and behavioural determinants of client homework engagement.
A further limitation of previous research is the limited scope of therapist behaviours examined. Subsequent guidelines and models have been developed that include other methods considered relevant to enhancing homework compliance (e.g., Kazantzis, MacEwan, & Dattilio, 2005; Robinson, 2008). Additionally, with few studies conducted to investigate practitioners’ use of a systematic approach and the moderate sample sizes of some studies (i.e., Deane et al., 2005; Kelly et al., 2006), the generalisability of findings is limited.

**The emphasis on homework in psychologists’ training.**

The effect of training on practitioners’ systematic use of homework in clinical practice has not been examined empirically. It is possible that inadequate skills training in the implementation of homework may be one factor contributing to psychologists’ inconsistent use of a systematic approach to homework implementation (Deane et al., 2005).

A considerable amount of empirical work has been conducted to examine the extent of skills transfer to clinical practice following CBT training (Ashworth, Williams, & Blackburn, 1999; Kennedy-Merrick, Haarhoff, Stenhouse, Merrick, & Kazantzis, 2008; Mathleson, Beaumont, & Barnfield, 2010; Myles & Milne, 2004). The findings indicate that trainees generally transfer CBT skills from training to practice. For example, a survey was conducted with 27 New Zealand non-psychologist mental health professionals following training in a halftime year-long postgraduate level CBT course (Mathleson et al., 2010). These results showed that most graduates reported continued use of CBT skills in their practice, with the techniques of homework setting, Socratic questioning, problem solving, and activity scheduling, most frequently used.
In another study, 73 New Zealand mental health professionals, comprising of psychologists, were surveyed following the completion of all or part of a Postgraduate Diploma in Cognitive-Behaviour Therapy (PGDipCBT; Kennedy-Merrick et al., 2008). In this study, both confidence and training were examined. Whilst graduates reported a moderate degree of perceived transfer of training to work practice following training, a high level of perceived confidence in using a range of CBT techniques was reported. The CBT techniques examined included designing, assigning, and reviewing clients’ homework. It was suggested that the moderate level of transfer of training observed in the study may possibly be attributed to only 38% of the sample having had completed all theoretical and practical components of the training at the time of study participation (Kennedy-Merrick et al., 2008). Thus, practitioner training and confidence in using homework integration procedures will be assessed in the present research.

**Summary**

It is important to know which homework procedures practitioners are implementing in clinical practice so that therapeutic change may be optimised. Limited research has been conducted to investigate practitioners’ use of homework in clinical practice, with a limited scope of homework behaviours examined. Most of the empirical work conducted to date indicates that a small proportion of practitioners are being systematic when integrating homework into therapy. However, the conceptualisation of systematic use in previous research is considered problematic. A definition of systematic use founded on both principles of cognitive and behaviour change is considered necessary in order to account for the range of determinants of client homework
engagement. Further empirical work is needed to affirm and extend the existing literature.

**Summary**

In summary, limited research has been conducted to investigate the effects of therapist behaviour on client homework compliance and practitioners’ use of homework in clinical practice. A review of the literature indicates that therapist behaviour is an important determinant of client homework compliance. Specific therapist behaviours have been found to aptly predict homework compliance, with therapist competence at homework implementation found to enhance both client homework compliance and treatment outcomes. Practitioner survey research findings indicate that a large majority of mental health professionals generally use homework assignments in clinical practice, with greater use reported by CBT practitioners. Although a small proportion of practitioners have generally been found to be systematic when implementing homework in therapy, the conceptualisation of systematic use in previous research is considered problematic. Further, factors that may influence practitioners’ use of homework enhancement strategies (e.g., training) have not been investigated. Therefore, methods for enhancing client homework compliance, with a particular focus on therapist behaviour, will be examined in the present research.
CHAPTER 6

THE PRESENT RESEARCH

The positive relationship between homework compliance and treatment outcome (e.g., Kazantzis et al., 2010; Mausbach et al., 2010), and homework’s causal effects on improved treatment outcomes in psychotherapy (Kazantzis et al., 2000; Kazantzis et al., 2010) has been demonstrated. Homework is an important vehicle for enhancing therapeutic change as it allows for the development and generalisation of skills, and for continued learning to occur out of sessions. However, a better understanding of how homework leads to therapeutic change is needed. Consequently, this knowledge may lead to the further development of strategies to promote and ultimately optimise therapeutic change.

A factor that has been found to influence homework compliance is therapist behaviour. The present research comprises of two studies that aim to examine methods for enhancing homework compliance, with a particular focus on therapist behaviours. Therapist behaviours as outlined in a cognitive-behavioural homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005) will be investigated. This protocol will be utilised in the present research as it aptly consolidates the numerous recommendations from previous homework enhancement models, as well as extends past work. The protocol also has firm theoretical and empirical foundations (see discussion in Chapters 2, 4, and 5). Study 1 will investigate psychologists’ use of a systematic approach to homework integration in clinical practice. Study 2 will provide an initial experimental test of the CBT homework protocol (Kazantzis, MacEwan, & Dattilio, 2005) on homework compliance.
Limited research has been conducted to investigate practitioners’ use of homework enhancement strategies in clinical practice, with a limited scope of homework behaviours examined. It is important to know which homework procedures practitioners are implementing in clinical practice so that therapeutic change may be optimised. A greater understanding of what occurs in routine clinical practice may ultimately lead to the development of evidence-based guidelines for homework integration, for which currently none exist. Further empirical work in this area may also help guide the dissemination of empirical evidence to clinicians, and assist in monitoring changes and trends in service delivery (J. M. Cook et al., 2010). The definition of a systematic approach, commonly used in the research literature to describe therapist homework behaviour, is considered inadequate as it does not incorporate a range of behaviours considered important to the process of homework integration. In addition, factors that may influence practitioners’ use of homework enhancement strategies (e.g., training) have not been examined. Thus, Study 1 will address the limitations of previous research by: (a) examining psychologists’ systematic use of a broad range of homework integration procedures in clinical practice, and (b) examining the influence of training on practitioners’ systematic use of homework in clinical practice.

The limited empirical work to date indicates that specific therapist behaviours influence client homework engagement, with some inconsistencies in findings. Most studies have examined a limited scope of therapist behaviours, with this work predominantly correlational. More research is needed to better understand the determinants of homework compliance, in particular, methods implemented by
therapists to enhance homework compliance. As reviewed earlier, numerous recommendations for improving homework compliance have been proposed, with the strengths and limitations of each discussed. Study 2 will extend previous research by providing an initial experimental test of a cognitive-behavioural homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005) on homework compliance, using a standardised homework assignment. As a preliminary step, an analogue study design will be utilised to empirically evaluate the protocol, which could subsequently lead to future research conducted in real life settings.

The two studies in the present research were parallel studies, conducted concurrently. The findings of Study 1 thus were not available and consequently did not inform the design of Study 2.
CHAPTER 7

STUDY 1

Overview

Based on theoretical considerations and the empirical literature, as discussed in Chapters 2 and 5, it is proposed that therapists need to regularly integrate homework into treatment in a carefully planned and thought through manner, that is, use a “systematic” approach, to enhance homework engagement. The need for therapists to use a systematic approach to integrate homework into therapy is emphasised in both cognitive (A. T. Beck et al., 1979) and behavioural approaches (Shelton & Ackerman, 1974; Shelton & Levy, 1981). However, in the empirical work that has been conducted to examine practitioners’ use of a systematic approach to homework administration (i.e., Deane et al., 2005; Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kelly et al., 2006), a limited scope of therapist behaviours have been examined. The operationalisation of systematic use in the existing literature has also been problematic. Surveys have primarily defined systematic use based on principles of behaviour change, focused only on homework planning procedures. These empirical efforts have utilised criteria that originated from work conducted in the field of behaviour therapy (Shelton & Ackerman, 1974; Shelton & Levy, 1981). This operationalisation is considered inadequate as it does not incorporate a range of therapist behaviours considered important to the process of homework integration, that are based on both principles of cognitive and behaviour change (e.g., discussing client reactions to task; exploring client coping strategies; Kazantzis, MacEwan, & Dattilio, 2005). Further, empirically, factors
that determine the extent to which practitioners’ use a systematic approach, such as training, have not been examined.

**Aims and Hypotheses**

The aim of Study 1 was to extend previous research by examining therapists’ systematic use of a broad range of homework integration procedures in clinical practice. Specifically, Study 1 aimed to contrast the ecological validity of the indices of systematic homework use derived from two practitioner homework enhancement models: (i) Shelton and Levy’s (1981) behavioural model, and (ii) Kazantzis, MacEwan, and Dattilio’s (2005) cognitive-behavioural model. Study 1 also aimed to contribute to the literature by examining the influence of training on therapists’ use of a systematic approach to homework.

Based on the theoretical and empirical literature previously outlined, several hypotheses were proposed for Study 1. It was hypothesised that systematic homework use conceptualised as per Kazantzis, MacEwan, and Dattilio’s (2005) model would better represent practitioners’ self-reported practices than Shelton and Levy’s (1981) model (Hypothesis 1). It was also hypothesised that cognitive-behavioural therapists would report using a systematic approach for the administration of homework to a greater extent than therapists from other theoretical orientations, on all indices of systematic homework use (Hypothesis 2). It was further hypothesised that cognitive-behavioural therapists would report using homework assignments to a greater extent than therapists from other theoretical orientations (Hypothesis 3). Lastly, it was hypothesised that psychologists who have had more training in how to integrate homework into therapy (Hypothesis 4) or who have more confidence in being able to
administer homework (Hypothesis 5), according to theory, guidelines, and models, would be more systematic in their use of homework procedures.

**Method**

**Recruitment Strategy**

Several participant recruitment strategies were employed in the present study. Participants were recruited via online business listings for psychologists, at clinical workshops, through advertising in a local psychologist magazine, personal contacts of the researcher, and from participants’ networks. To achieve greater sample homogeneity, participation criteria included: (a) current full registration as a psychologist, and (b) current engagement in therapy practice in Australia. Data were collected over a period of five months, from June 2011 to October 2011. The study was approved by the Human Ethics Committee at La Trobe University (FHEC 10/R52).

A participant recruitment strategy employed was the search of an online business directory, the Yellow Pages, for practice listings of “psychologists” across all states in Australia. The search yielded 6,833 listings, but contact email addresses were only available for 9% (n = 641) of listings. A total of 641 psychologists were invited to participate via email and 32 email addresses were undeliverable, resulting in a total of 607 valid email addresses. A second participant recruitment strategy was to invite attendees at clinical workshops, conducted by the research supervisor (NK), in various states in Australia. At the workshops, a presentation slide about the study was displayed and flyers placed at registration desks, openly accessible to potential participants. A third strategy was to place an advertisement in a magazine distributed by a professional association for psychologists in Australia to over 20,000 of its members (i.e., Australian
Psychological Society “InPsych” magazine). A final strategy was for the researcher to invite 25 personal contacts to complete the survey. In addition, participants had the opportunity to refer colleagues to complete the survey. As the number participants invited via workshop invitations and referrals by participants was not known, the convenience sampling approach, similar to that adopted in other practitioner surveys (e.g., Orlinsky, Schofield, Schroder, & Kazantzis, 2011), precludes calculation of a meaningful response rate.

**Screening of participant responses.**

Of the 145 overall survey responses received, 20% \( (n = 29) \) were unusable: 7 participants did not proceed further after reading the Participant Information Sheet; 1 participant did not consent to take part; 1 participant indicated that they were not a fully registered psychologist and treating clients in therapy; 3 participants indicated that they did not use between-session activities at all; 17 participants completed less than 25% of the survey questionnaire (i.e., generally the first few questions only). Therefore, a total of 116 surveys were usable. The final sample of usable surveys comprised of 77% \( (n = 85) \) of respondents recruited via the online business directory, 19% \( (n = 21) \) by an email forwarded by a colleague, 2% \( (n = 2) \) via personal contacts of the researcher, and 2% \( (n = 2) \) specified “other”.

**Representativeness of sample.**

Although the sample size in the present study was small \( (N = 116) \) in proportion to the total population of registered psychologists in all of Australia (i.e., approximately 25,800; Stokes, Mathews, Grenyer, & Stokes, 2010), it was still important to evaluate the representativeness of the present sample. Therefore, sample characteristics were
compared with data from the most recent Australian psychology workforce survey of practitioners who reported independent private practice as their primary workplace setting (Stokes, Mathews, Grenyer, & Crea, 2010). This analysis indicated that the present sample was essentially identical in terms of gender and age, with similar patterns observed for caseload characteristics. By contrast, the present sample had a higher percentage of respondents who had attained a postgraduate qualification \((n = 87, 76.3\%)\) compared to the comparison dataset \((n = 2062, 55.0\%; \text{Stokes, Mathews, Grenyer, & Crea, 2010})\). Data for ethnicity was not collected in this most recent workforce survey (Stokes, Mathews, Grenyer, & Crea, 2010) and thus was not available for comparison. It is considered practically impossible to obtain a sample that is fully representative of the population of psychotherapists (Orlinsky et al., 2001). Although reporting therapist characteristics is proposed to aid in the generalisability of findings to therapists with comparable characteristics (Lincoln & Guba, 1985; Orlinsky et al., 2001), the probability of sampling error is higher in small samples (Hinkle, Wiersma, & Jurs, 2002). Therefore, the present sample cannot be considered representative of the larger population of psychologists in all of Australia. However, it is still encouraging that the characteristics of the present sample were comparable to that of practising independent private practitioners in Australia (Stokes, Mathews, Grenyer, & Crea, 2010).

**Measures**

**Survey questionnaire.**

A survey questionnaire consisting of 54 items was developed for the present study to examine in-session procedures used by practitioners to integrate homework into therapy. To ensure that the survey would be applicable to psychologists practicing
across a range of theoretical orientations, wording and phrasing that was neutral to orientation were selected. Thus, the term *between-session activities* was used instead of *homework*, as the latter term is largely associated with CBT and not generally used by other therapeutic orientations (Ellison & Greenberg, 2007; Gelso & Harbin, 2007; Kazantzis & Ronan, 2006b; Nelson et al., 2007). Between-session activities were defined as referring to “*any between-session therapeutic activities discussed collaboratively between client and therapist. This definition is distinct from client initiated activities that are not explicitly negotiated in-session with the therapist.*” The definition utilised is consistent with the definition of homework in CBT (A. T. Beck et al., 1979; Kazantzis, 2005; Kazantzis, Petrik, & Cummins, 2012).

*Psychologists’ use of homework.*

The questionnaire comprised of five items that measured practitioners’ use of between-session activities. This included a screening question which assessed practitioners’ use of between-session activities in their clinical practice (i.e., “*How often do you use between-session activities in your current clinical practice?*”) on a 5-point Likert response scale, ranging from 0 (*none of the time*) to 4 (*always*). Practitioners were asked to indicate how many different between-session activities they usually recommended during the first 10 treatment sessions, on a 6-point Likert scale ranging from 1 (*one*) to 6 (*six or more*). The average number of different between-session activities generally recommended at each session was assessed on a 4-point Likert scale ranging from 1 (*one*) to 4 (*four or more*). These latter three items were taken from a previous study questionnaire (i.e., Kazantzis, Lampropoulos, & Deane, 2005) to enable

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1 This 5-point Likert response scale was used as research has found the response categories to approximate equal interval measurements (Schriesheim & Gardiner, 1992; Schriesheim & Novelli, 1989).
comparison. Practitioner perceptions of the importance of homework (i.e., “How important would you say it is for you to use between-session activities in therapy?”) was rated on a scale ranging from 0 (not at all) to 4 (extremely). Finally, the questionnaire included an open ended question that asked respondents to indicate the three most common types of between-session activities assigned.

**Psychologists’ use of homework procedures.**

Thirty items assessed procedures used to integrate homework into therapy. These items were based on the recommendations as outlined in a cognitive-behavioural homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005). The protocol contains procedure items founded on principles of both cognitive and behaviour change. It includes items that draw on theory underpinning engagement in health behaviours, motivational interviewing, and collaborative case formulation in the selection, planning and review of homework (i.e., individualised [client specific]) and situational [task specific] level conceptualisation). Practitioners were asked to estimate how often they had used the homework procedures when recommending between-session activities in the past three months, on a scale ranging from 0 (none of the time) to 4 (always). Items were grouped according to the design (i.e., selecting tasks), assign (i.e., planning tasks) and review (i.e., reviewing tasks) phases of homework administration (Kazantzis, MacEwan, & Dattilio, 2005). Example items included “Discussed clients’ existing helpful and unhelpful coping strategies, and ideas and beliefs related to their between-session activities (e.g., used guided discovery, explored client strengths)”, “Collaboratively arrived at a decision for when the task(s) will be practiced”, and
“Provided verbal reinforcement (i.e., praise) for any portion carried out.” Appendix A outlines all 30 procedure items examined in the survey questionnaire.

**Psychologists’ training and confidence in the use of homework.**

Practitioner training and confidence in being able to administer homework according to theory, research, or recommended guidelines, were rated on a scale ranging from 0 (not at all) to 4 (extremely). Items included “Please specify the degree to which your training involved specifics on the use of between-session activities in therapy [i.e., according to theory, research, or recommended guidelines and models]” and “Please indicate how confident you are in your ability to integrate between-session activities into therapy according to theory, research, or recommended guidelines and models.”

**Demographic characteristics.**

Demographic items included age, gender, ethnicity, specialist area of practice, clinical experience, practice setting, caseload, client characteristics, and theoretical orientation. In relation to theoretical orientation, practitioner surveys indicate that most practising practitioners endorse influences from multiple therapeutic approaches, with integrated practice commonplace (e.g., Hill & O’Grady, 1985; Norcross & Prochaska, 1982; Thoma & Cecero, 2009). In a survey conducted by Thoma and Cecro (2009), the majority of therapists endorsed techniques outside of their self-identified orientation. It remains unclear what therapeutic practices underlie the concept of theoretical orientation for psychotherapists. Therefore, to gain a more accurate measure of theoretical orientation in the present study, practitioners were asked to indicate which therapeutic approaches influenced their practice from a broad list of 23 approaches (i.e., “Please indicate the extent to which your practice is influenced by the following therapeutic
approach(es). If you consider your practice to be integrative/eclectic, please rate which approaches make up your practice’"). Items were rated on a scale ranging from 0 (not at all) to 4 (extremely).

**Peer review of the survey questionnaire.**

To further refine and identify any potential difficulties with the questionnaire, feedback was elicited. Input on the survey questionnaire content was provided by five relevant international experts in the field of psychotherapy research (i.e., Professor George Stricker, Professor Louis Castonguay, Professor Jay Lebow, Professor Laura Mufson, and Professor Robert A. Neimeyer). Additionally, postgraduate psychology students at La Trobe University were invited to provide feedback, with feedback provided by two students. Feedback on questionnaire content was received and changes made accordingly. The survey questionnaire utilised in the present study is provided in Appendix A.

**Procedure**

The survey questionnaire was administered as an online survey, uploaded onto Qualtrics, a web-based survey software tool (Qualtrics Labs Inc., 2011). The study was anonymous. Incentives for participation included a personal profile of the participant’s use of between-session activities (i.e., participant’s responses to survey items in comparison to previous research data), the opportunity to enter an equal chance draw to win one of three practitioner textbooks, and provision of the study results. Eligibility criteria were outlined in the invitational emails sent out to potential participants and also assessed in the survey questionnaire. Participants who indicated in the survey that they
did not use between-session activities at all in their clinical practice were excluded, and only demographic data collected from these participants.

Invitational emails were sent to participants recruited via publicly available email listings, personal contacts of the researcher, or by fellow colleagues. The sampling strategy utilised for participants recruited via the publicly available email listings is detailed in the following section. Participants recruited at clinical workshops and through advertising were asked to express their interest to participate by sending an email to the researcher. Participants who expressed interest to participate were sent an invitational email along with two follow-up thank you/reminder emails 7 days apart. The invitational and reminder emails contained the survey link that participants clicked on to in order to commence the survey.

The first page of the survey informed participants of the purpose of the study. Participants were informed that the survey may take approximately 20 minutes to complete. Participants were asked to provide informed consent electronically before survey commencement. At the completion of the survey, the personal profile was output. To ensure anonymity, at the end of the survey, participants were redirected to a separate data set website to provide their contact details to request the study findings and enter the prize draw.

**Pilot Study**

Following peer review of the survey questionnaire, a pilot study was conducted with the first 20 surveys completed. The aim of the pilot was to check on the ease of use of the online survey instrument, clarity of the questionnaire, and elicit any other feedback. Participants were invited to provide feedback following survey completion.
Overall, the feedback received was positive. Consequently, no modifications were made, with all responses included in the final data set.

**Sampling Strategy**

Due to low response rates found in online practitioner survey research (Aitken, Power, & Dwyer, 2008; Crouch, Robinson, & Pitts, 2011; Edwards et al., 2009) and with limited empirical evidence regarding the optimal combination of contacts to use for online research (Dillman, Smyth, & Christian, 2009), the optimal sampling methodology for the email listings utilised in the present study was determined by piloting three alternate sampling methods. Sampling Method 1 involved sending out emails to a batch of psychologists ($n = 83$) using a mail survey protocol (Dillman et al., 2009). This method involved sending out a prenotice email to inform potential participants in advance that they would be invited to take part in the survey (Day 1), followed by an invitational email with the survey link (Day 5), and two follow up thank you/reminder emails seven days apart (Day 12 & 19). Alternately, in Sampling Method 2, emails were sent to a batch of psychologists ($n = 83$) excluding a prenotice email. Method 3 involved sending out emails to a batch of psychologists ($n = 83$) that comprised of a personalised invitation email, followed by three reminders seven days apart. Method 3 was informed by research that has demonstrated the benefits of using reminders (C. Cook, Heath, & Thompson, 2000; Crawford, Couper, & Lamias, 2001), sending out reminder emails at weekly intervals (Anderson & Gansneder, 1995), and personalising emails (Barron & Yechiam, 2002; C. Cook et al., 2000; Edwards et al., 2009; Heerwegh & Loosveldt, 2006), on response rate. To monitor the response rate for each method, the online survey was duplicated and a separate survey link generated for
each batch. The pilot test of recruitment methods yielded similar response rates, with 12% \((n = 10)\) for Method 1, 16% \((n = 13)\) for Method 2, and 10% \((n = 8)\) for Method 3. Due to its time efficiency (i.e., 3 contacts compared to 4), Method 2 was adopted for the remainder of data collection.

Steps were taken to minimise survey emails being flagged as spam. This involved sending individual emails rather than bulk (i.e., “To” not “Bcc”), as research has shown that bulk emails diffuse responsibility in a group (e.g., Barron & Yechiam, 2002). A separate La Trobe University email account was set up and the subject line text for email communications carefully selected so as to communicate professionalism and the legitimacy of the study.

**Statistical Analysis Procedure**

Data analyses were conducted using the Predictive Analytics Software Statistics (PASW; Version 18) program. Data were checked for accuracy, missing values, outliers, and normality. The minimum and maximum values, means, and standard deviations were examined for all variables for validity. Data screening of the usable surveys \((N = 116)\) revealed a small portion of missing data (5%) that was assessed to be largely due to respondents omitting questionnaire responses in a random pattern across items. A conservative approach was taken to the handling of missing data where pairwise exclusion was adopted and imputation not carried out.

The resultant dataset were inspected for outliers by identifying values that exceeded a distance of 3 times the interquartile range (IQR) below the lower quartile \((Q_1)\) or above the upper quartile \((Q_3)\;\text{(Field, 2009)}\). Although outliers were identified for the item assessing confidence in being able to administer homework according to
theory, research, or recommended guidelines (i.e., “Please indicate how confident you are in your ability to integrate between-session activities into therapy according to theory, research, or recommended guidelines and models”), these data were retained for analyses as their inclusion had no impact on results.

Normality was assessed by evaluating standardised skewness and kurtosis statistics (Field, 2009). Standard error and z score calculations were performed for all variables. The skewness and kurtosis values for each variable were divided by their respective standard errors and then the result compared with zero using the z distribution. Variables that had a z statistic at or above 3.3 were considered to be outliers. All variables were found to be normally distributed, with skewness and kurtosis z scores between -3.3 and +3.3.

**Preliminary Analyses**

It is possible that respondents’ use of homework procedures may have been compromised by systematic differences in caseload, clinical experience, or practice setting. Practitioner attitudes regarding the process of integrating homework assignments into therapy have been found to vary as a function of clinical experience and practice setting (Fehm & Kazantzis, 2004). The dependent variables analysed were respondents’ use of homework assign, design, and review procedures, as well as total use of all 30 homework procedures. Correlational analyses were performed in order to examine whether systematic differences in the dependent variables varied as a function of caseload and clinical experience, and thus whether these demographic variables need to be used as covariates in the primary analyses. These relationships were examined using Pearson’s product-moment correlation coefficient. Weak correlations were found
for all comparisons, with correlations ranging from .01 to .19 (ps > .05). These analyses indicated that variations in respondents’ use of homework procedures were not a function of caseload and clinical experience.

To examine whether systematic differences in respondents’ use of homework procedures varied as a function of practice setting, a series of one-way between-groups analysis of variance (ANOVA) analyses were conducted. The independent variable was practice setting (i.e., with 7 distinct categories), with respondents’ use of homework procedures (i.e., assign, design, review, and overall total) analysed separately as the dependent variables. Preliminary assumption testing revealed no violations of normality and homogeneity of variance. The assumptions of random sampling and independence of observations were met due to the experimental design utilised. All comparisons were found to be non-significant (ps > .05). These analyses indicated that variations in respondents’ use of homework procedures were not a function of practice setting.

Overall, these preliminary analyses indicate no effects of caseload, clinical experience, or practice setting, on respondents’ use of homework procedures.

**Statistical Power**

To determine an appropriate sample size for the present study, statistical power was considered in the design phase. Power is the probability of obtaining statistically significant results in data analysis (Cohen, 1988). It is the probability of rejecting the null hypothesis and finding that a phenomenon exists. The required sample size can be computed by estimating the alpha level, desired power, and effect size (Cohen, 1988). Effect size refers to the amount of variance in the dependent variable accounted for by the independent variable (Tabachnick & Fidell, 2007). The effect size provides an
indication of the practical and theoretical importance of the relation between variables. The effect size for a study can be estimated based on previous research. Therefore, in the present study, an appropriate effect size index was derived from previous research. The difference in use of homework procedures among therapists of different theoretical orientations has consistently been shown to exist in the medium range (average $d_s = 0.49$ in Kazantzis, Busch, et al., 2006; average $d_s = 0.43$ in Kazantzis & Deane, 1999).

An *a priori* power analysis was conducted using G*Power 3 (Faul, Erdfelder, Lang, & Buchner, 2007), a power analysis program, given a medium effect size of $d = 0.50$ as defined by Cohen, $\alpha = .05$, and power at .80. This analysis indicated that a sample size of 128 would be needed to test the main effect of theoretical orientation. Despite the multiple recruitment strategies employed in the present study, the desired sample ($n = 128$) was not obtained within the specified time-frame.

**Tests of Hypothesised Effects**

Frequency and descriptive statistics were utilised to summarise and describe all data collected including demographic data, respondents’ use of homework assignments, and homework integration procedures. Frequencies were obtained for categorical variables and descriptive statistics for continuous variables.

To examine the hypothesis that systematic homework use conceptualised as per Kazantzis, MacEwan, and Dattilio’s (2005) model would better represent practitioners’ self-reported practices than Shelton and Levy’s (1981) model (Hypothesis 1), frequency data of respondents’ use of homework procedures were examined. It was also hypothesised that cognitive-behavioural therapists would report using a systematic approach for the administration of homework to a greater extent than therapists from
other theoretical orientations, on all indices of systematic homework use (Hypothesis 2). It was also hypothesised that cognitive-behavioural therapists would report using homework assignments to a greater extent than therapists from other theoretical orientations (Hypothesis 3). However, the second and third hypotheses of the present study could not be investigated as initially planned. Both hypotheses involve testing for differences between psychologists from different theoretical orientations. The present study had a highly homogenous sample of respondents who identified practising from a cognitive-behavioural therapeutic approach ($n = 108, 93\%$), with $85\%$ ($n = 96$) who identified having two or more salient orientations. Consequently, the main effect of theoretical orientation could not be meaningfully examined in the present study.

To examine the hypothesised effects of training and confidence on respondents’ use of a systematic approach to homework (Hypotheses 4 & 5), one-way between-groups ANOVAs were conducted. Preliminary assumption testing was conducted for each one-way between-groups ANOVA performed. The independent variable was systematic approach (i.e., with 4 distinct categories as outlined in the following section), with training and confidence analysed separately as the dependent variables. The assumptions of random sampling and independence of observations were assumed due to the study design utilised. Preliminary assumption testing revealed no violations of normality. The assumption of homogeneity of variances was assessed using Levene’s test for homogeneity of variances. The analysis indicated that this assumption was violated for the confidence variable, therefore to interpret the main effects Welch's $F$ test was utilised in place of the ANOVA $F$ test (Myers & Well, 1995).
In order to reduce the risk of Type 1 error when multiple statistical tests are carried out, a more stringent criterion for determining statistical significance was set in the present study by applying a Bonferroni adjustment (Bland & Altman, 1995). The conventional alpha level of .05 was divided by the number of ANOVA tests to be performed (i.e., 2), to yield a more stringent alpha criterion of .025.

The p values, 95% confidence intervals, and observed effect sizes are reported. Cohen’s $d$, a widely used effect size index in the behavioural sciences, is used in the present study, with $d = 0.2$ considered a small effect size, $d = 0.5$ medium, and $d = 0.8$ large (Cohen, 1988).

**Definition of a Systematic Approach to Homework**

Previous research investigating practitioners’ use of a systematic approach to homework has defined systematic use based on a behaviourally based assignment model (Shelton & Ackerman, 1974; Shelton & Levy, 1981). This definition is considered problematic as it focuses primarily on planning strategies and principles of behaviour change, not including other therapist behaviours considered important to the process of homework delivery. Therefore, for present study purposes, the operationalisation of systematic use was extended from the narrow definition utilised in previous research to examine strategies founded on both principles of cognitive and behaviour change, as outlined in a homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005).

To assess whether a response item was systematic, criteria applied in previous research was initially utilised. Response items were coded as systematic for ratings greater than and equal to the second most extreme value on the scale (i.e., Deane et al., 2005; Kazantzis, Busch, et al., 2006; Kelly et al., 2006). Firstly, respondents who
reported using all 5 homework procedures according to Shelton and Levy’s (1981) model, with a rating of 3 or higher on the 5-point Likert scale ranging from 0 (none of the time) to 4 (always), were defined as systematic (Planning Index). Secondly, respondents’ use of CBT focused strategies was examined. Respondents who reported all 30 homework procedures as outlined in a CBT homework protocol (Kazantzis, MacEwan, & Dattilio, 2005), with a rating of 3 or higher on the 5-point Likert scale ranging from 0 (none of the time) to 4 (always) were examined. This analysis revealed that no respondents were systematic for all 30 procedure items. Therefore, in order to examine the extent to which respondents used all 30 homework procedures at least some of the time, the assessment criteria was relaxed, with ratings of 2 (fairly many times) or higher, and 1 (occasionally) or higher, on the 5-point Likert scale ranging from 0 (none of the time) to 4 (always) examined.

Thirdly, guided by a conceptual framework, respondents’ systematic use of homework procedures that were behaviourally or cognitively focused were examined. Strategies in the homework protocol (Kazantzis, MacEwan, & Dattilio, 2005) were categorised as either behaviourally or cognitively focused. Two procedures were identified as both behaviourally and cognitively focused (i.e., explore coping strategies, collaboratively select tasks), and thus coded into both categories. The extent to which respondents used behaviourally focused and cognitively focused procedures at least very often, at least fairly many times, or at least occasionally in their clinical work “in the past 3 months” were examined. Table 2 contains a detailed description of the homework procedures included for each conceptualisation of systematic use examined.
Lastly, guided by an integrative conceptual framework, a hierarchy of systematic use was developed. The highest level of the hierarchy was use of CBT focused procedures at least occasionally (CBT Focused Index), followed by use of either behaviourally (Behaviourally Focused Index) or cognitively focused (Cognitively Focused Index) procedures at least occasionally on the second level, and irregular use of procedures (Non-Systematic Index) on the third level. Thus, four indices for systematic use were developed for present study purposes. Accordingly, respondents were classified into one of these mutually exclusive categories for systematic use. Subsequent analyses examining the effects of respondents’ training and confidence were performed using these indices (Table 2).
Table 2

Coding of Homework Procedures for Each Conceptualisation of Systematic Use

<table>
<thead>
<tr>
<th>Homework Procedure</th>
<th>Planning Index</th>
<th>Behaviourally Focused Index</th>
<th>Cognitively Focused Index</th>
<th>CBT Focused Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homework Design</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider client ability</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>In-session practice of task</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Use a disorder specific cognitive model and individualised conceptualisation</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Present a rationale</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Present a rationale that aligns with clients' goals</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Check perceived task difficulty</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Guided imagery as part of in-session practice</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Identify beliefs and triggers for the task</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Explore coping strategies</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Collaboratively select tasks</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Homework Assign</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify when task practice will occur</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Specify where task practice will occur</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Specify how often the task will be practiced</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Specify how long task practice will take</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Client has written summary of task</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Consider potential difficulties</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Ask client to summarise rationale</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Emphasise learning 'experiment' focus</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Ask client to summarise the task</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Obtain feedback regarding readiness</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Obtain feedback regarding task importance</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Obtain feedback regarding confidence</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Homework Review</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss quantity of task completion</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Discuss task non-completion</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Discuss quality of task completion</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Provide verbal reinforcement</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Problem solve obstacles</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Discuss reactions to task</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Use of theoretical framework</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Homework procedures are derived from the CBT homework protocol (Kazantzis, MacEwan, & Dattilio, 2005) and categorised by phase of homework administration.
Theoretical Orientation

Respondents predominantly endorsed influences from more than one therapeutic approach. Responses were coded into superordinate categories as utilised in a recent survey of psychotherapists practicing in six English speaking countries including Australia (Orlinsky et al., 2011). Orientations rated 3 (very) or 4 (extremely) were considered prominent or “salient”. Salient orientations were identified for each participant and then coded into superordinate categories: (i) Analytic; (ii) Client-centred; (iii) Cognitive-behavioural; (iv) Behavioural; (v) Systemic, and (vi) Humanistic. A description of the theoretical orientations comprised within each superordinate category is provided in Appendix B and the findings reported in the results section of this chapter.

Types of Different Homework Activities Used by Psychologists

Data coding was required for the free response item used to assess the most common types of between-session activities used by respondents (i.e., “Please specify the three most common types of between-session activities that you use in your practice”), with space provided for respondents to list three activities. Existing literature was reviewed for suitable categories to use for coding data (e.g., Fehm & Kazantzis, 2004; Kazantzis & Dattilio, 2010). However, existing categories did not adequately fit the present data. Categories utilised in previous research were either too restrictive with regards to the number of categories utilised (e.g., four categories; Fehm & Kazantzis, 2004) or contained a high level of specificity that the present dataset could not be coded to (e.g., Kazantzis & Dattilio, 2010). For instance, in the present study respondents indicated “self-monitoring”, whereas in previous research five separate categories for monitoring were utilised including the monitoring of cognitions, behaviour,
interpersonal interactions, emotions, and physiological changes (Kazantzis & Dattilio, 2010). Therefore, categories were generated for the present data and frequency analyses performed.

**Results**

**Sample Characteristics**

The age of the 116 respondents ranged from 26 to 73 years, with a mean age of 48.4 years ($SD = 12.22$). The sample was 72.8% ($n = 83$) female and 27.2% ($n = 31$) male. The sample was comprised of respondents from every state and territory in Australia. Primary states or territories of practice included 24.6% ($n = 28$) in New South Wales, 23.7% ($n = 27$) in Queensland, 15.8% ($n = 18$) in South Australia, 13.2% ($n = 15$) in Victoria, 7.9% ($n = 9$) in Western Australia, 7.0% ($n = 8$) in Tasmania, 6.1% ($n = 7$) in the Australian Capital Territory, and 1.8% ($n = 2$) in the Northern Territory.

The majority of respondents indicated that their ethnicity was Australian ($n = 90, 78.9$%), with the remaining European ($n = 5, 4.4$%), British ($n = 5, 4.4$%), New Zealand ($n = 4, 3.5$%), Asian ($n = 3, 2.6$%), and other (i.e., American: $n = 2, 1.8$%; South African: $n = 2, 1.8$%; Middle Eastern: $n = 1, 0.9$%; Latin American: $n = 1, 0.9$%; British/Irish/Australian: $n = 1, 0.9$%).

The sample comprised of 54.4% ($n = 62$) of respondents who had attained a masters degree, 12.3% ($n = 14$) a PhD, 9.6% ($n = 11$) a DPsych, 16.7% ($n = 19$) a bachelor degree, and 7.0% ($n = 8$) specified other training qualifications. Approximately half of the sample indicated that their specialist area of practice was clinical psychology ($n = 62, 53.4$%), followed by counselling psychology ($n = 32, 27.6$%), and “other” ($n = 22, 19.0$%). Respondents had been practising psychotherapy for an average of 14 years
full-time ($SD = 9.79$), ranging from 1 to 44 years with a modal number of 20 years. Sample characteristics are presented in Table 3.

When asked about primary workplace setting, more than half of the respondents indicated working in individual private practice ($n = 70$, 61.9%), followed by group private practice ($n = 35$, 31.0%), public service ($n = 3$, 2.7%), “other” ($n = 2$, 1.8%), public hospital inpatient ($n = 1$, 0.9%), public hospital outpatient ($n = 1$, 0.9%), and private hospital outpatient ($n = 1$, 0.9%). Respondents indicated that they had an average current caseload of 20 clients per week ($SD = 7.97$), and reported spending on average 21 hours ($SD = 8.62$) engaged in client contact per week. Respondents indicated that their current caseloads comprised of 83.8% individual cases, 8.2% couple, 6.2% family, 0.8% group, and 1.0% “other”. In relation to age groups treated, the average current caseload comprised of 4.7 clients ($SD = 8.30$) treated were 12 years and younger, 6.8 clients ($SD = 10.80$) 13 to 19 years, 28.6 clients ($SD = 20.37$) 20 to 49 years, 12.9 clients ($SD = 11.89$) 50 to 64 years, and 3.3 clients ($SD = 2.92$) 65 years and older. Caseload data for the sample of respondents is presented in Table 4.
Table 3

*Characteristics of Responding Psychologists in Clinical Practice (N = 116)*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>%</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>31</td>
<td>27.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>83</td>
<td>72.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (in years)</td>
<td>112</td>
<td>48.4</td>
<td>12.2</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australian</td>
<td>90</td>
<td>78.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Zealand</td>
<td>4</td>
<td>3.5</td>
<td></td>
<td></td>
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<tr>
<td>European</td>
<td>5</td>
<td>4.4</td>
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<tr>
<td>British</td>
<td>5</td>
<td>4.4</td>
<td></td>
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<tr>
<td>Asian</td>
<td>3</td>
<td>2.6</td>
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<tr>
<td>Middle Eastern</td>
<td>1</td>
<td>0.9</td>
<td></td>
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</tr>
<tr>
<td>American</td>
<td>2</td>
<td>1.8</td>
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<tr>
<td>South African</td>
<td>2</td>
<td>1.8</td>
<td></td>
<td></td>
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<tr>
<td>Latin American</td>
<td>1</td>
<td>0.9</td>
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</tr>
<tr>
<td>British/Irish/Australian</td>
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<td>0.9</td>
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<tr>
<td>Degree</td>
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<td></td>
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<tr>
<td>Masters</td>
<td>62</td>
<td>54.4</td>
<td></td>
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<tr>
<td>PhD</td>
<td>14</td>
<td>12.3</td>
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<td></td>
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<tr>
<td>DPsych</td>
<td>11</td>
<td>9.6</td>
<td></td>
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<tr>
<td>Bachelor</td>
<td>19</td>
<td>16.7</td>
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</tr>
<tr>
<td>Diploma</td>
<td>4</td>
<td>3.5</td>
<td></td>
<td></td>
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<tr>
<td>Honours</td>
<td>4</td>
<td>3.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years in practice</td>
<td>112</td>
<td>14.1</td>
<td>9.8</td>
<td></td>
</tr>
<tr>
<td>Specialist areas of practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical</td>
<td>62</td>
<td>53.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling</td>
<td>32</td>
<td>27.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational and Developmental</td>
<td>4</td>
<td>3.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forensic Psychologist</td>
<td>1</td>
<td>0.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Neuropsychologist</td>
<td>1</td>
<td>0.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisational</td>
<td>2</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td>3</td>
<td>2.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generalist</td>
<td>9</td>
<td>7.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Reported sample sizes vary due to missing data.
Table 4
Caseload of Responding Psychologists in Clinical Practice (N = 116)

<table>
<thead>
<tr>
<th>Item</th>
<th>n</th>
<th>%</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average weekly client caseload(^a)</td>
<td>112</td>
<td></td>
<td>20.3</td>
<td>8.0</td>
</tr>
<tr>
<td>Primary practice setting(^a)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public hospital inpatient</td>
<td>1</td>
<td>0.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public hospital outpatient</td>
<td>1</td>
<td>0.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private hospital outpatient</td>
<td>1</td>
<td>0.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public service</td>
<td>3</td>
<td>2.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group private practice</td>
<td>35</td>
<td>31.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual private practice</td>
<td>70</td>
<td>61.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment modalities(^b)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>110</td>
<td>83.8</td>
<td>17.4</td>
<td></td>
</tr>
<tr>
<td>Couple</td>
<td>109</td>
<td>8.2</td>
<td>10.4</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>110</td>
<td>6.2</td>
<td>12.1</td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>110</td>
<td>0.8</td>
<td>2.7</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>109</td>
<td>1.0</td>
<td>7.9</td>
<td></td>
</tr>
<tr>
<td>Age of current caseload(^b)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 years and younger</td>
<td>72</td>
<td>4.7</td>
<td>8.3</td>
<td></td>
</tr>
<tr>
<td>13-19 years</td>
<td>88</td>
<td>6.8</td>
<td>10.8</td>
<td></td>
</tr>
<tr>
<td>20-49 years</td>
<td>107</td>
<td>28.6</td>
<td>20.4</td>
<td></td>
</tr>
<tr>
<td>50-64 years</td>
<td>102</td>
<td>12.9</td>
<td>11.9</td>
<td></td>
</tr>
<tr>
<td>65 years and older</td>
<td>77</td>
<td>3.3</td>
<td>2.9</td>
<td></td>
</tr>
</tbody>
</table>

Note. Data represent the characteristics of respondents’ current client caseload at the time of the survey. \(^a\) Sample size varies due to missing data. \(^b\) Multiple response variable.
Theoretical orientation.

The vast majority of respondents were classified as salient for the cognitive-behavioural orientation \((n = 108, 93\%)\), followed by client-centred \((n = 70, 60\%)\), behavioural \((n = 65, 56\%)\), analytic \((n = 55, 47\%)\), humanistic \((n = 49, 42\%)\), and systemic \((n = 30, 26\%)\) orientations (percentages exceed 100 as multiple ratings were allowed). Of the respondents, 85\% \((n = 96)\) had two or more salient orientations (Figure 6).

*Figure 6.* Respondents’ salient theoretical orientations. Frequencies represent the number of prominent or “salient” orientations endorsed by respondents \((n = 113)\). Orientations rated 3 (very) or 4 (extremely), on a rating scale ranging from 0 (not at all) to 4 (extremely) were categorised as salient.
Psychologists’ General Use of Homework

Frequency of homework use.

The majority of respondents \((n = 116, 97\%)\) reported the use of between-session activities in their current clinical practice. Respondents most frequently reported using between-session activities very often \((n = 49, 42.2\%)\), followed by always \((n = 28, 24.1\%)\), fairly many times \((n = 24, 20.7\%)\), and occasionally \((n = 15, 12.9\%)\). Respondents reported that they considered the use of between-session activities in therapy as being very \((n = 49, 42.2\%)\) or extremely \((n = 41, 35.3\%)\) important.

Types of homework assignments.

The frequency of respondents’ use of different types of between-session activities was examined. Respondents were asked to indicate on average how many different between-session activities they would usually recommend at each session. Approximately half of the respondents \((n = 63, 55.8\%)\) reported assigning one different activity per therapy session, followed by 37.2 \%(\(n = 42\)) who reported assigning two different activities per therapy session. During the first 10 therapy sessions, most respondents \((n = 50, 43.1\%)\) indicated that they would generally assign six or more different types of between-session activities for a client, followed by respondents who used three \((n = 17, 14.7\%)\), four \((n = 20, 17.2\%)\), or five \((n = 17, 14.7\%)\) activities.

Respondents were asked to indicate the three most common types of homework assignments they used in clinical practice. Respondents indicated predominantly using self monitoring assignments \((n = 62, 53.9\%)\), followed by the use of reading material (i.e., relevant to therapy or psychoeducation; \(n = 32, 27.8\%\)), relaxation strategies (e.g., controlled breathing, meditation; \(n = 31, 27.0\%\)), mindfulness techniques \((n = 29,\)
25.2%), and monitoring of cognitions (e.g., thought records; \( n = 25, 21.7\% \)). Due to multiple responses permitted for this variable, percentages exceed 100.

**Psychologists’ Use of Homework Procedures**

Respondents’ use of a range of homework procedures was examined, as outlined in a CBT homework enhancement protocol (i.e., 30 procedure items; Kazantzis, MacEwan, & Dattilio, 2005). Homework procedures were examined on an item level and by phase (i.e., design, assign, and review; Kazantzis, MacEwan, & Dattilio, 2005). These analyses are presented in the following section.

**Psychologists’ use of specific homework procedures.**

**Homework design (selecting tasks).**

When selecting between-session activities (i.e., design phase), respondents reported that they regularly explored clients’ coping strategies (\( M = 2.79, SD = 0.92 \)), 95% CIs [2.62, 2.96], selected tasks collaboratively with clients (\( M = 2.91, SD = 0.92 \)), 95% CIs [2.74, 3.08], considered client ability (\( M = 3.05, SD = 0.93 \)), 95% CIs [2.88, 3.22], presented a rationale (\( M = 3.29, SD = 0.98 \)), 95% CIs [3.11, 3.47], and presented a rationale that aligned with clients’ treatment goals (\( M = 3.12, SD = 0.88 \)), 95% CIs [2.96, 3.28]. Respondents reported rarely using guided imagery as part of in-session practice (\( M = 1.67, SD = 1.02 \)), 95% CIs [1.48, 1.86], or a disorder specific cognitive model and individualised conceptualisation (\( M = 1.91, SD = 1.27 \)), 95% CIs [1.68, 2.15], when selecting tasks in the design phase. Table 5 provides the mean and standard deviation scores, including confidence intervals, for respondents’ use of procedures in the homework design phase.
Table 5

Summary of Respondents’ Use of Procedures When Selecting Homework Tasks

(Homework Design Phase; N = 116)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present a rationale</td>
<td>116</td>
<td>3.29</td>
<td>0.98</td>
<td>[3.11, 3.47]</td>
</tr>
<tr>
<td>Present a rationale that aligns with clients’ goals</td>
<td>116</td>
<td>3.12</td>
<td>0.88</td>
<td>[2.96, 3.28]</td>
</tr>
<tr>
<td>Consider client ability</td>
<td>115</td>
<td>3.05</td>
<td>0.93</td>
<td>[2.88, 3.22]</td>
</tr>
<tr>
<td>Collaboratively select tasks</td>
<td>116</td>
<td>2.91</td>
<td>0.92</td>
<td>[2.74, 3.08]</td>
</tr>
<tr>
<td>Explore coping strategies</td>
<td>116</td>
<td>2.79</td>
<td>0.92</td>
<td>[2.62, 2.96]</td>
</tr>
<tr>
<td>Check perceived task difficulty</td>
<td>115</td>
<td>2.77</td>
<td>1.05</td>
<td>[2.57, 2.96]</td>
</tr>
<tr>
<td>In-session practice of task</td>
<td>114</td>
<td>2.51</td>
<td>1.02</td>
<td>[2.32, 2.70]</td>
</tr>
<tr>
<td>Identify beliefs and triggers for the task</td>
<td>115</td>
<td>2.47</td>
<td>1.02</td>
<td>[2.28, 2.66]</td>
</tr>
<tr>
<td>Use a disorder specific cognitive model and individualised conceptualisation</td>
<td>116</td>
<td>1.91</td>
<td>1.27</td>
<td>[1.68, 2.15]</td>
</tr>
<tr>
<td>Guided imagery as part of in-session practice</td>
<td>114</td>
<td>1.67</td>
<td>1.02</td>
<td>[1.48, 1.86]</td>
</tr>
</tbody>
</table>

Note. Respondents rated how often they had used various homework procedures when recommending between-session activities in the past three months, on a 5-point Likert scale ranging from 0 (not at all) to 4 (extremely). The item descriptions have been abbreviated with full descriptions provided in Appendix C.

**Homework assign (planning tasks).**

Respondents reported that when planning between-session activities (i.e., assign phase), they regularly obtained client feedback regarding the client’s readiness to carry out a task ($M = 2.86$, $SD = 1.04$), 95% CIs [2.67, 3.05], and emphasised between-session
activities as having a learning ‘experiment’ focus ($M = 2.96$, $SD = 0.98$), 95% CIs [2.78, 3.15]. However, in the assign phase, respondents were less consistent in asking clients to summarise the rationale for the task in relation to their therapy goals ($M = 1.64$, $SD = 1.00$), 95% CIs [1.46, 1.83]. The mean and standard deviation scores, including confidence intervals, for respondents’ use of procedures in the homework assign phase are presented in Table 6.

**Homework review.**

When reviewing homework (i.e., review phase), respondents reported regularly using most of the review procedures, however, did not report regular use of a theoretical framework to make sense of task non-completion or completion ($M = 2.38$, $SD = 1.08$), 95% CIs [2.18, 2.58]. Table 7 provides the mean and standard deviation scores, including confidence intervals, for respondents’ use of procedures in the homework review phase.
Table 6

*Summary of Respondents’ Use of Procedures When Planning Homework Tasks*

(*Homework Assign Phase; N = 116*)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emphasise learning 'experiment' focus</td>
<td>113</td>
<td>2.96</td>
<td>0.98</td>
<td>[2.78, 3.15]</td>
</tr>
<tr>
<td>Obtain feedback regarding readiness</td>
<td>114</td>
<td>2.86</td>
<td>1.04</td>
<td>[2.67, 3.05]</td>
</tr>
<tr>
<td>Obtain feedback regarding confidence</td>
<td>112</td>
<td>2.71</td>
<td>0.95</td>
<td>[2.54, 2.89]</td>
</tr>
<tr>
<td>Consider potential difficulties</td>
<td>114</td>
<td>2.70</td>
<td>1.04</td>
<td>[2.51, 2.89]</td>
</tr>
<tr>
<td>Specify how often the task will be practiced</td>
<td>115</td>
<td>2.36</td>
<td>1.00</td>
<td>[2.17, 2.54]</td>
</tr>
<tr>
<td>Specify when task practice will occur</td>
<td>114</td>
<td>2.34</td>
<td>1.06</td>
<td>[2.14, 2.54]</td>
</tr>
<tr>
<td>Obtain feedback regarding task importance</td>
<td>114</td>
<td>2.29</td>
<td>1.14</td>
<td>[2.08, 2.50]</td>
</tr>
<tr>
<td>Client has written summary of task</td>
<td>114</td>
<td>2.24</td>
<td>1.26</td>
<td>[2.00, 2.47]</td>
</tr>
<tr>
<td>Ask client to summarise the task</td>
<td>114</td>
<td>2.18</td>
<td>1.15</td>
<td>[1.97, 2.40]</td>
</tr>
<tr>
<td>Specify where task practice will occur</td>
<td>115</td>
<td>2.12</td>
<td>1.01</td>
<td>[1.92, 2.32]</td>
</tr>
<tr>
<td>Specify how long task practice will take</td>
<td>115</td>
<td>2.04</td>
<td>1.10</td>
<td>[1.84, 2.25]</td>
</tr>
<tr>
<td>Ask client to summarise rationale</td>
<td>114</td>
<td>1.64</td>
<td>1.00</td>
<td>[1.46, 1.83]</td>
</tr>
</tbody>
</table>

*Note.* Respondents rated how often they had used various homework procedures when recommending between-session activities in the past three months, on a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*). The item descriptions have been abbreviated with full descriptions provided in Appendix C.
Table 7

Summary of Respondents’ Use of Procedures When Reviewing Homework Tasks

(Homework Review Phase; N = 116)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide verbal reinforcement</td>
<td>113</td>
<td>3.35</td>
<td>0.90</td>
<td>[3.18, 3.51]</td>
</tr>
<tr>
<td>Discuss quantity of task completion</td>
<td>114</td>
<td>3.34</td>
<td>0.82</td>
<td>[3.19, 3.49]</td>
</tr>
<tr>
<td>Discuss reactions to task</td>
<td>114</td>
<td>3.13</td>
<td>0.91</td>
<td>[2.96, 3.30]</td>
</tr>
<tr>
<td>Discuss task non-completion</td>
<td>114</td>
<td>3.11</td>
<td>0.94</td>
<td>[2.93, 3.28]</td>
</tr>
<tr>
<td>Problem solve obstacles</td>
<td>113</td>
<td>3.05</td>
<td>0.92</td>
<td>[2.88, 3.22]</td>
</tr>
<tr>
<td>Record task completion in session notes</td>
<td>113</td>
<td>3.05</td>
<td>1.09</td>
<td>[2.85, 3.26]</td>
</tr>
<tr>
<td>Discuss quality of task completion</td>
<td>113</td>
<td>2.79</td>
<td>1.04</td>
<td>[2.59, 2.98]</td>
</tr>
<tr>
<td>Use of theoretical framework</td>
<td>114</td>
<td>2.38</td>
<td>1.08</td>
<td>[2.18, 2.58]</td>
</tr>
</tbody>
</table>

Note. Respondents rated how often they had used various homework procedures when recommending between-session activities in the past three months, on a 5-point Likert scale ranging from 0 (not at all) to 4 (extremely). The item descriptions have been abbreviated with full descriptions provided in Appendix C.

Psychologists’ overall use of homework procedures for each phase of homework integration.

Respondents’ overall use of homework procedures for each phase of homework administration (i.e., design, assign, review) were examined. The summed mean and standard deviation scores for each phase were obtained. The degree to which respondents’ used procedures in each phase was determined by dividing the summed mean score by the total possible score for the phase to obtain a percentage. This analysis
indicated that, on average, respondents mostly used homework review procedures \( (n = 114, 75.3\%) \), followed by design \( (n = 116, 65.9\%) \), and assign \( (n = 115, 58.7\%) \). Table 8 presents the findings of this analysis.

### Table 8

*Summary of Respondents’ Use of Homework Procedures for Each Phase of Homework Integration \( (N = 116) \)*

<table>
<thead>
<tr>
<th>Phase</th>
<th>( n )</th>
<th>( M )</th>
<th>( SD )</th>
<th>95% CI</th>
<th>% of total possible phase score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design (10 items)</td>
<td>116</td>
<td>26.35</td>
<td>7.02</td>
<td>[25.16, 27.72]</td>
<td>65.9</td>
</tr>
<tr>
<td>Review (8 items)</td>
<td>114</td>
<td>24.09</td>
<td>6.01</td>
<td>[22.97, 25.20]</td>
<td>75.3</td>
</tr>
<tr>
<td>Total Homework Integration (30 items)</td>
<td>116</td>
<td>77.95</td>
<td>21.23</td>
<td>[75.04, 82.55]</td>
<td>65.0</td>
</tr>
</tbody>
</table>

*Note.* Respondents rated how often they had used various homework procedures when recommending between-session activities in the past three months, on a 5-point Likert ranging from 0 (*not at all*) to 4 (*extremely*). Percentages were calculated for each phase by dividing the mean for the phase by the total possible score for the phase. The total possible scores for the design, assign, and review phases were 40, 48, and 32 respectively. The total possible homework integration score was 120.

**Psychologists’ use of a systematic approach to homework.**

Analyses were conducted to examine respondents’ systematic approach to homework integration according to different conceptualisations of systematic use, as discussed earlier in this chapter. These results are outlined in the following section.
**Planning Index.**

Only 12.9% ($n = 15$) of respondents were identified as systematic according to Shelton and Levy’s (1981) model (Planning Index). This analysis indicated that respondents reported to rarely specify when, where, how often, and how long to practice, and ensure the client has a written summary of the task (Hypothesis 1).

**CBT focused strategies.**

Respondents’ use of CBT focused strategies was examined. Comparatively few respondents ($n = 20, 17.2\%$) indicated using all 30 homework procedures in the CBT homework protocol (Kazantzis, MacEwan, & Dattilio, 2005) at least *fairly many times* in their clinical practice. Approximately half of the respondents ($n = 60, 51.7\%$) indicated using all 30 homework procedures at least *occasionally* in their clinical practice (Hypothesis 1). Table 9 presents the findings of these analyses (categories are not mutually exclusive).
Table 9

An Examination of Respondents’ Use of Homework Procedures According to Different Conceptualisations of Systematic Use ($N = 116$)

<table>
<thead>
<tr>
<th>Systematic Use</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CBT Focused</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very often</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fairly many times</td>
<td>20</td>
<td>17.2</td>
</tr>
<tr>
<td>Occasionally</td>
<td>60</td>
<td>51.7</td>
</tr>
<tr>
<td><strong>Behaviourally Focused</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very often</td>
<td>7</td>
<td>6.0</td>
</tr>
<tr>
<td>Fairly many times</td>
<td>43</td>
<td>37.1</td>
</tr>
<tr>
<td>Occasionally</td>
<td>88</td>
<td>75.9</td>
</tr>
<tr>
<td><strong>Cognitively Focused</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very often</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Fairly many times</td>
<td>29</td>
<td>25.0</td>
</tr>
<tr>
<td>Occasionally</td>
<td>68</td>
<td>58.6</td>
</tr>
<tr>
<td><strong>Planning Focused</strong></td>
<td>15</td>
<td>12.9</td>
</tr>
</tbody>
</table>

*Note.* Percentage of respondents who utilised homework procedures at least occasionally, at least fairly many times, and at least very often for the CBT, behaviourally, and cognitively focused conceptualisations of systematic use. The Planning Focused Index defines systematic use as per Shelton and Levy’s (1981) model of practice. Categories are not mutually exclusive.
The extent to which respondents used behaviourally focused and cognitively focused procedures, as outlined in the CBT homework protocol (Kazantzis, MacEwan, & Dattilio, 2005), was examined. The percentage of respondents who utilised these procedures at least occasionally, at least fairly many times, and at least very often was examined (percentages exceed 100 as categories are not mutually exclusive; Table 9). This analysis indicated a trend of respondents reportedly using behaviourally focused homework procedures to a greater extent than cognitively focused procedures (Figure 7).

*Figure 7.* Percentage of respondents who reported use of behaviourally focused and cognitively focused homework procedures, as outlined in a CBT homework protocol (Kazantzis, MacEwan, & Dattilio, 2005), in their clinical work in the past three months (percentages exceed 100 as categories are not mutually exclusive).
Indices of systematic use.

Respondents’ use of a systematic approach to homework was examined according to the four indices for systematic use developed for present study purposes. The findings indicated that approximately half of the present sample of psychologists were identified as systematic in their use of a broad range of cognitive-behavioural homework strategies at least occasionally in their clinical practice \( (n = 60, 51.7\%); \) CBT Focused Index). Approximately a quarter of the present sample of psychologists were identified as systematic in their use of a wide range of behaviourally focused homework strategies at least occasionally \( (n = 28, 24.1\%); \) Behaviourally Focused Index). A small proportion of the sample were reportedly systematic in their use of cognitively focused homework strategies at least occasionally \( (n = 8, 6.9\%); \) Cognitively Focused Index). Lastly, \( 17.2\% \) \( (n = 20) \) of the sample were reportedly non-systematic in their use of homework procedures (Non-Systematic Index). These findings are presented in Table 10.
Table 10

Respondents’ Systematic Use of Homework According to a Hierarchy of Indices of Systematic Use ($N = 116$)

<table>
<thead>
<tr>
<th>Index</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT Focused</td>
<td>60</td>
<td>51.7</td>
</tr>
<tr>
<td>Level 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaviourally Focused</td>
<td>28</td>
<td>24.1</td>
</tr>
<tr>
<td>Cognitively Focused</td>
<td>8</td>
<td>6.9</td>
</tr>
<tr>
<td>Level 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Systematic</td>
<td>20</td>
<td>17.2</td>
</tr>
</tbody>
</table>

Note. Indices are presented in a hierarchy. Hierarchy development was guided by a conceptual framework. For the CBT, behaviourally, and cognitively focused indices, percentages represent the proportion of respondents who utilised homework procedures at least occasionally in their clinical work in the past three months. The Non-Systematic Index represents the proportion of respondents who reported an irregular pattern of use of homework procedures.

Psychologists’ Training and Confidence in Using Homework

Respondents were asked to indicate the extent to which they had been trained in the specifics of how to integrate homework into therapy (i.e., according to theory, research, or recommended guidelines and models). Overall, most respondents ($n = 107, 92.2\%$) in the sample reported that they had been trained in how to integrate homework into therapy, however, to varying degrees with $19.8\%$ ($n = 23$) reporting having had a little training, $28.4\%$ ($n = 33$) somewhat, $31.9\%$ ($n = 37$) very, and $12.1\%$ ($n = 14$)
extremely. With regards to confidence in being able to integrate between-session activities into therapy according to theory, research, or recommended guidelines and models, only a small portion of respondents indicated being not at all ($n = 3, 2.6\%)$ or a little ($n = 2, 1.7\%)$ confident, $24.1\% (n = 28)$ reported being somewhat confident, approximately half ($n = 64, 55.2\%)$ reported being very confident, and $16.4\% (n = 19)$ extremely confident.

In order to examine the relationship between confidence and training, a Pearson product-moment correlation was conducted. Training and confidence were significantly correlated, with a strong positive correlation between the two variables, $r = .55, n = 116, p < .01$. This analysis indicated that respondents who had more training were also more confident in their ability to integrate homework into therapy.

**Systematic use.**

To examine the hypothesised effects of training and confidence on respondents’ use of a systematic approach to homework, comparisons were made between respondents who were systematic according to the four different indices of systematic use developed for present study purposes. These indices included: (i) CBT Focused; (ii) Behaviourally Focused; (iii) Cognitively Focused, and (iv) Non-Systematic. The mean training scores with 95% confidence intervals for each index of systematic use are presented in Figure 8. Figure 8 demonstrates that there was little observed difference in the extent of training among respondents who were systematic according to the four indices.
Respondents rated the extent to which they had been trained to integrate homework into therapy according to theory, research, or recommended guidelines and models, on a scale ranging from 0 (not at all) to 4 (extremely). Error bars represent 95% confidence intervals for observed mean training scores for each index of systematic use.

A one-way between-groups ANOVA confirmed that the observed difference in training for the four groups of systematic use was not statistically significant, at the adjusted alpha level of .025, $F(3, 112) = 2.02, p = .115, d = 0.47$ (Hypothesis 4). The mean confidence scores with 95% confidence intervals for each index of systematic use are presented in Figure 9. Figure 9 demonstrates that there was minimal observed difference in reported confidence in the use of homework procedures among respondents who were systematic according to the four indices.
Figure 9. Respondents rated confidence in their ability to integrate homework into therapy according to theory, research, or recommended guidelines and models, on a scale ranging from 0 (not at all) to 4 (extremely). Error bars represent 95% confidence intervals for observed mean confidence scores for each index of systematic use.

A one-way between-groups ANOVA confirmed that the observed difference in confidence for the four groups of systematic use was not statistically significant, at the adjusted alpha level of .025, Welch’s $F(3, 24.09) = 1.76, p = .181, d = 0.49$ (Hypothesis 5).

Discussion

Summary of Results

The use of a systematic approach to homework administration is proposed to yield better therapeutic outcomes (A. T. Beck et al., 1979; Shelton & Ackerman, 1974; Shelton & Levy, 1981). Although it has been demonstrated that specific therapist
homework strategies are associated with increased homework compliance (e.g., Cox et al., 1988; Detweiler & Whisman, 1999; Ley et al., 1977; Mahrer et al., 1994; Scheel et al., 1999), few studies have examined the clinical use of these strategies, with a limited scope of strategies examined. It is important to know which homework procedures practitioners are implementing in clinical practice so that therapeutic change may be optimised. A greater understanding of what occurs in routine clinical practice may ultimately lead to the development of evidence-based guidelines for homework integration, for which currently none exist. Further empirical work may also help guide the dissemination of empirical evidence to clinicians, and assist in monitoring changes and trends in service delivery (J. M. Cook et al., 2010).

The aim of the present study was to investigate psychologists’ use of a systematic approach to homework in clinical practice. To extend the empirical literature, the present study examined psychologists’ systematic use of a broad range of strategies founded on both principles of cognitive and behaviour change, as outlined in a homework protocol (Kazantzis, MacEwan, & Dattilio, 2005). Specifically, Study 1 aimed to contrast the ecological validity of the indices of systematic homework use derived from two practitioner homework enhancement models: (i) Shelton and Levy’s (1981) behavioural model, and (ii) Kazantzis, MacEwan, and Dattilio’s (2005) cognitive-behavioural model. Study 1 also aimed to contribute to the literature by examining the influence of training on therapists’ use of a systematic approach. A survey methodology was utilised.

It was hypothesised that systematic homework use conceptualised as per Kazantzis, MacEwan, and Dattilio’s (2005) model would better represent practitioners’
self-reported practices than Shelton and Levy’s (1981) model (Hypothesis 1). This prediction was supported. Only 12.9% of the present sample reported regularly specifying when, where, how often, and how long to practice, and ensuring the client has a written summary of the task, *very often or always* in their clinical work (Shelton & Levy, 1981). An examination of systematic use, according to a CBT homework protocol (Kazantzis, MacEwan, & Dattilio, 2005), showed that a moderate proportion of the present sample of psychologists were classified as systematic in their use of cognitive-behavioural homework strategies (51.7%; CBT Focused Index), followed by behaviourally focused strategies (24.1%; Behaviourally Focused Index), and cognitively focused strategies (6.9%; Cognitively Focused Index), with a small portion classified as non-systematic in their use of homework strategies (17.2%; Non-Systematic Index). Therefore, systematic homework use conceptualised as per Kazantzis, MacEwan, and Dattilio’s model (51.7%) was found to better represent the present sample of psychologists’ self-reported practices than Shelton and Levy’s model (12.9%).

Contrary to Hypothesis 4, obtained results indicate that there were no significant group differences in training in homework among psychologists who were systematic and non-systematic, according to the four indices of systematic use examined. Most of the present sample reported that they had been trained in how to integrate homework into therapy at some level (92.2%). Further, it was hypothesised that psychologists who had more confidence in being able to administer homework, according to theory, guidelines, and models, would be more systematic in their use of homework procedures (Hypothesis 5). This prediction was not supported. A large proportion of the present
sample were found to report being at least very confident in their ability to use homework (71.6%).

Two of the study’s hypotheses related to theoretical orientation could not be examined as intended. It was hypothesised that cognitive-behavioural therapists would report using a systematic approach for the administration of homework to a greater extent than therapists from other theoretical orientations, on all indices of systematic homework use (Hypothesis 2). It was also hypothesised that cognitive-behavioural therapists would report using homework assignments to a greater extent than therapists from other theoretical orientations (Hypothesis 3). In the present study, efforts were undertaken to gain a more accurate measure of theoretical orientation. Many therapists have been found to endorse techniques outside of their self-identified orientation (Thoma & Cecero, 2009). Therefore, in the present study, respondents were not asked to indicate which theoretical orientations they most identified with, as has been conducted in previous research (e.g., Deane et al., 2005; Kazantzis, Busch, et al., 2006), rather to indicate which therapeutic approaches influenced their practice from a broad list of 23 approaches. This data was then coded into superordinate categories (Appendix B). The findings showed that 93% of the sample was homogeneous and identified practising from a cognitive-behavioural therapeutic approach. The prominence of the CBT approach in the present sample is consistent with Australian survey data which indicates that CBT is the most popular training approach in Australian universities (Kazantzis & Munro, 2011; Pachana, O'Donovan, & Helmes, 2006). Therefore, due to the highly homogenous sample of respondents in the present study, the main effect of theoretical orientation could not be examined.
The main findings of Study 1 are discussed further in the following section. The strengths and limitations of Study 1 are also discussed. Implications of the findings and future research directions are discussed in Chapter 9.

Main Findings

Psychologists’ general use of homework.

In order to understand psychologists’ use of a systematic approach to homework, it is important that this is considered in the context of their general use of homework. A total of 97% of the present sample of psychologists indicated using homework in their clinical work. This finding is consistent with previous research which has found a high rate of reported homework use among psychologists (Deane et al., 2005; Kazantzis & Deane, 1999) and other mental health professionals (Kazantzis, Busch, et al., 2006; Kelly et al., 2006). A high rate of reported homework use in the present sample of psychologists, who mostly identified practising from a CBT approach, is consistent with the CBT approach to treatment in which homework is considered an essential part of therapy (A. T. Beck et al., 1979). Approximately 78% of the present sample of psychologists indicated that homework assignments were considered to be at least a very important aspect of therapy. Thus, the present samples’ reported use of homework corresponded with their view that homework was an integral component of therapy.

The finding that approximately half of the present sample of Australian psychologists (55.8%) indicated that they assigned one different homework task at each session, followed by 37.2% who assigned two different tasks at each session, is inconsistent with previous research. Kazantzis, Lampropoulos, and Deane (2005) found that a greater proportion of the sample of American psychologists surveyed indicated
assigning one different homework task at each session (77%) compared to those in the present study (55.8%). The present sample of psychologists reported assigning two different tasks at each therapy session (37.2%) to a greater extent than the sample of psychologists in Kazantzis, Lampropoulos, and Deane’s study (20%). It is possible that these differences observed across studies may be related to theoretical orientation. The sample in Kazantzis, Lampropoulos, and Deane’s study comprised mostly of CBT (n = 324, 39%) and psychodynamic/analytic (n = 200, 24%) practising psychologists, whereas the present sample of psychologists were predominantly CBT (93%) practitioners. However, this seems unlikely as in Kazantzis, Lampropoulos, and Deane’s study, CBT practitioners were not found to differ from practitioners from other theoretical orientations with regards to the average number of different homework tasks recommended at each session. Another possible explanation for these observed differences may be related to differences in training between Australian and American psychologists. Empirical work indicates that trainees generally transfer CBT skills from training to practice (e.g., Ashworth et al., 1999; Mathleson et al., 2010; Myles & Milne, 2004). As most of the present sample of psychologists indicated having been trained at some level on how to integrate homework into therapy (92.2%), this may have been a factor that contributed to their implementation of homework. Training, however, was not assessed in Kazantzis, Lampropoulos, and Deane’s study.

The present sample of psychologists indicated assigning a greater number of different types of homework assignments during the first 10 therapy sessions than was found in previous research (Kazantzis, Lampropoulos, & Deane, 2005). Most of the present sample of psychologists (n = 50, 43.1%) indicated that they generally assigned
six or more different types of homework tasks during the first 10 therapy sessions for a client, followed by psychologists who assigned four \((n = 20, 17.2\%)\), three \((n = 17, 14.7\%)\), or five \((n = 17, 14.7\%)\) different tasks. By contrast, Kazantzis, Lampropoulos, and Deane (2005) found that most of the sample of psychologists surveyed estimated that they assigned two \((24\%)\), three \((30\%)\), or four \((14\%)\) different types of homework tasks during the first 10 therapy sessions. It is important to note, that in Kazantzis, Lampropoulos, and Deane’s study significant group differences were found for theoretical orientation, with CBT practitioners found to assign a greater number of different homework tasks in the first 10 therapy sessions than their non-CBT counterparts. Therefore, the subsample of CBT practitioners in Kazantzis, Lampropoulos, and Deane’s study were compared to the present sample of mostly CBT psychologists, with the average number of different homework tasks assigned in the first 10 sessions of therapy examined. This analysis indicated minimal difference in the mean number of different tasks assigned in the first 10 sessions of therapy between the present sample of psychologists \((M = 4.62, SD = 1.50)\) and CBT practitioners in Kazantzis, Lampropoulos, and Deane’s study \((M = 3.61, d = 0.29)\). These findings suggest that on average CBT practitioners assign three to four different homework tasks in the first 10 therapy sessions with a client.

The most common types of homework assignments utilised by the present sample of psychologists were self-monitoring tasks \((53.9\%)\), followed by reading material \((27.8\%)\), relaxation strategies \((27.0\%)\), mindfulness techniques \((25.2\%)\), and monitoring of cognitions \((21.7\%)\). These homework assignments are frequently used in CBT treatment (A. T. Beck et al., 1979; Dimidjian & Linehan, 2008; Fehm & Kazantzis,
2004; Kazantzis & Dattilio, 2010), thus consistent with the present samples’ theoretical orientation. A strength of the present study was that an open ended question was used to assess types of homework assignments used rather than a forced choice approach (Fehm & Kazantzis, 2004; Kazantzis & Dattilio, 2010), thus not limiting responses. It is therefore difficult to make direct comparisons across studies. Nevertheless, the present study findings are generally consistent with previous research which has found that CBT practitioners commonly report the use of self-monitoring tasks, cognitive restructuring tasks, and tasks that require the client to engage in new behaviour (e.g., applying a new technique; Fehm & Kazantzis, 2004; Kazantzis & Dattilio, 2010), as well as reading material (Kazantzis & Dattilio, 2010).

**Psychologists’ use of homework integration procedures.**

The present study findings showed that the sample of psychologists reportedly used a broad range of cognitive-behavioural homework enhancement strategies in their clinical work, however, were not consistent in their use of all strategies outlined in the CBT homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005). The present sample of psychologists reportedly used mostly homework review procedures (75.3%), followed by homework design (i.e., selecting tasks; 65.9%), and homework assign (i.e., planning tasks; 58.7%) procedures. This finding is consistent with previous practitioner survey research which has found greater reported use of homework review and design procedures over assign procedures (Deane et al., 2005; Houlding, Schmidt, & Walker, 2010; Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kelly et al., 2006). These findings indicate that therapists are often using homework enhancement
strategies in the selection and review of tasks, however, are less consistent in their use of homework planning strategies.

If the present samples’ self-reported homework behaviours are representative of practice, the present findings suggest that clients are less likely to have a well developed, clear, and specific plan about how to carry out a homework task. From a theoretical and empirical perspective, task completion is less likely to occur with a lack of planning as the client may not have anticipated potential obstacles to completion (Ajzen & Fishbein, 1977; Gollwitzer, 1999; Gollwitzer & Sheeran, 2006). The theory of planned behaviour contends that having an intention to perform a behaviour does not always lead to action (Ajzen, 1985, 1988), as the individual may not be aware of factors that may hinder goal attainment (Gollwitzer, 1999; Gollwitzer & Sheeran, 2006). Goal attainment has been found to be enhanced by the formation of plans, specifically plans that specify when, where, and how an individual intends to pursue a goal (i.e., implementation intentions; Gollwitzer & Sheeran, 2006; Oettingen et al., 2000; Webb & Sheeran, 2004). Thus, client engagement with homework is likely to be compromised with a lack of planning, and ultimately the achievement of optimal therapeutic outcomes.

Obtained results indicate that specific homework procedures were rarely utilised. The present sample of psychologists were reportedly less consistent in using a disorder specific cognitive model and individualised conceptualisation when selecting tasks, and using a theoretical framework to make sense of task non-completion or completion. Consistent with previous research, the present sample of psychologists reported rarely using guided imagery as part of in-session practice, assessing client readiness to carry
out the task, and asking clients to summarise task rationale in relation to therapy goals (Houlding et al., 2010). A possible explanation for practitioners’ irregular use of particular homework enhancement strategies may be related to a lack of training in the use of these procedures. For instance, the need to tailor homework assignments to the client’s individualised cognitive conceptualisation is a recommendation in the protocol (Kazantzis, MacEwan, & Dattilio, 2005) not featured in previous homework models. Thus, perhaps practitioners are less familiar with this strategy and therefore are not implementing it. It is also possible that therapists’ clinical decisions to implement particular strategies may be influenced by other factors such as client resistance. Therapists’ selection of interventions have been found to be influenced by a client’s level of resistance (e.g., Beutler, Rocco, Moleiro, & Talebi, 2001; Kazantzis, Ford, & Dattilio, 2012).

*Psychologists’ use of a systematic approach to homework.*

As predicted, the results of Study 1 provide support for the hypothesis that systematic homework use conceptualised as per Kazantzis, MacEwan, and Dattilio’s (2005) model would better represent practitioners’ self-reported practices than Shelton and Levy’s (1981) model (Hypothesis 1). Only 12.9% of the present sample of psychologists reported regularly specifying when, where, how often, and how long to practice, and ensuring the client has a written summary of the homework task (Planning Index). This result is consistent with findings from previous practitioner samples which have similarly found that few report a practice consistent with Shelton and Levy’s model (i.e., Deane et al., 2005; Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kelly et al., 2006). Moreover, the present sample of psychologists endorsed a systematic
approach to a similar extent as broad samples of mental health professionals (12%, Kazantzis, Busch, et al., 2006; 15%, Kelly et al., 2006) but less than previous samples of psychologists (23%, Deane et al., 2005; 25%, Kazantzis & Deane, 1999). The reason for this observed difference across studies may be associated with characteristics of the present sample, including differences in training and the emphasis on CBT. Recent survey findings indicate that most CBT training in Australian and New Zealand universities is integrated as an emphasis in clinical training programme units, with few universities offering individual academic units focused exclusively on CBT, and only one university found to offer a post-qualification training course in CBT (Kazantzis & Munro, 2011). In addition, previous studies in this area have omitted to assess pre-post-qualification training in this specific aspect of CBT practice, whereas 92.2% of the present sample reported that they had been trained in how to integrate homework into therapy at some level.

A further strength of the present study was the investigation of a broad range of specific therapist homework behaviours, as outlined in a homework protocol (Kazantzis, MacEwan, & Dattilio, 2005). Previous research was limited in that it examined practitioners’ systematic use of homework primarily based on Shelton and Levy’s (1981) model, which focuses primarily on planning strategies and principles of behaviour change (i.e., Deane et al., 2005; Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kelly et al., 2006), and were published prior to the development of the protocol (Kazantzis, MacEwan, & Dattilio, 2005). Therefore, the inclusion of strategies founded on principles of both cognitive and behaviour change required a re-conceptualisation of the concept of “systematic” homework use in the present study.
The operationalisation of systematic use was expanded for present study purposes from the narrow definition utilised in previous research in order to account for important cognitive and behavioural theory determinants of homework engagement (see discussion in Chapters 2 and 4). Guided by an integrative conceptual framework, psychologists’ systematic use was examined using four indices, as outlined earlier in this chapter. These indices were CBT Focused, Behaviourally Focused, Cognitively Focused, and Non-Systematic. The findings indicate that a moderate proportion of the present sample of psychologists were classified as systematic in their use of cognitive-behavioural homework strategies (51.7%; CBT Focused Index), followed by behaviourally focused strategies (24.1%; Behaviourally Focused Index), and cognitively focused strategies (6.9%; Cognitively Focused Index). A small portion of the sample were classified as non-systematic in their use of homework strategies (17.2%; Non-Systematic Index). Psychologists who were non-systematic indicated an irregular pattern of use of homework strategies in their clinical work. Thus, when data were analysed according to these indices, psychologists who had been classified as systematic according to Shelton and Levy’s (1981) model were all re-classified as systematic according to one of the four indices (i.e., CBT Focused Index, Behaviourally Focused Index, Cognitively Focused Index). Therefore, the present study findings provide support for the use of the CBT homework protocol (Kazantzis, MacEwan, & Dattilio, 2005) as a useful framework for conceptualising therapist homework practices. When systematic use was examined according to important cognitive and behavioural theory determinants of homework engagement, a large proportion of the present sample were classified as using a systematic approach (82.7%) compared to previous research that
has defined systematic use based primarily on planning strategies and principles of behaviour change (i.e., findings ranged from 12% - 25%; Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999).

In more recent times and during the course of the present research, a practitioner survey was published which examined therapists’ routine use of a broad range of homework enhancement strategies (Houlding et al., 2010), as outlined in the CBT homework protocol (Kazantzis, MacEwan, & Dattilio, 2005). Thirty-two youth therapists completed a survey about their use of homework procedures. They were asked to indicate whether they routinely used a broad range of homework procedures (‘yes/no’). “Routinely” was defined as “the use of a strategy at any point in therapy with most clients” (Houlding et al., 2010, p. 105). More than half of the therapists indicated routine use of most (83%) of the procedures. The definition of “routine” use in Houlding et al.’s (2010) study is considered rather broad and imprecise. Due to the differences in measurement of therapist homework practices in the present study and Houlding et al.’s study, it is difficult to make direct comparisons. However, it is apparent that what constitutes competent or “best” practice for therapeutic homework delivery has not been well defined in the empirical literature.

It is possible that factors such theoretical orientation and attitudes contributed to the pattern of systematic use observed in the present sample. CBT practitioners have been found to report the use of a systematic approach to homework, as per Shelton and Levy’s (1981) model, more than non-CBT practitioners (Kazantzis & Deane, 1999). In the present study, 93% of the sample were identified as CBT practitioners, with 56% of the sample identified as salient for behavioural approaches. Therefore, the finding that
51.7% of the present sample utilised a systematic approach that was CBT focused, followed by 24.1% that used a behaviourally focused approach, is consistent with the present samples’ identified theoretical orientations. These results are consistent with the emphasis afforded to homework in cognitive-behavioural and behavioural therapies, in which it is considered an integral component of treatment (A. T. Beck et al., 1979; Kazantzis & L’Abate, 2005; Shelton & Levy, 1981). However, it is important to note that in the present sample of respondents who mostly identified as CBT practitioners, only half were found to report the systematic use of CBT focused homework strategies. As a large proportion of the present sample identified as having two or more salient orientations, perhaps more stringent adherence to CBT focused systematic procedures would be expected from ‘purist’ CBT practitioners. It is also possible that the present sample of psychologists may have held positive attitudes toward homework that determined their use of a systematic approach to homework. CBT practitioners have reported more positive attitudes toward homework compared to psychoanalytic practitioners (Fehm & Kazantzis, 2004; Kazantzis, Lampropoulos, & Deane, 2005).

Theoretically, each of the 30 strategies outlined in the CBT homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005) are proposed to determine client homework engagement (as discussed in Chapters 2 and 4). The present study findings indicate the clinical relevance of the 30 homework procedure items outlined in protocol (Kazantzis, MacEwan, & Dattilio, 2005). However, only a moderate proportion of the present sample reported systematic use of CBT focused procedures (51.7%). Therefore, if the present samples’ self-reported behaviours are reflective of practice, from a theoretical perspective it is proposed that client homework engagement
is likely to be compromised. Consequently, treatment outcomes are likely to be less than optimal (Kazantzis et al., 2010; Mausbach et al., 2010). Although approximately a quarter of the sample reported use of a systematic approach that was behaviourally focused, theoretically, important cognitive theory determinants of homework engagement also need to be implemented. For instance, discussing client reactions to a task, asking about perceived task difficulty, identifying beliefs and triggers for the task, and presenting a rationale, are all factors proposed to determine homework engagement (A. T. Beck et al., 1979; Kazantzis, MacEwan, & Dattilio, 2005).

Many of the procedures in the CBT homework protocol (Kazantzis, MacEwan, & Dattilio, 2005) have empirical support (e.g., Bryant et al., 1999; Cox et al., 1988; Detweiler & Whisman, 1999; Mahrer et al., 1994). However, there is a need for focused evaluations of the protocol to evaluate the extent to which it leads to enhanced homework engagement. Therefore, the extent to which all 30 of the homework strategies in the protocol need to be utilised by practitioners in order to enhance compliance, remains an empirical question. Study 2 of the present research provides an initial experimental test of the protocol on homework compliance.

Psychologists’ training and confidence in using homework.

It was hypothesised that psychologists who have had more training in how to integrate homework into therapy according to theory, guidelines, and models, would be more systematic in their use of homework procedures (Hypothesis 4). The results of Study 1 do not provide support for this hypothesis. No significant differences in training were observed among the present sample of psychologists who used a systematic approach that was cognitive-behaviourally focused, behaviourally focused, or
cognitively focused, and those who were non-systematic. These findings suggest that training may not be a determining factor for the present sample of psychologists’ use of a systematic approach. It is important to note, however, that most of the present sample of psychologists reported that they had been trained in how to integrate homework into therapy (92.2%), however, to varying degrees. Therefore, it may have been difficult to detect potential differences in training in a predominantly trained sample. Another possibility is that the present study’s efforts to survey prior training, through a brief self-report item (i.e., one question) were ineffective in capturing the range of training possible (i.e., comprehensive coverage of how to integrate homework based on case formulation through coverage of behavioural specificity).

A strength of the present study was that the influence of training on practising practitioners’ use of a systematic approach to homework was examined, as factors that may affect psychologists’ use of systematic approach have not been surveyed. A large proportion of the present sample indicated that they had been trained in how to use homework (92.2%) and were classified as using a systematic approach to homework at some level (82.7%; i.e., CBT Focused, Behaviourally Focused, or Cognitively Focused Index). These findings are consistent with the empirical literature on CBT skills transfer which has found that trainees generally transfer CBT skills which include homework techniques, from training to clinical practice (Ashworth et al., 1999; Kennedy-Merrick et al., 2008; Mathleson et al., 2010; Myles & Milne, 2004).

It was also hypothesised that psychologists who have more confidence in being able to administer homework according to theory, research, or recommended guidelines, would be more systematic in their use of homework procedures (Hypothesis 5). The
results of Study 1 do not provide support for this hypothesis. No significant differences in reported confidence were found among the present sample of psychologists who used a systematic approach that was cognitive-behaviourally focused, behaviourally focused, or cognitively focused, and those who were non-systematic. Approximately half of the present sample of psychologists reported being very confident (55.2%) and 16.4% reported being extremely confident in their ability to use homework. This finding is consistent with previous research conducted by Kennedy-Merrick et al. (2008) in which a sample of mental health professionals, comprising of psychologists, reported a high level of perceived confidence in using a range of CBT techniques which included designing, assigning, and reviewing homework, following CBT training (i.e., PGDipCBT). A significant positive correlation was found between training and confidence ($r = .55$) in the present study. These findings suggest that training is associated with increased confidence in the use of homework procedures.

**Limitations**

In addition to the limitations discussed above, the present research had several other limitations that need to be acknowledged. First, the small sample size limits the generalisability of findings. Second, the research topic may have been a cause for bias. It is possible that respondents with a particular interest in homework (e.g., CBT therapists) may have chosen to participate in the current study, potentially inflating responses. Third, the present study data represents psychologists’ self-reported reflections of their practice and not actual implementation of homework procedures. Perceived degree of training was also assessed using self-report which may not accurately reflect actual training undertaken. Thus, the reliability and validity of the self-
report data may have been limited by socially desirable responding and possible inaccurate reporting, factors that are unavoidable in practitioner surveys.

**Conclusion**

The results of Study 1 provide support for the hypothesis that systematic homework use conceptualised as per Kazantzis, MacEwan, and Dattilio’s (2005) model would better represent practitioners’ self-reported practices than Shelton and Levy’s (1981) model. Systematic homework use conceptualised as per Kazantzis, MacEwan, and Dattilio’s model (51.7%) was found to better represent the present sample of psychologists’ self-reported practices than Shelton and Levy’s model (12.9%). The hypothesised effects of theoretical orientation on respondents’ use of homework assignments and homework procedures could not be examined due to a highly homogenous sample of respondents who identified practising from a CBT approach. The results did not provide support for the hypothesis that psychologists who had more training in how to integrate homework into therapy would be more systematic in their use of homework procedures. It is possible that it may have been difficult to detect potential differences in training in a predominantly trained sample. Further, Study 1 results do not provide support for the hypothesis that psychologists who have more confidence in being able to administer homework would be more systematic in their use of homework procedures. A majority of the present sample were found to report a high level of confidence in their ability to use homework in therapy. The extent to which all of the homework strategies examined in Study 1, as outlined in a CBT homework protocol (Kazantzis, MacEwan, & Dattilio, 2005), need to be utilised by practitioners in order to enhance compliance, remains an empirical question. Study 2 of the present
research provides an initial experimental test of the protocol (Kazantzis, MacEwan, & Dattilio, 2005) on homework compliance.
CHAPTER 8

STUDY 2

Overview

The finding that homework compliance is associated with enhanced treatment outcomes is well established in the empirical literature, as discussed in Chapter 3. However, further empirical work is needed to better understand the determinants of client homework engagement. A factor that has been found to determine client homework engagement is therapist behaviour. The limited empirical work conducted to date indicates that specific therapist behaviours enhance homework compliance, (Bryant et al., 1999; Conoley et al., 1994; Cox et al., 1988; Detweiler-Bedell & Whisman, 2005; Mahrer et al., 1994; Scheel et al., 1999; Worthington, 1986) with some inconsistencies in findings (Startup & Edmonds, 1994). Of note, these empirical efforts have mostly examined a limited scope of therapist behaviours. However, a large number of therapist methods for enhancing compliance have been proposed in the literature. As critically reviewed in Chapter 4, different practitioner models for homework enhancement have been proposed, some that are behaviourally focused and others that integrate behavioural and cognitive theoretical determinants of homework compliance. A model that aptly consolidates the numerous recommendations of previous homework enhancement models, as well as extends past work is the cognitive-behavioural homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005). Both behavioural and cognitive principles of behaviour change underpin this protocol. Whilst some propositions in the protocol have empirical support, there is a need for focused
evaluations of the protocol to evaluate the extent to which it leads to enhanced homework compliance and positive beliefs about therapeutic homework.

**Aims and Hypotheses**

The aim of Study 2 was to extend previous research by providing an initial experimental test of a cognitive-behavioural homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005) on homework compliance, using a self-monitoring task with a non-clinical sample, in an analogue study design. The comparison condition involved the use of homework integration procedures generally used in clinical practice.

Based on the theoretical and empirical literature, as discussed in Chapters 2, 4, and 5, two hypotheses were proposed for Study 2. It was hypothesised that participants in the experimental condition would have higher levels of homework compliance than participants in the control condition (Hypothesis 1). It was also hypothesised that participants in the experimental condition would have more positive beliefs about homework than participants in the control condition (Hypothesis 2).

**Method**

The present study was conducted as part of a larger analogue research project which investigated factors that affect homework compliance. The project comprised of four experimental conditions: the two conditions in the present study and two additional theoretically independent comparison conditions. The present study was approved by the Human Ethics Committee at La Trobe University (FHEC 10/R49).
Participants

Sixty-seven adults participated in the study. Participants’ ages ranged between 18 and 51 years, with a mean age of 25.8 years. The sample was 76.1% \((n = 51)\) female and 23.9% \((n = 16)\) male. Participants were recruited from a participant pool database of student volunteers compiled by the La Trobe University School of Psychological Science and members of the community who had expressed interest to participate in psychological research. Inclusion criteria were: being aged between 18 and 65 years; proficient in reading, writing, and conversing in English; free of current mental illness, and no history of significant brain injury or memory deficits. Participants were asked to consider the eligibility criteria, as outlined on the project flyer or provided via email, and determine their own suitability for the study. The demographic characteristics of the sample are presented in Table 11.
Table 11

Summary of Participant Demographic Characteristics ($N = 67$)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>$n$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>16</td>
<td>23.9</td>
</tr>
<tr>
<td>Female</td>
<td>51</td>
<td>76.1</td>
</tr>
<tr>
<td>Marital status</td>
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<td></td>
</tr>
<tr>
<td>Single</td>
<td>53</td>
<td>79.1</td>
</tr>
<tr>
<td>Married</td>
<td>13</td>
<td>19.4</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>48</td>
<td>72.7</td>
</tr>
<tr>
<td>Technical</td>
<td>3</td>
<td>4.5</td>
</tr>
<tr>
<td>Medical</td>
<td>3</td>
<td>4.5</td>
</tr>
<tr>
<td>Educational</td>
<td>4</td>
<td>6.1</td>
</tr>
<tr>
<td>Hospitality</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Office worker</td>
<td>4</td>
<td>6.1</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>4.5</td>
</tr>
<tr>
<td>Ethnicity</td>
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<td></td>
</tr>
<tr>
<td>Australian</td>
<td>32</td>
<td>48.5</td>
</tr>
<tr>
<td>European</td>
<td>8</td>
<td>12.1</td>
</tr>
<tr>
<td>Asian</td>
<td>18</td>
<td>27.3</td>
</tr>
<tr>
<td>American</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>British</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Irish</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>7.6</td>
</tr>
</tbody>
</table>
Statistical Power

In order to estimate the required sample size likely to detect a meaningful effect for the present study, a power analysis was conducted \textit{a priori}. Statistical power is the probability of obtaining statistically significant results in data analysis (Cohen, 1988). The required sample size can be computed by estimating the alpha level, desired power, and effect size (Cohen, 1988). Effect size refers to the amount of variance in the dependent variable accounted for by the independent variable (Tabachnick & Fidell, 2007). Reporting statistical significance alone is considered inadequate as it does not indicate the magnitude of the effect being investigated (Rossi, 1990). The effect size provides an indication of the practical and theoretical importance of the relation between variables. The effect size for a study can be estimated based on previous research.

An appropriate effect size index was not available for the present study. Previous research has largely examined the association between: (i) homework compliance and treatment outcome (e.g., Kazantzis et al., 2010, meta-analysis); (ii) specific therapist behaviours and homework compliance (e.g., Conoley et al., 1994; Detweiler-Bedell & Whisman, 2005; Worthington, 1986); (iii) therapist competence and homework compliance (Bryant et al., 1999), and (iv) therapist competence and treatment outcome (Ryum et al., 2010; Shaw et al., 1999). Homework research is known to have low statistical power issues (Kazantzis, 2000). As previous research has been predominantly correlational and the present study is a preliminary experimental test of the use of a CBT homework protocol (Kazantzis, MacEwan, & Dattilio, 2005) on homework compliance, the effect size was calculated following an initial phase of data collection \((n = 33)\). An \textit{a priori} power analysis was conducted using G*Power 3 (Faul et al., 2007), a power
analysis program, which computed a sample size of 92 given a medium effect size of $f^2 = .15$ as defined by Cohen (1988), $\alpha = .05$ and power $(1-\beta) = .8$.

**Recruitment Strategy**

Data collection occurred in two phases. In Phase 1, data were collected over a period of 3 months, from August 2010 to October 2010. Due to insufficient statistical power, further data collection was undertaken over a period of 5 months from May 2011 to September 2011. A total of 42 participants who attended all sessions had the opportunity to enter into an equal chance draw to win one of five $100 retail vouchers. Due to a low response rate to recruitment efforts, a total of 25 participants were compensated with a $20 retail voucher for attending all sessions. Notably, recruitment issues included: (i) individuals choosing not to participate as the demands of participation were considered high (e.g., the need to attend 2 sessions, the need to complete a self-monitoring task for 7 days), and (ii) participant non-attendance which resulted in the cancellation of groups due to insufficient numbers to run a group. Consequently, it was not feasible to recruit the desired sample ($n = 92$; see section on statistical power in this chapter) within the specified time-frame.

**Design**

In the present study, an experimental analogue study design was utilised. Analogue research allows for the investigation of conditions that occur in real life settings to be simulated under controlled conditions (Kazdin, 2003). This design was considered appropriate for present study purposes as the practical and ethical issues of

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2 The power level of the statistical tests $(1 - \beta)$ for data analysed in Phase 1 ($n = 33$) ranged from .1427 to .3750. These analyses indicated insufficient power as a power level of .80 or higher (80 percent chance of detecting a difference) is considered ideal (Cohen, 1988).
conducting research in a clinical setting can be circumvented (Kazdin, 2003). It allows for tight control to be exercised over the implementation of interventions, consequently minimising confounds and increasing internal validity (B. G. Cook & Rumrill, 2005). Although external validity is decreased and the generalisability of findings to real life settings is compromised in analogue research, the methodology is recommended for preliminary investigations which can then inform future research conducted in real life settings (B. G. Cook & Rumrill, 2005). Therefore, the sessions conducted in the present study were not therapy but rather they were analogue to therapy.

A single-blind randomised controlled independent samples design was employed in the present study. In order to minimise demand characteristics, some form of deception was utilised with participants naive to the aims of the experiment (i.e., approved by the Human Ethics Committee). That is, participants were not aware that the study was examining their levels of homework engagement, instead they were informed that the study involved learning about “what makes them happy”. Participants were randomly assigned to one of two conditions: experimental or control. In the experimental condition, homework was administered following a CBT homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005). In the control condition, homework was implemented according to the strategies reportedly used by practitioners in general clinical practice, as outlined in the following section. Figure 10 presents the participant flow through the present experimental study.
Figure 10. Participant flow through the present experimental study.
To be analogue to therapy, the homework task utilised in the present study was a self-monitoring activity, a task frequently used in CBT treatment (A. T. Beck et al., 1979) and by practitioners (Fehm & Kazantzis, 2004; Humphreys, Marx, & Lexington, 2008; Kazantzis & Dattilio, 2010). Participants were asked to complete the standardised homework assignment over 7 days, the duration clients often have between therapy sessions.

Group sessions were conducted as they were considered a suitable and effective means of delivering the interventions and investigating the study aims. A minimum criterion of 3 participants was set as constituting a Session 1 group. A total of 15 Session 1 and 15 Session 2 groups were conducted in the present study. The number of participants in Session 1 groups ranged from 3 to 6 (M = 4.47, SD = 0.99), with a modal number of 5 participants. The number of participants in Session 2 groups ranged from 2 to 8 (M = 3.93, SD = 1.75), with modes of 2 and 5. Participants who were unable to attend their scheduled Session 2 group (e.g., for reasons such as unanticipated work or study commitments) were asked to attend an upcoming Session 2 group. Eight participants were unable to attend any Session 2 groups. These participants met with a facilitator to review the Session 2 material individually.

**Homework conditions.**

**Experimental condition.**

In the experimental condition, homework was administered with a high degree of specificity utilising the entire set of procedures outlined in the CBT homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005). The procedures in the protocol were adapted for the study and included items from the phases of homework
design, assign, and review. Appendix C contains a detailed description of the steps implemented in each phase. A summary of the procedures used in the design, assign, and review phases of the experimental condition are presented in Figure 11.
Figure 11. Summary of procedures used in the design, assign, and review phases of homework integration for the experimental and control conditions.
Control condition.

Research findings from practitioner surveys (i.e., Deane et al., 2005; Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kelly et al., 2006) informed the selection of procedures for the control condition. Homework procedures that practitioners indicated regularly using in their clinical work were selected. Although the findings of Study 1 were not available to inform the selection of procedures for this condition, Study 1 findings similarly found that practitioners’ regularly used the procedures selected for this condition.

In the homework design phase for the control condition, four procedures were implemented. Research has found that practitioners regularly discuss homework rationale, consider client ability, and engage in in-session practice of the homework task (i.e., Deane et al., 2005; Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kelly et al., 2006). Practitioners also report to regularly work collaboratively with clients to select homework tasks (Kelly et al., 2006).

In the homework assign phase for the control condition, three procedures were implemented. Research indicates that practitioners regularly discuss homework rationale with clients (i.e., Deane et al., 2005; Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kelly et al., 2006), consider potential difficulties to task completion (Kelly et al., 2006), and specify frequency of task practice (Deane et al., 2005; Kazantzis & Deane, 1999; Kelly et al., 2006).

All the steps of the homework review phase as outlined in the homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005) were implemented in the control condition as the effects of the experimental manipulation on task performance
had occurred by Session 2. Thus, it was considered most appropriate to offer all participants in the present study a detailed review of task completion. Appendix C provides a detailed description of all the steps implemented in the control condition. Figure 11 presents a summary of the procedures used in the design, assign, and review phases of the control condition.

Facilitators

Facilitator characteristics.

Group sessions were delivered by three facilitators. The facilitators were all female students from La Trobe University, with ages ranging from 22 to 33 years. One facilitator was undertaking a Doctor of Psychology in Clinical Psychology degree, and had approximately six months experience in clinical practice, and in conducting educational groups. The other two facilitators were completing their Honours in a Bachelor of Psychological Science, with no previous clinical or group work experience.

Facilitator training.

Facilitator training was provided by the research supervisor (NK) on how to practically implement the homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005). To ensure that the propositions of the protocol were followed as intended (i.e., treatment integrity), a manual was produced (Appendix D). Facilitators were trained to 100% adherence of the protocol. The facilitators conducted role-plays that were video recorded, and rated for adherence using the training version of the Homework Adherence and Competency Scale (HAACS; Kazantzis, Wedge, & Dobson, 2006). Ratings were conducted by the facilitators and evaluated by the trainer to 100%
adherence. Facilitators were supervised by the research supervisor (NK) for the duration of the research project.

Assessment of Internal Validity

To monitor and regulate for protocol adherence, group sessions were audio recorded using a digital audio recorder and rated using the HAACS (Kazantzis, Wedge, & Dobson, 2006). The HAACS is an observer-rated measure that assesses a range of therapist behaviours relating to the administration of homework in therapy. The HAACS adherence scale consists of 19 items measuring therapist behaviours in three phases of homework administration: (i) assign (5 items); (ii) design (8 items), and (iii) review (6 items). Table 12 presents the items of the HAACS.

Items on the HAACS are rated on a dichotomous scale of yes or no. The sum of the total observed behaviours is divided by the maximum possible and then multiplied by 100 to yield a percentage, referred to as the Adherence Index (AI). A higher AI indicates more adherence. Adherence to all behaviours specified in the HAACS was required for the experimental protocol. By contrast, only the behaviours specified in the HAACS that were reportedly utilised by practitioners in clinical practice were required for the control protocol. Recent research has found the HAACS instrument to demonstrate high reliability, with intraclass correlations (ICCs) of .92 (Miller, 2009) and .77 (Kazantzis, Dobson, Munro, & Wedge, 2006). The HAACS adherence scale can be found in Appendix E.
Table 12

*Homework Adherence and Competency Scale (HAACS; Kazantzis, Wedge, & Dobson, 2006)*

<table>
<thead>
<tr>
<th>HAACS Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homework Design</td>
</tr>
<tr>
<td>Discuss new or revised homework</td>
</tr>
<tr>
<td>Use guided discovery to identify coping strategies and beliefs</td>
</tr>
<tr>
<td>Use a disorder specific cognitive model and individualised conceptualisation</td>
</tr>
<tr>
<td>Collaboratively select tasks</td>
</tr>
<tr>
<td>Present a rationale for the homework</td>
</tr>
<tr>
<td>Ask about client’s ability and perceived task difficulty</td>
</tr>
<tr>
<td>In-session practice of task</td>
</tr>
<tr>
<td>Use guided imagery as part of in-session practice</td>
</tr>
<tr>
<td>Use a situational conceptualisation to identify beliefs and situational triggers</td>
</tr>
<tr>
<td>Homework Assign</td>
</tr>
<tr>
<td>Ask client to summarise rationale in relation to therapy goals</td>
</tr>
<tr>
<td>Collaborate to specify when task completion will be practically possible</td>
</tr>
<tr>
<td>Collaborate to specify where the task will be practiced</td>
</tr>
<tr>
<td>Collaborate to specify how often the task will be practiced</td>
</tr>
<tr>
<td>Collaborate to specify how long the task will take to complete</td>
</tr>
<tr>
<td>Consider potential difficulties</td>
</tr>
<tr>
<td>Emphasise a learning ‘experiment’ focus</td>
</tr>
<tr>
<td>Summarise task and obtain ratings of readiness, confidence and importance</td>
</tr>
<tr>
<td>Homework Review</td>
</tr>
<tr>
<td>Discuss quantity and quality of task completion</td>
</tr>
<tr>
<td>Provide verbal reinforcement for any portion carried out</td>
</tr>
<tr>
<td>Use situational conceptualisation to review previously assigned homework</td>
</tr>
<tr>
<td>Use individualised conceptualisation to understand task non-completion</td>
</tr>
<tr>
<td>Problem solve obstacles</td>
</tr>
</tbody>
</table>

*Note.* Adapted from “Homework adherence and competence scale (HAACS),” by N. Kazantzis, P. Wedge, and K. S. Dobson, 2006, From the Team Research Project “Cognitive Behavior Therapy Homework Project” at Massey University. The HAACS was slightly adjusted for present study purposes with an item in the Assign phase split so that the therapist behaviour relating to collaboratively discussing when, where, how often and how long the task will be practiced, could be assessed separately. Consequently, the HAACS adherence scale comprised of 22 items in the present study.
Facilitator adherence to the protocol was assessed at regular intervals during data collection, with no protocol violations identified. A random sample of 33% of audio recordings \((n = 8)\) from the first group sessions, when the experimental manipulation was conducted, were independently rated. Sessions were rated by the facilitator who did not conduct the session, along with a randomly selected facilitator who had conducted the session. Raters were blind to the condition being rated. Inter-rater agreement was determined using Cohen’s Kappa, a measure suitable for assessing rater agreement beyond chance agreement for categorical data (Sim & Wright, 2005). A Kappa value of 0 indicates chance agreement, above 0.5 indicates moderate agreement, above 0.7 good agreement, above 0.8 very good agreement, and 1 indicates perfect agreement (Peat, 2001). The value of Kappa in the present study was 0.952, \(p < .001\). This finding indicates an excellent level of inter-rater agreement and high internal validity.

**Measures**

**Homework compliance and theoretically meaningful determinants of engagement.**

In the present study, homework compliance and theoretically meaningful determinants of engagement were assessed using both subjective and objective measures. Two indices of quantity of homework completion were evaluated. A measure assessing homework engagement, beliefs, and consequences was utilised, as well as a measure assessing homework quality. These measures are outlined in the following section.
Homework quantity.

The first index of quantity of homework completion was quantity of hours logged on the self-monitoring task, an independent facilitator rated measure of compliance. A self-monitoring task (i.e., Rating Positive Emotion Log) was used as the standardised homework assignment in the study. A standardised homework task was utilised in order to control for potential confounds that may arise from collaboratively selecting different tasks with participants. Self-monitoring is a central component of CBT treatment (A. T. Beck et al., 1979) and a frequent homework assignment used by clinicians (Fehm & Kazantzis, 2004; Humphreys et al., 2008; Kazantzis & Dattilio, 2010). It involves actively observing one’s behaviour and provides feedback that may impact on an individual’s perception of their behaviour, and consequently guide future action (Humphreys et al., 2008). The log comprised of 7 days with hourly timeslots for each hour of the day. Participants were asked to record the main activity that they were engaged in for each hour, to rate the amount of pleasure, and indicate whether the activity involved social interaction. Each participant developed their own pleasure rating scale ranging from either 0 (no pleasure experienced at all) to 10 (most pleasure experienced) or 0 (no pleasure experienced at all) to 100 (most pleasure experienced). The recording of sleep hours was optional. A count of the total number of hours logged by each participant was performed, with sleep hours excluded as this was optional. The Rating Positive Emotion Log utilised in the present study is provided in Appendix F. A sample completed log is presented in Figure 12.
Figure 12. Sample completed self-monitoring task.
The second index utilised to assess quantity of homework completion was the Assignment Compliance Rating Scale (ACRS; Primakoff et al., 1986). The ACRS is a clinician-rated measure that provides a single global rating of homework completion on a scale ranging from 1 (the client did not attempt the assigned homework) to 6 (the client did more of the assigned homework than as requested).

**Homework engagement, consequences, and beliefs measure.**

The Homework Rating Scale – Revised Version (HRS-II; Kazantzis, Deane, & Ronan, 2005) was used to assess homework compliance and theoretically meaningful determinants of engagement. The HRS-II is a 12-item client feedback questionnaire that measures aspects related to homework engagement, client beliefs, and consequences associated with homework engagement (Kazantzis, Deane, & Ronan, 2005). It is based on theoretical and empirical foundations for the use of homework in CBT (see discussion in Chapter 3). Items are rated on a 5-point Likert scale ranging from 0 (not at all) to 4 (completely/extremely/extensively). It comprises three factors: engagement (quantity, quality, difficulty, and obstacles), beliefs (comprehension, rationale, collaboration, specificity, and match with therapy goals), and consequences (pleasure, mastery, and progress; Kazantzis, Zelencich, et al., 2012). The difficulty and obstacles items are reverse coded. The HRS-II factors are presented in Table 13.
Table 13

*Factor Structure of the Homework Rating Scale – Revised Version (HRS-II; Kazantzis, Deane, & Ronan, 2005)*

<table>
<thead>
<tr>
<th>Factor</th>
<th>HRS-II Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement</td>
<td>Quantity</td>
</tr>
<tr>
<td></td>
<td>Quality</td>
</tr>
<tr>
<td></td>
<td>Difficulty</td>
</tr>
<tr>
<td></td>
<td>Obstacles</td>
</tr>
<tr>
<td>Beliefs</td>
<td>Comprehension</td>
</tr>
<tr>
<td></td>
<td>Rationale</td>
</tr>
<tr>
<td></td>
<td>Collaboration</td>
</tr>
<tr>
<td></td>
<td>Specificity</td>
</tr>
<tr>
<td></td>
<td>Match with Therapy Goals</td>
</tr>
<tr>
<td>Consequences</td>
<td>Pleasure</td>
</tr>
<tr>
<td></td>
<td>Mastery</td>
</tr>
<tr>
<td></td>
<td>Progress</td>
</tr>
</tbody>
</table>


Research with clinical populations has found the HRS-II to have high internal consistency for client ($\alpha = .83, .87$), therapist ($\alpha = .86, .84$), and independent observer ($\alpha = .86$) ratings (Kazantzis, Zelencich, et al., 2012). Factorial validity of the HRS-II has
been demonstrated, yielding a clearly defined three factor structure (i.e., engagement, beliefs, and consequences; Kazantzis, Zelencich, et al., 2012). The Cronbach’s alpha in the present study indicated good internal consistency, $\alpha = .74$. Due to the small sample size ($N = 67$) in the present study, the data set was considered unsuitable for factor analysis (Comrey & Lee, 1992). Therefore, based on previous research findings (Kazantzis, Zelencich, et al., 2012), the HRS-II factor structure was assumed to exist in the present study. The HRS-II Engagement and Consequences factors were found to both have adequate internal consistency ($\alpha = .69$ and $\alpha = .80$, respectively) in the present study. The Beliefs factor was found to have low internal consistency, with a Cronbach’s alpha of .53 in the present study. The poor scale reliability of the Beliefs factor indicates that the subscale did not measure one single construct in the present study and therefore was not utilised in analyses. Instead, all items of the Beliefs subscale were examined for any possible effects on an individual item basis that may not have been evident on the subscale total.

A correlation is expected between the ACRS and HRS-II Engagement factor measures of homework compliance utilised in the present study. A Pearson product-moment correlation coefficient analysis was performed to assess the strength of association between the ACRS and HRS-II Engagement factor. This analysis revealed no correlation between the two variables in the present study, $r = -.05$, $n = 66$, $p = .722$.

**Homework quality.**

The Quality Rating Scale (QRS) was a measure designed for the present study to assess the quality of homework completion. It contains three items that measure the quality of the self-monitoring logs completed. Item 1 is completed by participants and
assesses frequency of task completion, with six response options ranging from A (after each hour) to F (didn’t complete at all). Items 2 and 3 are rated by the researcher or clinician. Item 2 measures participants’ breadth of use of the pleasure scale, comprising of low (rated pleasure for all activities within the same range of 2 or 20 points), medium (rated pleasure for all activities within the same 5 or 50 points) and high (used the entire scale e.g., 1-10 or 1-100) categories. Item 3 measures the quality of activity descriptions recorded, with a count of the total number of activity descriptions recorded minus sleep conducted for each category: low (a one word attribute), medium (some detail beyond a one word attribute), and high (high activity descriptions). The QRS measure can be found in Appendix G.

QRS Items 2 and 3 were rated by the three group session facilitators. A check on the consistency in quality ratings between the raters for QRS Item 3 (i.e., low, medium, high activity descriptions) was conducted. To determine inter-rater reliability for ratings of QRS Item 3, percentage of absolute agreement was calculated. A 10% (n = 7) random sample of self-monitoring logs were analysed. The quality of activity descriptions for each hour logged (low, medium, high) by each participant were re-rated by the doctoral student. Agreement was found to be high (i.e., above 90%) for all logs except one (i.e., 52%). Consequently, a further 10% (n = 7) of logs were re-rated. Similarly, the findings indicated that agreement was high (i.e., above 90%) for all logs except one (i.e., 48%). An examination of the findings indicated that the observed low levels of agreement were from one rater. Therefore, all logs rated by this rater were re-rated for this variable.
Well-being.

The World Health Organisation Well-being Index (WHO-5; Bech, Gudex, & Johansen, 1996), a widely used measure of mental health, was used to assess positive psychological well-being in the present study. The WHO-5 is a 5-item self-report questionnaire that asks participants to rate how they have been feeling over the past two weeks on a 6-point scale ranging from 0 (at no time) to 5 (all of the time). Responses to the items are added to obtain a total score ranging from 0 to 25, with a higher score indicating more positive mental health. The WHO-5 has demonstrated high reliability ($\alpha = .89$) and good convergent validity with other measures of mental health (Newnham, Hooke, & Page, 2010). The reliability of the WHO-5 instrument in the present study was high with a Cronbach alpha’s of .83.

Group climate.

The Group Climate Questionnaire – Short Form (GCQ-S; MacKenzie, 1983) was used to measure group member perceptions of the group environment. The GCQ-S is the most widely used measure of group process in group psychotherapy research (e.g., Bakali, Baldwin, & Lorentzen, 2009; Borge et al., 2008; Crowe & Grenyer, 2008; Illing, Tasca, Balfour, & Bissada, 2011), applicable for use across a range of settings (Johnson et al., 2006). It is a 12-item self-report measure, with group participants asked to rate the extent of agreement with items on a 7-point Likert scale ranging from 0 (not at all) to 6 (extremely). The measure contains three subscales: Engagement, Avoidance, and Conflict. The Engagement scale comprises of items that measure the working atmosphere, cognitive understanding, participation, confrontation, and degree of self-disclosure. The Avoidance scale measures the extent to which group members avoided
constructive involvement in the group such as attending to issues between members, depending on the group leader, and engaging in behaviour thought to be acceptable to the group. The Conflict scale measures interpersonal conflict and distrust.

The GCQ-S subscales of Engagement, Avoidance, and Conflict have demonstrated high internal reliability with Cronbach alpha’s of .94, .92, and .88 respectively (Kivlighan & Goldfine, 1991). This factor structure was assumed for the present study as the small sample size ($N = 67$) in the present study was considered unsuitable for factor analysis (Comrey & Lee, 1992). In the present study, the reliability of the Engagement and Conflict subscales were considered acceptable, with Cronbach alpha’s of .65 and .68 respectively. However, the Avoidance subscale demonstrated low internal reliability ($\alpha = .38$) and consequently was not analysed. Instead, all items of the Avoidance subscale were examined for any possible effects on an individual item basis that may not have been evident on the subscale total.

**Demographic information.**

Demographic information was collected using a Demographic Information Form. Information about participant age, sex, marital status, occupation, ethnicity, previous training in psychology, previous therapy received, and pre-existing relationships with group members was collected.

**Procedure**

Participants attended two group sessions, 7 days apart. Group session times were scheduled in advance at various times of the day, with participants selecting session times to attend. Session 1 was no more than 70 minutes in duration and Session 2 no more than 30 minutes. Group sessions were conducted in a range of small tutorial rooms.
at La Trobe University that accommodate up to 15 people. Participants were seated at tables configured in a circle, with participants facing each other. Session 1 and 2 groups were delivered by the three facilitators either in pairs (n = 7 groups) or individually (n = 8 groups). For practical reasons, sessions were delivered individually by the doctoral student when the honours students had completed collecting data for their research projects. The doctoral student facilitator delivered 13 Session 1 and 2 groups, with one honours student facilitator delivering 5 and the other delivering 4 groups respectively.

At the start of Session 1, participants were welcomed to the group, facilitator introductions made, and the group agreement read out. Informed consent was obtained prior to first session commencement with participants asked to read the participant information sheet and complete the study consent form. Following this, they were informed about the study withdrawal procedure. Participants then completed the demographic form and well-being measure. The homework task was then administered, with the method of homework administration, for the design and assign phases, manipulated according to the experimental condition (as outlined earlier in this chapter). Participants were asked to complete the self-monitoring homework task (Appendix F) for 7 days and return for Session 2. At the conclusion of Session 1, participants completed the group climate measure.

Session 2 commenced with participants being welcomed to the group and reminded of the group agreement. Participants then completed the well-being measure, Item 1 of the quality measure that assessed main task completion strategy (Appendix G), and the HRS-II (Figure 4) homework compliance measure. Following this, the homework review phase was administered as per the homework enhancement protocol.
(Kazantzis, Deane, & Ronan, 2005). Lastly, participants were debriefed. A detailed manual of the procedures followed by the facilitators to conduct the groups is provided in Appendix D.

**Statistical Analysis Procedure**

Data analyses were conducted using the Predictive Analytics Software Statistics (PASW; Version 18) program. Data were screened for accuracy by checking entered data against original data record forms. Data were checked for accuracy, missing values, outliers, and normality. The minimum and maximum values, means, and standard deviations were examined for all variables for validity. Data screening revealed a small proportion of missing data (10%), which was assessed to be due to participants omitting questionnaire responses. A conservative approach was taken to the handling of missing data where pairwise exclusion was adopted and imputation was not carried out (Pigott, 2001).

The resultant dataset were inspected for outliers, with values that exceeded a distance of 3 times the interquartile range (IQR) below the lower quartile (Q₁) or above the upper quartile (Q₃) identified as outliers (Field, 2009). Outliers were identified for hours logged, the GCQ-S Conflict subscale variable, and QRS Item 3 (i.e., quality of activity descriptions). To reduce the impact of outliers, outlier scores were changed to a unit smaller or larger than the next extreme value of the variable (Tabachnick & Fidell (2007).³

³ Outliers were included in analyses rather than removed due to low statistical power. The sensitivity of the comparison between the two conditions for hours logged was reduced when 2 cases were removed in the analyses. The inclusion of the 2 cases increased the power of the test (1 – β) for hours logged from .3076 to .5161, with a significant result obtained at the alpha criterion of .05. A power level of .80 or higher (80 per cent chance of detecting a difference) is considered ideal (Cohen, 1998).
Normality was assessed by evaluating standardised skewness and kurtosis statistics. Using the methods outlined by Tabachnick and Fidell (2007), standard error and z score calculations were performed for all variables. The skewness and kurtosis values for each variable were divided by their respective standard errors and then the result compared with zero using the z distribution. As recommended by Tabachnick and Fidell, variables that had a z statistic at or above 3.3 were considered not normally distributed. Non-normal distributions were found for the GCQ-S Conflict subscale variable, with skewness and kurtosis z scores greater than 3.3. Consequently, this variable was transformed. Tabachnick and Fidell recommend considering data transformation for failures of normality in all situations. A natural log (LN) transformation was performed for the GCQ-S Conflict subscale variable. Following transformation, the variable was found to be normally distributed. All analyses using transformed data yielded comparable findings, therefore non-transformed data were reported for ease of interpretation.

Scale reliabilities that approximated or had Cronbach Alpha values above .7 were considered acceptable (George & Mallery, 2003). The HRS-II beliefs (α = .53) and GCQ-S Avoidance (α = .38) subscales demonstrated low internal reliability. Consequently, these factors were not utilised in subsequent analyses. Instead, separate multivariate analysis of variance analyses (MANOVAs) were conducted for each subscale to examine any possible between group effects (i.e., experimental, control) on an individual item basis that may not have been evident on the subscale total. The assumption of equality of variances was violated for the rationale variable on the HRS-
II Beliefs subscale, therefore a more conservative alpha level of .025 was set for determining significance for the variable (Keppel & Wickens, 2004).

**Preliminary Analyses**

In order to screen for potential confounds, preliminary analyses were conducted. These findings are presented in the following section.

**Examination of the randomisation procedure.**

It is possible that the randomisation process may have been compromised by systematic differences of particular groups. An examination of sample characteristics (i.e., gender, age, marital status, occupation, ethnicity) of both groups revealed no systematic group differences. In the present study, payment method varied with participants who entered a prize draw \( n = 42 \) and participants who were compensated with a voucher \( n = 25 \). Type of payment method was evenly distributed across groups. A total of 63.6% \( n = 21 \) of participants in the experimental condition and 61.8% \( n = 21 \) in the control condition entered into a prize draw, and 39.4% \( n = 13 \) in the experimental and 38.2% \( n = 13 \) in the control conditions were compensated with a voucher. It is possible that payment method may have affected motivation levels and consequently homework compliance. To test for this possible effect, a series of two-way between-groups analysis of variance (ANOVA) analyses were conducted. The independent variables were homework condition (experimental, control) and payment method (prize draw, voucher), with each main measure of homework compliance analysed separately as the dependent variable. Preliminary assumption testing revealed no violations of normality and homogeneity of variance. The assumptions of random
sampling and independence of observations were met due to the experimental design utilised.

No interaction effect was found between homework condition and payment method for hours logged, $F(1, 62) = 0.43, p = .513, d = 0.45$. Similarly, for self-reported engagement there was no interaction effect between homework condition and payment method, $F(1, 63) = 0.44, p = .512, d = 0.32$. The interaction effect between homework condition and payment method for self-reported consequences did not reach significance, $F(1, 60) = 0.76, p = .386, d = 0.10$. Overall, these analyses indicate no effect of payment method on homework compliance.

**Impact on participants’ well-being.**

It is possible that participants may have experienced a greater sense of well-being after engaging in the self-monitoring task. It is also possible that participants in the experimental condition may have completed more self-monitoring and thus reported a greater sense of well-being. To check this potential confound, a mixed between-within subjects ANOVA was conducted to examine the impact of the two conditions (control, experimental) on participants’ well-being scores over time (Session 1, Session 2). The assumptions of this statistical procedure were examined prior to analysis. The assumption of homogeneity of variance was violated for the Session 2 well-being measure, with Levene’s test for equality of variances found to be significant ($p = .042$). However, ANOVA is considered to be fairly robust to violations of this assumption when sample sizes are similar (Stevens, 1996), as was the case in the present study. To interpret the main effects, the Wilks’ Lambda statistic was utilised.
No significant interaction was observed between the two conditions and time, Wilks Lambda = .99, $F(1, 65) = 0.69$, $p = .411$, $d = 0.20$, indicating the same change in well-being scores over time for the two conditions. There was no main effect for time, Wilks Lambda = .10, $F(1, 65) = 0.31$, $p = .579$, $d = 0.14$. This analysis indicates that there was no change in participant well-being between Sessions 1 and 2. The main effect comparing the experimental and control conditions was not significant, $F(1, 65) = 0.26$, $p = .602$, $d = 0.13$, indicating that the two homework interventions (experimental, control) did not differentially impact on well-being. Overall, participants in both conditions had a mean score of 15.00 ($SD = 3.01$), 95% CIs [14.27, 15.73], out of a maximum possible score of 25 for well-being. This finding indicates that participants in the present study had positive well-being.

**Group climate.**

It is possible that the effectiveness of homework integration strategies may have been compromised by the relational context in which the strategies were applied (Norcross & Lambert, 2011). In order to assess whether the group environment differed in the experimental and control conditions, a series of independent samples $t$ tests were conducted the GCQ-S Engagement and Conflict subscale items (MacKenzie, 1983). The assumptions of this statistical procedure were examined prior to analysis, with no assumption violations noted. The findings revealed that all comparisons were non-significant, $ps > .05$. Due to low internal reliability for the GCQ-S Avoidance ($\alpha = .38$) subscale, a MANOVA was conducted to examine any possible between group effects (i.e., experimental, control) on an individual item basis that may not have been evident on the subscale total. No statistically significant difference was found between the
control and experimental conditions on the combined dependent variables, $F(3, 61) = 0.40, p = .756$; Pillai’s Trace = .02; $d = 0.28$. Consequently, differences on an individual item basis could not be investigated.

With no observed differences found in group environment among participants in the two conditions, descriptive analyses were performed to describe the group environment. Overall, participants in both conditions had a mean score of 2.67 ($SD = 0.83$), 95% CIs [2.47, 2.88], for GCQ-S Engagement on a scale ranging from 0 (not at all) to 6 (extremely). This result indicates a moderately cohesive group environment and willingness of participants to participate in the group. Participants had a mean score of 0.32 ($SD = 0.51$), 95% CIs [0.20, 0.45], for GCQ-S Conflict on a scale ranging from 0 (not at all) to 6 (extremely). This result indicates little or no presence of interpersonal friction in the groups. The GCQ-S Avoidance subscale was not analysed due to poor scale reliability.

**Tests of Hypothesised Effects**

To examine the hypothesised effects of homework administration procedures on homework compliance, a MANOVA statistical procedure was initially planned. It was hypothesised that participants in the experimental condition would have higher levels of homework compliance than participants in the control condition (Hypothesis 1). It was also hypothesised that participants in the experimental condition would have more positive beliefs about homework than participants in the control condition (Hypothesis 2).

Preliminary assumption testing was conducted for the MANOVA procedure. The assumptions of random sampling and independence of observations were assumed as a
single-blind randomised controlled independent samples design was utilised. Univariate normality was assumed as the sample size in each cell was at least 20 (Bock, 1975). Multivariate normality was assessed using Mahalanobis distance, with three multivariate outliers identified. However, as only a few multivariate outliers were identified (i.e., 3) and they were not too extreme, this was not considered a serious assumption violation (Glass, Peckham, & Sanders, 1972). Linearity was assessed using scatterplots. A visual inspection of the plots indicated non-linear relationships among most pairs of dependent variables (DV$s), thus the assumption of linearity was not satisfied. The assumptions of multicollinearity and singularity were checked. It is important that the DV$s used in MANOVA are only moderately correlated (Stevens, 1996). The present data indicated low correlations among DV$s, for which the MANOVA procedure is considered not suitable (Stevens, 1996). The assumption of homogeneity of variance-covariance matrices was assessed using Box’s M Test of Equality of Covariance Matrices. The analysis indicated that this assumption was not violated, with a non-significant Box’s M test. Levene’s Test of Equality of Error Variances was utilised to assess the assumption of equality of variance. The assumption of equality of variances was violated for the QRS Item 3 low quality activity descriptions variable. Consequently, a more conservative alpha level of .025 was set for determining significance for this variable (Keppel & Wickens, 2004). However, as the present data violated the assumptions for MANOVA, this statistical procedure could not be performed. Therefore, to examine the hypothesised effects a series of independent-samples t tests were conducted.

Preliminary assumption testing was conducted for each independent-samples t test. The assumptions of random sampling and independence of observations were
assumed, due to the use of a single-blind randomised controlled independent samples design in the present study. Normality was assessed by examining standardised skewness and kurtosis statistics, as outlined earlier in this chapter. The assumption of homogeneity of variance was satisfied, with the Levene’s test for equality of variances not significant (i.e., $p > .05$).

When multiple statistical tests are conducted, the risk of Type 1 error increases (Hinkle et al., 2002). To reduce the risk of Type 1 error, a more stringent criterion for determining statistical significance was set by performing a Bonferroni adjustment (Bland & Altman, 1995). The conventional alpha level of .05 was divided by the number of $t$ tests to be performed (i.e., 7), to yield a more stringent alpha criterion of .007 utilised in the present study (Bland & Altman, 1995).

For all tests of hypotheses, $p$ values, observed effect sizes, and 95% confidence intervals are reported. Cohen’s $d$, a widely used effect size index in the behavioural sciences, is used in the present study, with $d = 0.2$ considered a small effect size, $d = 0.5$ medium, and $d = 0.8$ large (Cohen, 1988).

For categorical data, a Chi-square test for independence was planned for QRS Item 1 (i.e., frequency of task completion), QRS Item 2 (i.e., breadth of use of the pleasure scale), and ACRS data. Prior to conducting these analyses, the minimum expected cell frequency assumption was checked. A minimum expected cell frequency of at least 5 is considered acceptable (Weinberg & Abramowitz, 2008). However, this assumption was violated for these categorical variables. The QRS Item 2 and ACRS variables both had 2 cells with an expected count less than 5. The QRS Item 1 had 6 cells with an expected count less than 5. Due to this assumption violation, Fisher’s Exact
Probability Test statistic was utilised instead for 2 by 2 tables (i.e., ACRS, QRS Item 2; Siegel & Castellan, 1988). Consequently, the Chi-square statistical procedure was not suitable for QRS Item 1 and descriptive analyses were examined instead.

**Results**

**Homework Compliance and Theoretically Meaningful Determinants of Engagement**

**Homework quantity.**

The two indices of quantity of homework completion were examined. Table 14 presents the means and standard deviations for hours logged for participants in the experimental and control conditions. The results indicate little observed difference in the amount of hours logged (Index 1) among participants in the experimental ($M = 111.42, SD = 10.32$) and control conditions ($M = 106.36, SD = 9.86$).
Table 14

 Means and Standard Deviations for Hours Logged, HRS-II Engagement, and HRS-II Consequences, for Participants in Each Homework Condition (N = 67)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Control</th>
<th>Experimental</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Hours logged</td>
<td>106.36</td>
<td>9.86</td>
</tr>
<tr>
<td>HRS-II Engagement factor</td>
<td>12.71</td>
<td>2.00</td>
</tr>
<tr>
<td>HRS-II Consequences factor</td>
<td>5.78</td>
<td>2.76</td>
</tr>
</tbody>
</table>

An independent-samples t test analysis confirmed that the observed difference in hours logged between the two conditions was not statistically significant, at the adjusted alpha level of .007, t(64) = -2.04, p = .046 (Hypothesis 1). The mean difference was -5.06, 95% CIs [-10.02, -0.10], d = -0.50.

The degree of homework completion as assessed by the ACRS (Primakoff et al., 1986) measure (Index 2) was examined. The results of the frequency analysis conducted on the ACRS are presented in Table 15. Similarly, there were little observed differences in the degree of homework completion between the groups, as assessed by the ACRS. The majority of participants in the two conditions completed the assigned homework, with 97.0% (n = 32) of participants in the experimental and 87.9% (n = 29) in the control conditions completing the assigned homework. The high rate of homework compliance observed in both conditions indicates a ceiling effect. Few participants in
the experimental \( (n = 1, 3\%) \) and control \( (n = 4, 12.1\%) \) conditions completed a portion of the assigned homework. Fisher’s Exact Probability Test confirmed that there was no significant association between the degree of homework completion, as assessed by the ACRS, and homework condition, \( p = .355 \) (Hypothesis 1).

Table 15

*Frequency Analysis of Homework Compliance Using the Assignment Compliance Rating Scale (ACRS) for Participants in Each Homework Condition (N = 66)*

<table>
<thead>
<tr>
<th>Degree of completion</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Control</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td>( n )</td>
</tr>
<tr>
<td>Completed a portion of the homework</td>
<td>4</td>
</tr>
<tr>
<td>Completed the homework</td>
<td>29</td>
</tr>
</tbody>
</table>

**Homework engagement, consequences, and beliefs.**

Table 14 presents the means and standard deviations for the HRS-II Engagement and Consequences factors, for participants in the two conditions. There was minimal observed difference in engagement among participants assigned to the experimental \( (M = 11.91, SD = 2.24) \) and control \( (M = 12.71, SD = 2.00) \) conditions. An independent-samples \( t \) test analysis confirmed that the observed difference in engagement between the two conditions was not statistically significant, at the adjusted alpha level of .007, \( t(65) = 1.54, p = .130 \) (Hypothesis 1). The mean difference was 0.80, 95% CIs [-0.24, 1.83], \( d = 0.38 \). Overall, participants had a mean score of 12.27 \( (SD = 2.16) \), 95% CIs
[11.73, 12.82], for engagement out of a maximum possible score of 16. This result indicates that participant engagement was high.

In terms of self-reported consequences of engagement, a negligible difference was observed between participants assigned to the experimental ($M = 5.38, SD = 2.46$) and control ($M = 5.78, SD = 2.76$) conditions. An independent-samples $t$ test analysis confirmed that the observed difference in consequences between the two groups was not statistically significant, at the adjusted alpha level of .007, $t(62) = .62, p = .536$ (Hypothesis 1). The mean difference was 0.41, 95% CIs [-0.90, 1.71], $d = -0.15$.

Overall, participants had a mean score of 5.61 ($SD = 2.62$), 95% CIs [4.95, 6.28], out of a maximum possible score of 12. This result indicates that participants received some benefits from engaging in the homework task.

Due to low internal reliability for the HRS-II Beliefs factor ($\alpha = .53$) subscale, a MANOVA was conducted to examine any possible between group effects (i.e., experimental, control) on an individual item basis that may not have been evident on the subscale total. No statistically significant differences were found between experimental and control conditions on the combined dependent variables, $F(5, 58) = 1.44, p = .224$; Pillai’s Trace = .11; $d = 0.70$. Consequently, differences on an individual item basis could not be investigated.

**Homework quality.**

In order to evaluate homework quality, the QRS was analysed. Table 16 presents the frequency analysis for the primary strategy utilised by participants to complete the self-monitoring task (QRS Item 1). Descriptive analyses indicate that very few ($n = 2, 6.5\%$) participants in the experimental condition completed the self-monitoring task.
after each hour compared to no participants using this strategy in the control condition. There was consistency between experimental and control conditions with regards to when task completion occurred, with most participants completing the task on a daily basis, either in hourly chunks or at the end of each day. Additionally, participants in the experimental \( (n = 1, 3.2\%) \) and control \( (n = 1, 2.9\%) \) conditions rarely completed the task an entire week all at once.

<table>
<thead>
<tr>
<th>Table 16</th>
</tr>
</thead>
</table>

*Frequency Analysis of Primary Self-Monitoring Task Completion Strategy Utilised by Participants in Each Homework Condition (N = 65)*

<table>
<thead>
<tr>
<th>Response</th>
<th>Control</th>
<th>Experimental</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( n )</td>
<td>%</td>
</tr>
<tr>
<td>After each hour</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Chunks of 2-5 hours at a time</td>
<td>14</td>
<td>41.2</td>
</tr>
<tr>
<td>At the end of each day</td>
<td>15</td>
<td>44.1</td>
</tr>
<tr>
<td>At the start of the following day</td>
<td>4</td>
<td>11.8</td>
</tr>
<tr>
<td>Entire week all at once</td>
<td>1</td>
<td>2.9</td>
</tr>
</tbody>
</table>

The frequency analyses of quality of participants’ breadth of use of the pleasure rating scale (QRS Item 2) are presented in Table 17. These analyses indicate that participants in the control condition \( (n = 31, 93.9\%) \) used the entire scale (i.e., high
quality) to a slightly greater extent than participants in the experimental condition \((n = 27, 81.8\%)\). Participants in the experimental condition \((n = 6, 18.2\%)\) had more ratings within 5 or 50 points of the scale (i.e., medium quality) compared to participants in the control condition \((n = 2, 6.1\%)\). No other differences were observed between the conditions. Results of Fisher’s Exact Probability Test indicate no significant association between participants’ breadth of use of the pleasure rating scale and homework condition, \(p = .258\) (Hypothesis 1).

Table 17

*Frequency Analysis of Quality of the Breadth of Use of the Pleasure Rating Scale to Rate Activities by Participants in Each Homework Condition \((N = 66)\)*

<table>
<thead>
<tr>
<th>Quality</th>
<th>Ratings of pleasure</th>
<th>Control</th>
<th>Experimental</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(n)</td>
<td>(n)</td>
</tr>
<tr>
<td>Low</td>
<td>Within 2 or 20 points of the scale</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medium</td>
<td>Within 5 or 50 points of the scale</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>High</td>
<td>Used the entire scale</td>
<td>31</td>
<td>93.9</td>
</tr>
</tbody>
</table>

The quality of activity descriptions recorded by participants was also evaluated (QRS Item 3). A count of the total amount of low, medium, and high quality activity descriptions was performed.\(^4\) The mean scores and 95% confidence intervals for

\(^4\) The relationship between QRS Item 3 activity descriptions and the HRS-II quality item were investigated using Pearson’s product-moment correlation coefficient. Weak correlations were found for all comparisons, with correlations ranging from .06 to .11 (\(p < .05\)).
observed mean scores are presented in Figure 13. An examination of the mean scores for quality of activity descriptions revealed no observed differences between the two conditions in quality of activity descriptions recorded.

![Figure 13](image)

*Figure 13.* Quality of activity descriptions recorded by participants in the experimental and control conditions. Means scores represent mean hours logged. Error bars represent 95% confidence intervals for observed mean scores.

**Discussion**

**Summary of Results**

In order to enhance client homework engagement, a better understanding of the determinants of homework compliance is needed. Therapist behaviour, a determinant of homework compliance, was examined in the present study. The aim of the present study
was to provide an experimental test of a cognitive-behavioural homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005) on homework compliance, using a standardised homework assignment. The comparison condition involved the use of homework procedures practitioners reportedly use in their everyday clinical practice. For ethical and pragmatic reasons, a non-clinical population and analogue study design were utilised. The sessions conducted in the present study were not therapy, they were analogue to therapy. Both objective and subjective measures of homework compliance were utilised. Homework *quantity* and *quality*, as well as participants’ beliefs about the task were assessed.

Contrary to Hypothesis 1, the results showed no significant differences between the experimental group and the control group on all measures of homework compliance. A high rate of homework compliance was observed in both groups, with over 85% of all participants completing the homework task, indicating a ceiling effect. The observed effect sizes for the use of the protocol (Kazantzis, MacEwan, & Dattilio, 2005) on homework compliance were found to be in the small-to-medium range (Cohen, 1988). Statistical power analyses indicated insufficient power to detect small-to-medium effects in the present non-clinical sample. It was also hypothesised that participants in the experimental condition would have more positive beliefs about homework than participants in the control condition (Hypothesis 2). This prediction could not be examined as intended due to poor scale reliability of the HRS-II Beliefs factor ($\alpha = .53$; Kazantzis, Deane, & Ronan, 2005; Kazantzis, Zelencich, et al., 2012). Therefore, in the present study, no support was found for the use of a homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005).
In the following section, the effect of factors such as participant motivation, type of homework task, and low statistical power, on the findings are discussed. Study 2 results are discussed in the following section in relation to the hypotheses. The strengths and limitations of Study 2 are also discussed. Implications of the findings and future research directions are discussed in Chapter 9.

**Main Findings**

**Homework compliance.**

In line with the theoretical and empirical literature, it was hypothesised that participants in the experimental condition would have higher levels of homework compliance than participants in the control condition (Hypothesis 1). No support was found for this prediction. The findings indicated no significant group differences in homework compliance for both the self-report and objective measures utilised.

Theoretically, relevant behavioural, cognitive, and social cognitive theories, provide a firm basis for understanding the factors that determine homework behaviour (see discussion in Chapter 2). In prior research, specific therapist behaviours have generally been found to be associated with homework compliance (see discussion in Chapter 5). A design strength of the present research is that it provided an initial experimental test of a broad range of therapist behaviours, as previous research has been predominantly correlational (e.g., Bryant et al., 1999; Conoley et al., 1994; Detweiler-Bedell & Whisman, 2005; Worthington, 1986). However, in the present study, the use of a theoretically and empirically driven homework protocol (Kazantzis, MacEwan, & Dattilio, 2005) did not lead to enhanced homework compliance as predicted.
It is possible that a lack of significant findings in the present study is due to insufficient statistical power to detect small or medium sized effects. Small effects were observed for the self-report measures of homework engagement ($d = 0.38$) and consequences of engagement ($d = 0.15$), with a medium sized effect observed for the objective measure of hours logged ($d = -0.50$). Of note, homework research is known to have low statistical power issues (Kazantzis, 2000). As multiple statistical analyses were conducted in the present study, a more stringent criterion for determining significance was applied (i.e., Bonferroni adjustment) to minimise the risk of Type 1 errors (i.e., incorrectly rejecting the null hypothesis when it is true). However, controlling for Type I errors increases the risk of making Type II errors (i.e., incorrectly accepting the null hypothesis when it is false). Post hoc estimations of statistical power for hours logged between the two conditions revealed insufficient power, with a 23% chance of detecting a difference at the adjusted alpha level of .007, and a 52% chance at the conventional level of .05. At the less stringent .05 probability level, the results were significant and in the expected direction with participants assigned to the experimental condition ($M = 111.42$, $SD = 10.32$) found to have logged more hours than participants in the control condition ($M = 106.36$, $SD = 9.86$), with a 95% confidence interval of -10.02 to -0.10.

As the power analysis indicated insufficient power, below the recommended level of .80 (i.e., 80 per cent; Cohen, 1988), the non-significant findings in the present study need to be interpreted with caution. The null findings may suggest insufficient statistical power rather than demonstrate that no real differences exist between the groups.

In the present study, no significant group differences were observed for self-reported homework engagement and the consequences of homework engagement, as
measured by the HRS-II (Kazantzis, Deane, & Ronan, 2005). There was little observed difference in the quantity of homework completion among participants assigned to the two conditions, as assessed by the objective measures of compliance (i.e., ACRS, Primakoff et al., 1986; hours logged). The findings showed that the vast majority of participants were able to complete the assigned homework task. Data from the ACRS indicates that 97.0% of the participants in the experimental condition and 87.9% of the participants in the control condition completed the assigned homework. Similarly, an examination of the amount of hours logged indicates a high rate of task completion, with no significant difference in the amount of hours logged among participants in the experimental and control conditions. To assess homework compliance meaningfully in the present study, homework quality was assessed. The findings indicate no significant group differences in the quality of homework completed among participants assigned to the two conditions, for all measures of quality.

The high rate of homework compliance observed suggests that possibly the potential effects of the experimental manipulation might have been confounded by a ceiling effect (i.e., easy task) or existing motivation in the control group. It is possible that participants in both conditions may have been highly motivated. Participation in the present study required that participants attend two sessions and complete a self-monitoring task for seven days to learn about “what makes them happy” (i.e., to ensure that experimental procedures were not confounded, participants were blind to the experimental manipulation). With demands of participation considered high and the nature of the activity focused on positive emotions, it is likely that a highly motivated group of participants were recruited into the study. Although motivation was not directly
assessed in the present study, feedback on aspects of motivation were elicited and responded to in the experimental condition, as part of the intervention. The findings indicate that participants in the experimental condition were very ready to engage in the task (85.2% ready on a scale of 0 to 100), highly confident in their ability to engage in the task (87.3% confident on a scale of 0 to 100), and considered the task to be important (77.0% important on a scale of 0 to 100). Readiness, confidence, and importance are critical conditions for change (Miller & Rollnick, 2002). These findings indicate that participants in the experimental condition were motivated for change.

Although this feedback was not elicited in the control condition (i.e., as per the study design), it is likely that participants in the control condition were also motivated to engage in the homework task.

Empirical work indicates that clients who are more engaged in the change process are more likely to engage in treatment such as homework (Westra, 2011). Homework compliance is viewed as key indicator of client commitment, motivation, and involvement in the change process (Addis & Jacobson, 2000; Scheel et al., 2004). Reduced levels of early resistance in therapy have been found to be associated with higher levels of subsequent homework compliance (Aviram & Westra, 2011). Similarly, reduced levels of resistance to change have been found to be associated with increased client engagement in cognitive-behavioural therapy (Aviram & Westra, 2011; Westra, 2011; Westra et al., 2009). Further, the theory of planned behaviour (Ajzen, 1985, 1988) would predict that a client who believes that homework is beneficial (i.e., positive attitude) will most likely form an intention to engage in homework activity, with intention predicted to lead to action. Therefore, the present study findings suggest that
the participants in both conditions were highly motivated and believed the homework to be of personal benefit, thereby determining homework compliance.

A strength of the present research is that the relationship between therapist homework enhancement strategies and homework quality was examined, as this has not been conducted empirically. Three indices were utilised to assess homework quality in the present study. The indices assessed the extent to which the self-monitoring task was carried out correctly and competence of effort (Primakoff et al., 1986). Most participants in both conditions completed the task on a daily basis, either in hourly chunks or at the end of each day. This frequency of completion suggests a moderate to high level of data accuracy. High quality use of the breadth of the pleasure scale (i.e., used the entire scale e.g., 1-10 or 1-100) was observed by participants in both groups. The quality of activity descriptions on the log were found to be mostly in the medium range for participants in both the experimental and control conditions, followed by low then high activity descriptions. Overall, homework quality was assessed to be in the medium to high range in the present study.

It is possible that the lack of observed group differences for homework quality in the present study may be related to type of homework assignment (Funk et al., 2011). A limited amount of empirical work has been conducted to assess the predictive ability of homework quality on treatment outcomes, with conflicting findings observed across studies (Funk et al., 2011; Rees et al., 2005; Schmidt & Woolaway-Bickel, 2000). Funk et al. (2011) suggest that the inconsistent findings across studies examining both quantity and quality of homework compliance as predictors of treatment outcomes may be related to patient population and type of homework tasks assigned. Perhaps the task
in the present study did not provide sufficient opportunity for participants to
differentiate themselves in terms of quality. For instance, limited space was available on
the self-monitoring log to provide activity descriptions. This may have restricted the
level of homework quality and ability to detect differences. Thus, at this stage it is not
possible to draw conclusions about the effects of homework enhancement strategies on
homework quality with further research needed.

A check on the Study 2 experimental design indicated that a high degree of
internal validity was achieved. Facilitator homework administration behaviours in the
first group sessions were assessed using the HAACS (Kazantzis, Wedge, & Dobson,
2006). An excellent level of inter-rater agreement was achieved, indicating strong
agreement between raters on the presence or absence of behaviours. Design integrity
checks were conducted regularly throughout the duration of group session deliveries to
ensure design integrity (Kazdin, 2003; Perepletchikova et al., 2009). Therefore, in the
present study, inferences may be drawn about the effects of the interventions and
outcome (Kazdin, 2003).

Of note, facilitator competence at integrating homework into the sessions was
not assessed due to financial and time constraints. Both treatment adherence and
competence are key components of treatment integrity (Perepletchikova et al., 2009).
Therapist competence has been found to enhance homework compliance (Bryant et al.,
1999). It is possible that differences in facilitator competence at integrating homework
into the sessions may have existed. Further, it is also possible that potentially
theoretically important features of the protocol may not have been adequately adapted
and thus affected participant homework compliance.
Design integrity was enhanced by the use of a detailed treatment manual. The manual provided a high degree of specificity regarding implementation procedures for both the experimental and control conditions, thereby reducing variability and enhancing design integrity, however, at the expense of external validity (Drozd & Goldfried, 1996). Use of a manual may be criticised for its lack of flexibility (Beutler, 2002; Strupp & Anderson, 1997). It has been suggested that optimal outcomes will most likely result from striving to promote both adherence and flexibility (Forehand, Dorsey, Jones, Long, & McMahon, 2010; Mazzucchelli & Sanders, 2010). The homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005) is generally intended as a process guide. However, in order to achieve high internal validity, both the content (i.e., type of homework assignment) and process were specified in the present study.

The findings also suggest that homework delivery in the present study was not compromised by the relational context in which it was applied (i.e., group environment; Norcross & Lambert, 2011). Participants indicated a moderate level of group cohesiveness and willingness to participate in the group (i.e., GCQ-S Engagement), and little or no interpersonal friction (i.e., GCQ-S Conflict). However, an aspect of the group environment relating to the extent to which participants assumed responsibility for psychological change (i.e., GCQ-S Avoidance) could not be assessed due to poor scale reliability ($\alpha = .38$). A possible explanation for poor GCQ-S Avoidance scale reliability in the present study may be related to the unsuitability of the subscale items in a non-clinical setting. The GCQ-S scale is the most commonly used measure of group process in group psychotherapy research (Johnson et al., 2006). As the present study was not therapy and participants were learning to engage in a self-monitoring activity to learn
about “what makes them happy”, assessing responsibility for psychological change may not have been appropriate.

Given that a non-clinical sample was utilised in the present study, it was not possible to assess the role of the therapeutic alliance on homework compliance. The therapeutic alliance is a variable that is present in both individual and group therapy contexts. Commonly used therapeutic alliance measures in cognitive therapy outcome research (e.g., Working Alliance Inventory [WAI]; Horvath & Greenberg, 1989, 1994) were considered not suitable for use in the present non-clinical sample. Further, a limitation of measures of therapeutic alliance often employed in previous research is that they often fail to capture key aspects of the therapeutic relationship that are important in CBT (e.g., collaborative empiricism; Tee & Kazantzis, 2011). Therefore, the effect that the therapeutic relationship has on homework compliance remains unclear.

The present study findings suggest that possibly the strategies utilised in the control condition are sufficient for homework integration, with no substantial benefit gained from the use of a protocol (Kazantzis, MacEwan, & Dattilio, 2005). Whilst a range of homework integration procedures were implemented in the control condition, not all the procedures outlined in the protocol were implemented. A total of eight homework design procedures were implemented in the experimental condition compared to four implemented in the control condition (Figure 11). Six homework assign procedures were implemented in the experimental condition compared to three implemented in the control condition (Figure 11). Procedures such as collaborative task selection (e.g., Mahrer et al., 1994), discussion of participants’ ability and perceived task difficulty (e.g., Conoley et al., 1994), providing a rationale (e.g., Mahrer et al., 1994),
discussion of potential barriers to task completion (e.g., Detweiler-Bedell & Whisman, 2005), and planning task completion (e.g., Gollwitzer & Sheeran, 2006), as implemented in the control condition, are all factors in and of themselves that increase the likelihood of client adherence. In the control condition, homework was delivered as per the procedures practitioners report to regularly use in their clinical work (e.g., Deane et al., 2005; Kelly et al., 2006). With practitioner surveys limited by socially desirable responding, it is possible that the control condition may have been an idealised version of actual practice.

An alternative explanation is that perhaps the homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005) did not affect homework compliance as predicted due to participant and task factors. The cognitive approach articulates that when individuals are psychologically distressed their beliefs about themselves, others, and the world or future, their problems, or ability to cope are more easily activated (A. T. Beck et al., 1979). According to this framework, such beliefs are less likely to be activated in a non-clinical population. In clinical trials, whilst participants are often motivated to engage in therapy, they are not necessarily ready to engage in homework (e.g., Carroll et al., 2005; Edelman & Chambless, 1995; Thorn et al., 2011). Participants in clinical trials are generally receiving treatment for mental health disorders such as depression or anxiety-related disorders. Therefore, homework often presents a challenge for clients to engage in the change process (e.g., exposure to a phobic situation) for which a range of beliefs may be activated (e.g., “I can’t do this”). To engage in the homework task the client needs to confront negative emotions. By contrast, participants in the present study were free of current mental illness (i.e., participants assessed their
own eligibility for the study), chose to take part in a study that involved completing a
task between two sessions, and engaged in a task that focused on positive emotions.

It is also possible that the self-monitoring activity was an easy task to execute for
the present sample, and thus forming implementation intentions provided little
additional benefit. The present sample were predominantly university students (72.7%) who were likely familiar with form completion and possibly did not require support from the facilitator to complete the task. Implementation intentions, as incorporated in the protocol (Kazantzis, MacEwan, & Dattilio, 2005), have been found to be more beneficial among individuals who have difficulties regulating their behaviour (e.g., frontal lobe patients, individuals with schizophrenia; Gollwitzer & Sheeran, 2006) and with goals that are difficult to implement (Gollwitzer & Brandstatter, 1997). High completion rates (80%) have been found for goals that are easy to implement (i.e., goals that are less complex, have more familiar action sequences, less unsuccessful attempts of goal initiation, and are associated with a higher subjective probability of success) regardless of whether participants had formed implementation intentions (Gollwitzer & Brandstatter, 1997). Similarly, clients are more likely to implement treatment recommendations that are of low difficulty level (e.g., Conoley et al., 1994).

From a theoretical standpoint, a lack of implementation intention effects is proposed to occur with easy to implement goals as it is suggested that these goals are more habituated than difficult goals (Gollwitzer & Brandstatter, 1997). Implementation intentions are proposed to achieve their effects by habitualising the initiation of goal achievement, that is, by creating a strong link between a situational cue and behavioural response (Gollwitzer & Brandstatter, 1997; Gollwitzer & Oettingen, 2011; Oettingen et
al., 2000; Webb & Sheeran, 2004). If however, actions are already habituated, implementation intentions are proposed to provide little additional benefit (Gollwitzer & Brandstatter, 1997).

A further strength of the present research is that both objective and subjective measures of homework compliance were utilised. Objective measures of homework compliance and client motivation have been found to be superior to self-report measures (Hoelscher et al., 1984, 1986; Schmidt & Woolaway-Bickel, 2000; Taylor et al., 1983; Westra, 2011). For instance, hidden electronic monitoring devices in tape players were utilised in empirical work to investigate objective (i.e., the amount of relaxation practice recorded by the devices) versus subjective (i.e., client kept record forms of practice) measurements of homework compliance (Hoelscher et al., 1984, 1986; Taylor et al., 1983). The findings of these studies revealed that self-reported practice markedly exceeded actual practice, with average overestimations ranging from 82% to 126% (Hoelscher et al., 1984, 1986; Taylor et al., 1983). Similarly, objective measures of homework compliance (Hoelscher et al., 1984, 1986; Schmidt & Woolaway-Bickel, 2000) and client motivation (e.g., Westra, 2011) have been found to more reliably predict treatment outcomes. In contrast, Taylor et al. (1983) found no significant correlation between objective or self-report measures of practice on treatment outcomes. It has been suggested that these divergent findings may possibly be related to an insufficient amount of relaxation practice undertaken by the participants in Taylor et al.’s study to reduce blood pressure (Hoelscher et al., 1986). Poor reliability of self-report indexes may be attributed to reporting bias, memory fallibility, or related to
different constructs being assessed by objective and self-report measures (Schmidt & Woolaway-Bickel, 2000).

It is also possible that participants in the present study may have responded to self-report measures in a socially desirable manner. To reduce this potential bias, participants were naive to the aims of the present study. They were also provided with the HRS-II measure at the very start of Session 2 before homework was reviewed in the group.

**Beliefs about homework.**

It was also hypothesised that participants in the experimental condition would have more positive beliefs about homework than participants in the control condition (Hypothesis 2). According to cognitive theory, clients form beliefs about the homework task (e.g., the costs and benefits of task engagement) which determine adherence, and these beliefs may be influenced by factors such as therapist behaviour (e.g., providing task rationale; A. T. Beck et al., 1979; Kazantzis & L’Abate, 2005; see discussion in Chapter 2). The use of the homework protocol (Kazantzis, MacEwan, & Dattilio, 2005) which emphasises the role of client beliefs, was predicted to lead to more positive beliefs about homework. However, this prediction could not be examined due to low internal reliability of the HRS-II Beliefs factor (α = .53; Kazantzis, Deane, & Ronan, 2005; Kazantzis, Zelencich, et al., 2012) in the present study. This finding indicates that the subscale did not measure one single construct. Further examination of the subscale to examine for any possible effects on an individual item basis between the two conditions revealed no significant differences.
It is possible that the poor subscale reliability may be related to the use of a non-clinical sample in the present study. The HRS-II factor structure, reliability, and validity has been demonstrated in a clinical sample (Kazantzis, Zelencich, et al., 2012). An item on the Beliefs subscale is match with therapy goals (i.e., The activity matched with my goals for therapy). Although participants in the present study were informed to consider the word therapy in this item as referring to the Session 1 meeting, participants nevertheless raised concerns about how to most appropriately complete this item. Another item on the subscale is collaboration (i.e., I had an active role in planning the activity). Although homework tasks are selected collaboratively in CBT (A. T. Beck et al., 1979; Kazantzis, 2005), this was not conducted in the present study. A standardised task was utilised instead in order to account for potential confounds that may arise from collaboratively selecting different tasks with participants. However, facilitators did work collaboratively with participants to design an individualised pleasure rating scale. The findings indicate that participants believed that they had a small degree of involvement in planning the homework activity ($M = 1.42, SD = 1.26$), 95% CIs [1.10, 1.74].

**Limitations**

In addition to the limitations discussed above, the present research had several other limitations that need to be considered when interpreting the results. First, the present study was intended to be a well-designed experiment, analogue to therapy. Clearly, any experiment has limited generalisability to clinical practice given design and sample selection requirements. Therefore, the results require replication with a clinical sample. Second, the demands of participation were considered high. Recruitment difficulties were encountered with individuals choosing not to participate in the present
study as it required that they attend two sessions and complete a self-monitoring task for seven days. It is therefore likely that a highly motivated group of participants were recruited into the study. Third, the protocol (Kazantzis, MacEwan, & Dattilio, 2005) was delivered in a group format where theoretically important features of the protocol may not have been adequately adapted for each participant. Fourth, two sessions were conducted, with the effects of facilitator behaviour in the first session examined. It is possible that the effects of variation in facilitator homework behaviour on homework engagement may be observed over time in subsequent sessions. However, in the psychotherapy process literature, therapist behaviour in the first session has been found to predict client involvement in the second and subsequent sessions (Jungbluth & Shirk, 2009), as well as predict alliance in subsequent sessions (Russell, Shirk, & Jungbluth, 2008). Evidently, further empirical work is required to ascertain the effects of homework enhancement strategies over time. Fifth, the use of either one or two facilitators to conduct the groups may have potentially introduced anomalies. However, the excellent level of inter-rater agreement observed indicates that the present study had high internal validity nevertheless.

**Conclusion**

In Study 2, no support was found for the hypothesis that participants in the experimental condition would have higher levels of homework compliance than participants in the control condition. The hypothesis that participants in the experimental condition would have more positive beliefs about homework than participants in the control condition could not be examined due to poor scale reliability. Thus, in the present study, no support was found for the use of a cognitive-behavioural homework
enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005). The effect of factors such as participant motivation, type of homework task, and low statistical power, need to be considered when interpreting the present study findings.
CHAPTER 9

GENERAL DISCUSSION

The purpose of this chapter is to provide a discussion of the main findings of the present research, as well as discuss the implications of the findings and future research directions. This chapter will not repeat the strengths and limitations of the present research previously discussed.

The overarching aim of the present research was to examine methods for enhancing homework compliance, with a particular focus on therapist behaviour. The positive relationship between homework compliance and treatment outcome, and homework’s causal effects on improved treatment outcomes, has been well established empirically. In order to better facilitate client engagement with homework and thus optimise therapeutic outcomes, an understanding of the in-session determinants of compliance is needed. Relevant theories that help explain the determinants of client homework engagement were reviewed in this thesis, for which there is limited discussion in the literature. Based on the theoretical and empirical literature, a factor that has been identified to determine client homework engagement is therapist behaviour.

From a theoretical and empirical standpoint, it has been suggested that therapists need to integrate homework into treatment in a carefully planned and thought through manner (i.e., use a “systematic” approach) to enhance homework engagement (see discussion in Chapters 2 and 5). In the medical compliance literature, the use of clearer prescriptions have been found to lead to enhanced medication compliance (e.g., Haynes, 2001; Lowe & Lutzker, 1979) and specific therapist behaviours have been found to be associated with homework compliance (e.g., Bryant et al., 1999; Conoley et al., 1994;
Detweiler-Bedell & Whisman, 2005). However, an experimental test of the use of a systematic approach on homework compliance has not been conducted.

Survey research has been conducted to examine practitioners’ systematic use of homework in clinical practice (i.e., Deane et al., 2005; Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kelly et al., 2006). However, the conceptualisation of systematic use in previous research was identified to be problematic. Previous studies have examined systematic use primarily based on homework planning strategies and principles of behaviour change, but omitting important cognitive and behavioural theory determinants of homework engagement. In addition, factors that may influence practitioners’ use of homework enhancement strategies (e.g., specific training in the use of therapeutic homework) have not been examined.

A limited amount of empirical work has been conducted to examine the effects of therapist behaviour on client engagement with homework. The findings indicate that specific therapist behaviours predict client homework compliance, with some inconsistencies in findings reported. Although a large number of therapist behaviours for homework enhancement have been proposed in the literature, empirical efforts have mostly examined the effects of a limited scope of behaviours, with this research predominantly correlational. Further, whilst many of the therapist behaviours outlined in the homework protocol (Kazantzis, MacEwan, & Dattilio, 2005) have empirical support, there have been no prior focused evaluations of the protocol.

In the present research, two studies were designed to overcome some of the limitations identified in the homework literature, as well as begin to fill the gap in the literature (see Chapters 7 and 8). The two studies of the present research were parallel.
studies, conducted concurrently. Therefore, the findings of Study 1 were not available and thus did not inform the design of Study 2.

**Summary of Research Findings**

**Study 1**

Study 1 aimed to examine therapists’ systematic use of a broad range of homework integration procedures in clinical practice. Specifically, Study 1 aimed to contrast the ecological validity of the indices of systematic homework use derived from two practitioner homework enhancement models: (i) Shelton and Levy’s (1981) behavioural model, and (ii) Kazantzis, MacEwan, and Dattilio’s (2005) cognitive-behavioural model. Systematic homework use, conceptualised as per Shelton and Levy’s model, focuses primarily on planning strategies and principles of behaviour change. By contrast, systematic homework use, conceptualised as per Kazantzis, MacEwan, and Dattilio’s model, incorporates a range of therapist behaviours considered important to the process of homework integration that are based on both principles of cognitive and behaviour change. Study 1 also aimed to examine the influence of training on therapists’ use of a systematic approach to homework. A survey methodology was utilised.

Study 1 results showed that the majority of respondents (97%) reported the use of homework in their clinical work. Consistent with previous research (i.e., Deane et al., 2005; Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kelly et al., 2006), few psychologists in the present sample were found to report a practice consistent with Shelton and Levy’s model (1981; 12.9%). When systematic use was examined according to a CBT homework protocol (Kazantzis, MacEwan, & Dattilio, 2005), approximately half of the present sample reported systematic use of CBT focused
homework strategies (51.7%), followed by those who reported systematic use of behaviourally focused (24.1%) and cognitively focused homework strategies (6.9%). A total of 17.2% of the sample were reportedly non-systematic in their use of strategies for discussing homework (Non-Systematic Index). These findings indicate that when “systematic” use is re-conceptualised to take into account a broad range of CBT homework strategies, a greater proportion of psychologists in the present sample were classified as using a systematic approach (82.7%) compared to when systematic use is defined according to planning strategies and principles of behaviour change (12.9%; Shelton & Levy, 1981). These findings suggest that the definition of systematic use based on Shelton and Levy’s model is too stringent, not adequately capturing the scope of homework strategies practitioners may be regularly implementing in their clinical work. Therefore, in the present study, Kazantzis, MacEwan, and Dattilio’s (2005) model for homework enhancement was found to better represent the present sample of psychologists’ self-reported practices than Shelton and Levy’s model.

Consistent with previous research (e.g., Deane et al., 2005; Houlding et al., 2010; Kazantzis & Deane, 1999; Kelly et al., 2006), the present sample of psychologists reportedly used homework review and design procedures over assign procedures. These findings indicate that therapists are often using homework enhancement strategies in the selection and review of tasks, however, are less consistent in their use of homework planning strategies.

The results of Study 1 showed no significant group differences in training in homework among psychologists who were systematic and non-systematic, according the four indices of systematic use examined. It is possible that it may have been difficult to
detect potential differences in training in a predominantly trained sample. Most of the present sample of psychologists reported that they had been trained in how to integrate homework into therapy, however, to varying degrees. These findings are consistent with previous research on CBT skills transfer which has found that trainees generally transfer CBT skills which include homework techniques, from training to clinical practice (e.g., Ashworth et al., 1999; Kennedy-Merrick et al., 2008; Myles & Milne, 2004). Study 1 findings also indicate that training is associated with increased confidence in the use of homework procedures, with a significant positive correlation found between training and confidence.

**Study 2**

Study 2 aimed to provide an experimental test of a cognitive-behavioural homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005) on homework compliance, using a standardised homework assignment. This protocol was examined as it has firm theoretical and empirical foundations and aptly consolidates the numerous recommendations from previous homework enhancement models, as well as extends past work (see discussion in Chapter 4). For ethical and pragmatic reasons, a non-clinical population and analogue experimental study design were utilised. The control condition involved the use of homework integration procedures practitioners reportedly use in clinical practice, as indicated in previous practitioner survey research and also consistent with Study 1 findings.

Study 2 results showed no significant differences between the experimental group and the control group on all measures of homework compliance. Therefore, no support was found for the use of a cognitive-behavioural homework enhancement
protocol (Kazantzis, MacEwan, & Dattilio, 2005) in Study 2. The effect of factors such as low statistical power, participant motivation, the use of a non-clinical sample, and type of homework task, need to be considered when interpreting the present study findings (see discussion in Chapter 8). The null findings may suggest insufficient statistical power rather than demonstrate that no real differences exist between the groups. In order to draw solid conclusions, further empirical work is needed to assess the utility of the CBT homework protocol (Kazantzis, MacEwan, & Dattilio, 2005).

**Implications of the Findings and Future Research Directions**

**Psychologists’ Use of Homework in Clinical Practice**

Study 1 findings indicate that when “systematic” use is re-conceptualised to take into account a broad range of CBT homework strategies, a greater proportion of psychologists in the present sample were classified as using a systematic approach compared to previous studies that have restricted the definition of systematic use to planning strategies based on principles of behaviour change (i.e., Deane et al., 2005; Kazantzis, Busch, et al., 2006; Kazantzis & Deane, 1999; Kelly et al., 2006). In order to account for important cognitive and behavioural theory determinants of homework engagement (see discussion in Chapters 2 and 4), the use of an integrative conceptual framework to define systematic use is proposed. Thus, the present research has presented a case for the re-conceptualisation of systematic use and provided support for the use of a CBT homework protocol (i.e., Kazantzis, MacEwan, & Dattilio, 2005) to represent practitioners’ systematic use of homework.

The present study findings suggest that most of the present sample of psychologists are using homework in their clinical work and expending effort to
promote client homework engagement. A moderate proportion of the present sample of psychologists were classified as using a systematic approach to homework according to their self-report of at least occasional use of behaviourally and cognitively focused strategies within the homework protocol (Kazantzis, MacEwan, & Dattilio, 2005). This finding indicates use of the strategies in the protocol in clinical practice. If the present sample of psychologists’ self-reported homework behaviours are representative of practice, these findings also indicate that many opportunities for therapeutic change to take place out-of-session and for better treatment outcomes to be achieved, may be hindered by therapists who do not implement the full compliment of cognitive and behavioural homework strategies. Despite approximately a quarter of the present sample classified as using a systematic approach according to their self-report of at least occasional use of behaviourally focused strategies within the homework protocol, theoretically, important cognitive theory determinants of homework engagement also need to be implemented (e.g., asking about perceived task difficulty, presenting a rationale).

Previous research findings indicate that therapists are often using homework enhancement strategies in the selection and review of tasks, however, are less consistent in their use of homework planning strategies (e.g., Deane et al., 2005; Houlding et al., 2010; Kazantzis & Deane, 1999; Kelly et al., 2006). This same pattern of use was observed in Study 1. These findings suggest that whilst efforts are being made to select suitable homework assignments and review task engagement, clients are possibly not being adequately prepared for task completion (see discussion in Chapter 7). These findings suggest that therapist behaviour, particularly insufficient homework planning,
may be a factor contributing to client homework noncompliance (Helbig & Fehm, 2004; Tompkins, 2002) and consequently the achievement of optimal therapeutic outcomes in clinical practice.

Further research is needed to better understand factors that determine therapists’ clinical decisions to implement particular strategies. Factors that could be further explored include training, client resistance, practitioner attitudes, or practical considerations such as time. With a predominantly trained sample in the present study, it may have been difficult to detect any potential training effects. The measure of training utilised in the present study may not have been specific enough, with the extent of training assessed on a scale ranging from 0 (not at all) to 4 (extremely). Therefore, future work could assess different levels and the extent of homework training completed (e.g., unit of study, post-qualification specialist training; Kazantzis & Munro, 2011). To increase the generalisability of findings, future work with a larger sample and across different practice settings is needed. Further, objective rather than subjective measures could be utilised in future research in order to more accurately assess therapists’ actual use of homework procedures in clinical practice.

**Effects of a Cognitive-Behavioural Homework Enhancement Protocol on Homework Compliance**

In Study 2, no support was found for the use of a cognitive-behavioural homework enhancement protocol (Kazantzis, MacEwan, & Dattilio, 2005). The high rate of homework compliance observed in both the experimental and control conditions, suggests that a homework enhancement protocol may have little added value to those who are already willing and/or motivated to engage with a relatively straightforward
activity. A trend was observed in the predicted direction for hours logged by participants in the experimental condition which is promising for future research. However, further empirical work with sufficient levels of statistical power is needed in order to draw solid conclusions.

In the present study, the observed effect sizes for the use of the protocol (Kazantzis, MacEwan, & Dattilio, 2005) on homework compliance were in the small-to-medium range (Cohen, 1988). There was insufficient statistical power to detect small-to-medium effects in the present non-clinical sample which comprised of 33 participants in the experimental condition and 34 participants in the control condition. If no significant differences were observed in a moderate sample size, it raises important questions about the practical and clinical significance of using the homework protocol to enhance homework compliance in the context of the limitations of Study 2 (see discussion in Chapter 8). For present study purposes, an analogue study design was utilised to circumvent the practical and ethical issues of conducting research in a clinical setting (Kazdin, 2003). Whilst an analogue study design allows for tight control to be exercised over the implementation of interventions and provides increased internal validity, external validity and the generalisability of findings to real life settings is compromised (B. G. Cook & Rumrill, 2005). In a clinical sample, larger effect sizes for the use of the protocol on homework compliance would be expected.

In a clinical context, a therapist may discuss with an anxious client the task of keeping a daily worry diary. When selecting and planning tasks in-session, a range of client beliefs may be activated. According to the cognitive approach, a range of unhelpful beliefs (e.g., “I won’t be able to do this”; “This won’t work for me”) are more
likely to be activated in this psychologically distressed client compared to a psychologically well individual (A. T. Beck et al., 1979). Providing a rationale for the task (e.g., the use of a worry diary is an effective technique to help you deal with your specific worries) and discussing how the benefits (e.g., improved sleep) may outweigh the costs (e.g., time commitment), may help increase client motivation to engage in the task (Kazantzis & Daniel, 2009). By checking client reactions to the task, such as perceived ability, the therapist finds out that the client thinks the task is too complex (e.g., “There are too many sections to fill out on the worry diary template”). The therapist may therefore work collaboratively with the client to design the task so that the client will be able to carry it out (i.e., build self-efficacy [social learning theory]; e.g., complete only the first two sections on the worry diary template). The therapist may also enable in-session practice of the task to assist the client with task completion and address any further concerns.

When the theoretical determinants of homework engagement are considered in the context of a client with a mental illness, homework activity is proposed to present itself as a greater challenge than for an individual who is free of mental illness. For instance, participants in the present study who were free of mental illness and predominantly university students, may have had a high sense of self-efficacy in being able to complete the self-monitoring task as they were likely familiar with form completion. It is also proposed that distressing beliefs about themselves, others, or their ability to cope were less likely to have been activated by the homework task (A. T. Beck et al., 1979). Therefore, it is possible that clients with mental illness may require more support from the therapist to manage the challenges of homework. The magnitude of the
effect of using homework enhancement strategies with a clinical population may therefore be greater than with a non-clinical population as utilised in the present study.

Study 2 findings suggest that the type of homework task selected by practitioners may determine homework engagement. A high rate of completion of the self-monitoring task was observed in both conditions. High task completion rates have been observed for goals (e.g., Gollwitzer & Brandstatter, 1997) or treatment recommendations (e.g., Conoley et al., 1994) that are easy to implement. The need to consider type of homework task has implications for research methodology. Study 2 findings suggest that features of a homework task need to be considered when assessing homework quantity (e.g., task difficulty) and quality (e.g., a task that provides sufficient scope for participants to differentiate themselves in terms of quality).

Further research is needed to assess the utility of the CBT homework protocol (Kazantzis, MacEwan, & Dattilio, 2005). This research could examine the entire protocol or strategies within the protocol individually. It is possible that particular strategies in the protocol may exert more influence on homework compliance than others. To aid in generalisation, it is suggested that a sample representative of the clinical population is utilised and different types of homework tasks are examined. The results of Study 2 suggest that perhaps homework enhancement strategies are not necessarily needed for the psychologically well or motivated individuals. To examine this possibility, future work may be undertaken to investigate the effects of the protocol for varying degrees of symptomology. Due to the association between client motivation and homework compliance (Addis & Jacobson, 2000; Scheel et al., 2004; Westra, 2011), it is considered important that future investigations measure participant
motivation. Future work may also include a ‘no support’ condition, to examine the
effects of no facilitator support for homework.

Conclusion

In conclusion, the present research has contributed to the literature on therapist
homework enhancement behaviours. The present research has contributed to a better
understanding of practitioners’ systematic use of a broad range of homework
enhancement methods based on both behavioural and cognitive principles of behaviour
change, and also presented a case for the re-conceptualisation of “systematic” use. The
present research findings may be utilised to guide the development of evidence-based
guidelines for homework integration, for which currently none exist. The present
research has also contributed to the literature by providing an initial experimental test of
a cognitive-behavioural homework enhancement protocol (Kazantzis, MacEwan, &
Dattilio, 2005) on homework compliance, highlighting potential factors that may
determine the utility of the protocol. To further optimise the benefits that homework
offers to psychotherapy practice, further research examining the determinants of
homework engagement is needed. Several potentially fruitful avenues for future
research have been presented in the present research.
APPENDICES
Appendix A

Survey Questionnaire

For the purpose of this survey, the term *between-session activities* will be used to refer to any between-session therapeutic activities discussed collaboratively between client and therapist. This definition is distinct from client initiated activities that are not explicitly negotiated in-session with the therapist.

**SECTION A: USE OF BETWEEN-SESSION ACTIVITIES**

A1. Are you currently fully registered or licensed as a psychologist and treating clients in therapy?
   - Yes
   - No [TERMINATE – “Thank you for your interest in participating in this survey, however, the focus of the survey is on psychologists who are fully registered or licensed and treating clients in therapy. We appreciate your time and effort.”]

A2. Please indicate in which country you primarily practice.
   - Australia  [GO TO QUESTION A3]
   - France  [SKIP TO A4]
   - New Zealand  [SKIP TO A4]
   - Russia  [SKIP TO A4]
   - United Kingdom  [SKIP TO A4]
   - United States  [SKIP TO A4]
   - Other (please specify) _____________  [SKIP TO A4]

A3. Please indicate in which state or territory you primarily practice.
   - ACT
   - QLD
   - NSW
   - NT
   - SA
   - TAS
   - VIC
   - WA

A4. Please select one option that best describes your specialist area of practice.
   - Clinical Psychologist
   - Counselling Psychologist
   - Educational & Developmental Psychologist
   - Forensic Psychologist
   - Clinical Neuropsychologist
   - Organisational Psychologist
   - Sport and Exercise Psychologist
   - Other (please specify)__________________
A5. Please indicate the extent to which your practice is influenced by the following therapeutic approach(es). If you consider your practice to be integrative/eclectic, please rate which approaches make up your practice. Please rate on a scale of 0 (not at all) to 4 (extremely).

<table>
<thead>
<tr>
<th>Approach</th>
<th>Not at all</th>
<th>Somewhat</th>
<th>Moderately</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance and Commitment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analytic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioural</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Client-Centred</td>
<td></td>
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</tr>
<tr>
<td>Cognitive Analytic</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive-behavioural</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Constructivist</td>
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</tr>
<tr>
<td>Dialectical Behaviour</td>
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<tr>
<td>Emotion Focused</td>
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<tr>
<td>Existential</td>
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<tr>
<td>Gestalt</td>
<td></td>
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<tr>
<td>Humanistic</td>
<td></td>
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<td></td>
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<tr>
<td>Interpersonal</td>
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<tr>
<td>Mindfulness-based</td>
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<tr>
<td>Narrative</td>
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<tr>
<td>Positive Psychology</td>
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<tr>
<td>Problem Solving</td>
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<tr>
<td>Psychoanalytic</td>
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<tr>
<td>Psychodynamic</td>
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<tr>
<td>Rational Emotive Behaviour</td>
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<tr>
<td>Relational</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Schema</td>
<td></td>
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<tr>
<td>Systemic</td>
<td></td>
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</tr>
</tbody>
</table>

Other (please specify) ____________

A6. How often do you use between-session activities in your current clinical practice?

- 0 None of the time [SKIP TO C1]
- 1 Occasionally
- 2 Fairly many times
- 3 Very often
- 4 Always

A7. On average, how many different between-session activities would you usually recommend during the first 10 treatment sessions for a client?
A8. On average, how many different between-session activities would you usually recommend at each session?

- One [IF SELECTED, A7 MUST BE ‘SIX OR MORE’]
- Two
- Three
- Four or more

A9. Please specify the three most common types of between-session activities that you use in your practice (e.g., bibliotherapy, self-monitoring).

- ............................................................
- ............................................................
- ............................................................
- Not applicable

A10. How important would you say it is for you to use between-session activities in therapy?

- 0 Not at all
- 1 Somewhat
- 2 Moderately
- 3 Very
- 4 Extremely

A11. Please specify the degree to which your training involved specifics on the use of between-session activities in therapy (i.e., according to theory, research or recommended guidelines and models).

- 0 Not at all
- 1 A little
- 2 Somewhat
- 3 Very
- 4 Extremely

A12. Please indicate how confident you are in your ability to integrate between-session activities into therapy according to theory, research or recommended guidelines and models.

- 0 Not at all
- 1 Somewhat
- 2 Moderately
SECTION B: INTEGRATING BETWEEN-SESSION ACTIVITIES INTO THERAPY

Although we know that this will vary from client to client, please estimate how often you have done the following when recommending between-session activities in the past 3 months. Please rate on a scale of 0 (none of the time) to 4 (always).

<table>
<thead>
<tr>
<th>None of the time</th>
<th>Occasionally</th>
<th>Fairly many times</th>
<th>Very often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

When selecting tasks have you......

In the past three months, when selecting tasks for between-session completion with clients, how often have you:

**B1.** Discussed clients’ existing helpful and unhelpful coping strategies, and ideas and beliefs related to their between-session activities (e.g., used guided discovery, explored client strengths)

**B2.** Integrated aetiological models of specific disorders (e.g., Axis I, II, III, etc) and the overarching case formulation/conceptualisation in the selection of tasks

**B3.** Collaboratively decided upon between-session activities with clients

**B4.** Presented a rationale for between-session activities

**B5.** Presented a rationale for between-session activities that is aligned with clients’ goals

**B6.** Asked about clients’ ability to engage in the task

**B7.** Asked about perceived task difficulty

**B8.** Facilitated or enabled client in-session practice of the task (e.g., rehearsal, experiential learning)

**B9.** Used guided imagery as part of in-session practice

**B10.** Used a theoretical framework to help identify clients’ beliefs and situational triggers for the task

When planning tasks have you......

In the past three months, when deciding how between-session activities will be practically implemented, how often have you:

**B11.** Asked clients to summarise the reason for the task (i.e., rationale) in relation to their therapy goals

**B12.** Collaboratively arrived at a decision for when the task(s) will be practiced

**B13.** Collaboratively arrived at a decision for where task(s) will be practiced

**B14.** Collaboratively arrived at a decision for how often task(s) will be practiced

**B15.** Collaboratively arrived at a decision for how long each task practice will take to complete

**B16.** Considered potential difficulties involved in the task (e.g., practical obstacles such as weather, emotional distress involved, work demands)
B17. Emphasised between-session activities as having a learning focus (e.g., an ‘experiment’, a no-lose scenario, partial completion is helpful, seeing what works and what doesn’t)

B18. Asked clients to summarise the between-session task

B19. Asked for clients’ feedback regarding their readiness to carry out the task

B20. Asked for clients’ feedback regarding perceived task importance

B21. Asked for clients’ feedback regarding their confidence in being able to carry out the task

B22. Client has a written summary of the task as a reference

________________________________________________________________________________________

When reviewing tasks have you....

In the past three months, when reviewing between-session activities, how often have you:

B23. Asked if the task was done (i.e., quantity)

B24. When relevant, discussed task non-completion

B25. Discussed quality of task completion

B26. Provided verbal reinforcement (i.e., praise) for any portion carried out

B27. Discussed reactions to the task (e.g., thoughts, emotions, physical reactions, behaviours)

B28. Used a theoretical framework (e.g., interpretation, cognitive conceptualisation) to make sense of task non-completion or completion

B29. Attempted to identify and problem solve practical obstacles (e.g., work demands, emotional distress, financial issues) that influenced the task

B30. Recorded between-session task completion in your session notes

________________________________________________________________________________________

SECTION C: DEMOGRAPHICS

A reminder that your participation in this survey is anonymous and data collected will be kept strictly confidential.

C1. Please indicate your gender.

☐ Male ☐ Female

C2. How old are you? _____ years

C3. Ethnicity

☐ Australian
☐ New Zealand
☐ European
☐ Asian
☐ Middle Eastern
☐ American
☐ British
☐ Irish
☐ African
☐ Other (please specify) _____________
C4. Highest academic degree:

- Masters
- PhD
- DPsych
- Bachelor
- Diploma
- Other (please specify) _______________

C5. For how long have you been practicing psychotherapy? Please provide an estimate in full-time years, including practice during training and excluding periods when you did not practice (e.g., annual leave, extended travel).

_________ full-time years

C6. Please specify which professional organisation(s) you belong to.

- Australian Psychological Society (APS)
- Australian Association of Cognitive Behavior Therapy (AACBT)
- New Zealand Psychological Society
- New Zealand College of Clinical Psychologists
- American Psychological Association (APA)
- American Psychological Society (APS)
- Association for Behavioral and Cognitive Psychotherapies (ABCT)
- British Association of Behavioral and Cognitive Psychotherapies (BABCP)
- Other (please specify) _______________

C7. Please select one setting that most accurately describes your primary work place.

- Public hospital inpatient
- Public hospital outpatient
- Private hospital inpatient
- Private hospital outpatient
- Public service
- Group private practice
- Individual private practice
- Other (please specify) _______________

C8. Please specify the average number of clients that you see in therapy per week

_______ clients

C9. Please specify your total contact time with clients in therapy per week on average

_______ hours

C10. Based on your current caseload, please indicate the percentage of clients that you treat from the following treatment modalities.

Individual _________ % of clients
Couple _________ % of clients
Family _________ % of clients
Group _________ % of clients
Other (please specify) ____________ and _________ % of clients
C11. Based on your current caseload, please indicate how many of your current clients you treat in the following age groups.

- 12 years and younger ____________ clients
- 13-19 years ____________ clients
- 20-49 years ____________ clients
- 50-64 years ____________ clients
- 65 years and older ____________ clients

C12. Please indicate how you heard about this survey. [ADD MORE OPTIONS....]
- Email - direct invitation from researcher
- Email – forwarded by colleague
- Facebook
- LinkedIn
- Social Networking
- Workshop conducted by Dr. Nikolaos Kazantzis
- Other (please specify) ____________

Thank you for taking the time to complete this questionnaire.

Following is the output of your personal profile.
SECTION D: FEEDBACK
Thank you once again for completing this survey. As you are one of the first 10 participants to complete this survey, we would like to invite you to provide some feedback. So that we can improve the delivery of the survey, we welcome your feedback regarding the usability of the survey, whether or not the questionnaire items and instructions were clear, the survey layout and any other feedback you may have. If you would like to, please provide feedback in the space provided below, otherwise click on the button below to proceed to the next section.

Please provide your email address if you would like to enter the draw to win one of three books which includes one on the topic of the use of between-session activities in therapy and two Cognitive Behavioural Therapy text books.

Email address:

Please provide your email address if you would like to be sent the study findings when they become available.

Email address:
Appendix B

Coding of Theoretical Orientation

Analytic
- Analytic
- Interpersonal
- Psychoanalytic
- Psychodynamic

Client-centred
- Client-Centred

Cognitive-behavioural
- Mindfulness-based
- Narrative
- Positive Psychology
- Problem Solving
- Rational Emotive Behaviour
- Schema
- Cognitive Analytic
- Cognitive-behavioural
- Constructivist

Behavioural
- Acceptance and Commitment
- Behavioural
- Dialectical Behaviour

Systemic
- Relational
- Systemic

Humanistic
- Existential
- Gestalt
- Humanistic
- Emotion Focused
Appendix C

Detailed Description of the Homework Procedures Implemented as Outlined in the CBT Homework Enhancement Protocol (Kazantzis, MacEwan, & Dattilio, 2005)

In the design phase, the following 8 steps were implemented:

a) Explored participants’ existing helpful and unhelpful coping strategies, and ideas and beliefs about the task. Participants were asked about whether they had engaged in a monitoring type task or rated their emotions before.

b) Used a disorder specific cognitive model and individualised conceptualisation. Participants were informed about the positive relationship between engagement in pleasant activities and well-being. The link between completing the self-monitoring task as a means of learning about what activities bring pleasure, so that those activities can be planned more often was explained.

c) Collaboratively decided homework task. In order to account for potential confounds that may arise from collaboratively selecting different tasks with participants, a standardised task was used. However, facilitators did work collaboratively with participants to design an individualised pleasure rating scale.

d) Presented a rationale for between-session activities that aligned with participants’ goals. The use of the self-monitoring task as a means to learn about what makes the participants happy was made explicit.

e) Asked about participants’ ability to engage in the task and perceived task difficulty.
f) Facilitated in-session practice of the task. Participants were provided with the opportunity to practice completing the task in-session with the guidance of the facilitators.

g) Guided imagery was used as part of in-session practice. Participants were able to rehearse engaging in the task through guided imagery. This enabled participants to identify environmental triggers (e.g., meal times) and obstacles to task completion.

h) Used a theoretical framework to help identify participants’ beliefs and situational triggers for the task. Following guided imagery, participants’ thoughts, feelings, physiology and behavioural responses to the task were explored.

In the assign phase, the following 6 steps were implemented:

a) Asked participants to summarise the reason for the task (i.e., rationale) in relation to study goals.

b) Collaboratively arrived at a decision about how task completion will be practically possible. This involved asking questions to attain a degree of specificity about when, where, and how often task practice will occur, and how long each task practice will take. Participants noted their plans for task completion on the Between-Session Activity Form (see Appendix D).

c) Considered potential difficulties to task completion. Practical obstacles (e.g., work demands, forgetting) were explored and strategies to overcome the obstacles identified. Plans for task completion were adjusted accordingly.

d) Emphasised task completion as having a learning ‘experiment' focus.

Participants were encouraged to view his or her engagement in the self-
monitoring task as a learning opportunity, that any information gathered will be useful to help them understand what activities are pleasurable for them. They were advised to attend the second session even if they had not completed any or only some of the log. Participants were informed that their experiences and any difficulties encountered will be discussed at the second meeting.

e) Participants were asked to summarise the task and provide ratings of their readiness and confidence (renegotiate if <70%) to carry out the task, as well as perceived task importance. Ratings were made on a scale of 0 to 100. Participants noted their responses to these items on the Between-Session Activity Form (Appendix D).

f) Make a written note of the task. Participants completed the Between-Session Activity Form (Appendix D) which provided them with a written summary of the task as a reference.

In the review phase, the following 6 steps were implemented:

a) Discussed quantity and quality of task completion and when relevant task non-completion. Focus was on learning not compliance.

b) Provided verbal reinforcement (i.e., praise) for any portion carried out.

c) Used situational conceptualisation to identify beliefs about the task. Participants’ reactions (e.g., thoughts, emotions, physical reactions, behaviours) to the task were elicited by asking them to think of a specific situation when they completed the task. Beliefs about the costs and benefits of engaging in the task were also explored.
d) Used a theoretical framework (e.g., cognitive conceptualisation) to understand task non-completion. If mentioned in earlier discussions, used information from a participants’ individualised conceptualisation to make sense of why they may not have completed the task.

e) Problem solved practical obstacles. Discuss any practical obstacles encountered that influenced task completion and collaboratively problem solved possible solutions.

f) Recorded task completion in session notes. Completed self-monitoring tasks were kept by the facilitators, with participants making a copy for themselves if desired. A record of other factors that may have affected task engagement (e.g., beliefs, obstacles) was obtained by administering the HRS-II measure (Kazantzis, Deane, & Ronan, 2005; Figure 4).
Appendix D

Protocol Manual

Manual for the Tracking Positive Emotion Study Meetings

2010

La Trobe University, Bundoora

Dr Nikolaos Kazantzis

Clare Allan

Melanie Cresci

Linda Troselj
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About this study

This study will investigate whether the way in which between-session activities are integrated into sessions will lead to increased task engagement. Participants will learn how to complete an activity log and rate the amount of pleasure they get from their activities. Two group meetings will be conducted by two student researchers, with each meeting running for no more than 70 minutes. The first meeting, will involve learning the task and planning for the completion of the task before the next meeting. In the second meeting, task completion will be reviewed. Participants will be randomly assigned to one of these four groups:

<table>
<thead>
<tr>
<th>CONDITION 1 [CONTROL]</th>
<th>Tracking positive emotions log minus therapist guidance for planning homework (participants will be assigned the task using a method based on data from practitioner surveys)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONDITION 2 [PROTOCOL]</td>
<td>Tracking positive emotions log plus the protocol (Kazantzis, MacEwan, &amp; Dattilio, 2005) for enhancing engagement with homework.</td>
</tr>
<tr>
<td>CONDITION 3 [WITHOUT IN-SESSION PRACTICE]</td>
<td>Tracking positive emotions log minus in-session practice from the protocol (Kazantzis, MacEwan, &amp; Dattilio, 2005).</td>
</tr>
<tr>
<td>CONDITION 4 [REMINDERS]</td>
<td>Tracking positive emotions log plus the protocol (Kazantzis, MacEwan, &amp; Dattilio, 2005) plus an SMS test message reminder to complete the activity.</td>
</tr>
</tbody>
</table>

This manual provides detailed instructions on how to conduct the meetings for each of the four conditions. Skip instructions are provided to guide facilitators with administering the conditions.
Meeting 1

Introduction

- Welcome participants to the study and thank them for their participation (we greatly appreciate it!)
- Introduce the facilitators
  - Provide information about the course of study being undertaken
- Before we begin, can everyone please make sure that their mobile phones are off or on silent
  - Explain the study
    “The purpose of this study is to gain an insight into the activities that you take part in everyday that give you pleasure. Being part of the study means that you will attend two group meetings. In this meeting today you will be provided with instructions on how to complete a log of your activities, along with a rating of how much pleasure you feel. You will also complete some questionnaires individually. After completing the activity schedule for 7 days consecutively, the second meeting will involve an opportunity for you to discuss your positive emotions log, and complete further questionnaires. The duration of each meeting will not exceed 70 mins, with both sessions being audio recorded. Please note that this study is not therapy.”
- Group agreement
  - “In these group meetings we agree to respect each other and not talk when others are talking. We agree to be mindful of how long we share, allowing others an opportunity to contribute. We agree to respect the different ideas and options others may hold, and refrain from commenting on other people’s experiences. We agree to respect the anonymity of group members and maintain confidentiality of the information disclosed during these meetings.”
  - On a whiteboard, write additional items for the group agreement by asking the group
- Assign confidential ID numbers to participants
  - advise them that the ID numbers are written on all forms and are to be kept confidential
- Hand out materials folder to each participant
- Ask participants to read Form 1 the Participant Information Sheet and then complete the Form 2 the Consent Form.
- Advise participants of the study withdrawal procedure and hand out Form 3 the Withdrawal of Consent Form.
“You have the right to withdraw from active participation in this project at any time and request that data arising from your participation not used, provided that this right is exercised within four weeks of the completion of your participation in the project. If you mislay your identification number you will not be able to withdraw from the study, nor will you be able to obtain a copy of your personal results. You are asked to complete the “Withdrawal of Consent Form” or to ‘notify the investigator by e-mail or telephone that you wish to withdraw from the study’”

- Ask participants to complete Form 4 the Demographic Form
- Ask participants to complete Form 5 the WHO-5 well-being measure
- **GOAL**
  - “Ok, I would know like you to turn to the person next to you and introduce yourself and for 2 minutes have a talk to them about what attracted you to participate in this study and what you think you will gain from completing the rating positive emotion log. We’ll give you 2 minutes to do this and then we will ask you to report back to the group.”
  - “Ok, would anyone like to share what attracted then to the study and what they think they will gain from completing the rating positive emotion log?”
  - Explain to participants that what they have said can be considered their goal

[Note to facilitator: The protocol items do not need to be followed in a sequential order]
Homework Design

***CONDITION 1 – SKIP TO PROTOCOL ITEM 3***

**PROTOCOL ITEM 1: Guided discovery to Identify Coping Strategies and Beliefs**

- “Today we are going to learn how to complete an activity log and rate the amount of pleasure you get from activities”
- Advise participants that you have some forms for them to follow, but you are curious to know if they have ever recorded their emotions before.
- Explain how/what they have done is similar/different to what they are going to be doing in this study.

**Example**

- Have you completed any daily recording before?
- How do you feel about recording your daily activities?
- Is this like anything you have had to do before?

**PROTOCOL ITEM 2: Use Disorder Specific Cognitive Model and Individualised Conceptualisation**

- Connection between what we are doing and what you are hoping to get out of the study.
- “We know that when people engage in pleasurable activities they have better well-being. By completing the rating positive emotions log will might gain a better understanding of the pleasure you receive from you daily activities. It might confirm what you already know. You may even discover which activities give you a lot of pleasure, and you can plan to do these activities more often.”

**Example**

- How do you know when you enjoy things?
- How do you connect pleasure to your activities?

**PROTOCOL ITEM 3: Collaboratively Select Tasks**

- “For the study we are giving you a form to fill out, but everyone will fill it out differently, as people will have different activities they are doing and different hours of the day that they do things.”
- “Part of the rating positive emotions log involves you recording the level of pleasure you receive from your daily activities. In order to complete the pleasure ratings we are going to help you develop a pleasure rating scale.”
- “Please use a 0 to 10, or 0 to 100 scale, with 0 being an event that gave you the least amount of pleasure and 10 or 100 the event that gave you the most amount of pleasure.”
- Ask participants to use the Blank Sheet of Paper provided in their folders to develop their pleasure rating scale.
- “Based on past experience write down what is the most pleasurable experience you have had, please put this on the scale at 10 or 100. What you put down will be unique to you and it will be different for everybody, none of this information will be shared with anyone outside of this room or with any of the researchers of the study. Therefore you can be quite specific about the activities you place on your scale.”
- “Does anyone feel comfortable to share what they have put down?” If no give a few examples:
  - your favourite sports team winning a final
  - travelling overseas
  - buying your first car
  - passing an exam
- “Next, let’s put down an event that gave you the least amount of pleasure or no pleasure at all. Put this on the scale at the 0 rating. Let’s select a midpoint and a couple of other points on the scale.”
- If the ratings are vague ask them to be more specific.
  - “Is your rating closer to being a 6 or a 7? Which one is it?”
  - “Do you think you’d be able to use that now, in the next 30 minutes?”
  - Remind people about confidentiality: “This is private, be a lot more specific”
- Make sure not condoning or judging what people put down.
- If people mention drugs as being pleasurable, you may say:
  - “I’m not condoning that, but let’s put that down”
  - “I’m not condoning that alcohol is a good thing but lots of people in the population drink alcohol”
- Ask participants to take out the Rating Positive Emotion Log from their materials folder. Explain to participants how to complete the log.
- Advise participants that they will need to rate their daily activities using their personal Pleasure Rating Scale.

- Explain social interaction and when they should/should not tick this box.
  
  Social interaction can be verbal or non-verbal communication (e.g., watching TV with another person); in-person or on the phone/Internet. For example, you would tick social interaction if you were in a class tutorial participating in a group activity. However, you would not tick social interaction if you were on the computer writing an essay, by yourself.

- Advise them there are no right or wrong answers and even if they think they are doing nothing at all still write this down.

- Remind participants about confidentiality: “We will be keeping a copy of your rating positive emotions log. The log will remain confidential as they only have your ID numbers on them and we will not know who they belong to.”

- Remind participants that the more detail they put into the activity descriptions they more they will gain from completing the log. For example
  
  “Instead of writing work as your main activity perhaps it would be more beneficial to write down what you were doing at work in that hour.”

**Example**

- “What sort of activities do you think you will be recording?”
- “Choose one thing that characterises the hour, as long as it captures...”
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**Example:**

- **Date:** June 22, 2010
- **Time:** 6:30 A.M.
- **Activity:** Walking the Dog
- **Rating:** 4

**Instructions:**

1. **Social Interaction:** Record who you interacted with and how you felt about the interaction.
2. **Task Activity:** Record what activity you did and how you felt about it.
3. **Environment:** Record where you were and how you felt about it.
4. **Rating:** Rate your overall mood on a scale of 1 to 10, where 1 is worst and 10 is best.

**Steps:**

- **Step 1:** Record the date and time you did the activity and your mood.
- **Step 2:** Rate your overall mood on a scale of 1 to 10.
- **Step 3:** Record the activity and your mood.
- **Step 4:** Record the environment and your mood.

**CBT Homework Protocol**

- **P.M.** Activities include: Walking the Dog, Social Interaction, Task Activity, Environment.
- **A.M.** Activities include: Walking the Dog, Social Interaction, Task Activity, Environment.
### PROTOCOL ITEM 4: Present a Rationale that Aligns with the Clients’ Treatment Goals

- Link what participants mentioned earlier as their goal to how the Rating Positive Emotion Log will help them achieve that goal.
- Emphasise the perceived benefit
- For example: “By keeping a log of how much pleasure you get from the activities that you do, you will better understand which activities bring you pleasure and which do not, helping you achieve your goal of [understanding what makes you happy].”

### PROTOCOL ITEM 5: Ask about Clients’ Ability and Perceived Task Difficulty

- Ask how confident they are that they will be able to complete the task.
- Query the participants’ ability to complete the Rating Positive Emotion Log before the next meeting.
- Any difficulties need to be discussed and worked through collaboratively.

**Example**

- “How does this task seem to you? Is it too difficult?”
- “Do you think you will be able to do the task?”

***CONDITION 3 – SKIP TO PROTOCOL ITEM 7***

### PROTOCOL ITEM 6: In-Session Practice of the Task

- Facilitator not doing the talking is to go around and check how the participants are going
- A practice of how to complete the Rating Positive Emotion Log
  - Get participants to fill in the Rating Positive Emotion Log in the session for today
  - Ask participants to fill in the first column with today’s day and date. Then ask them to fill in each hour, starting from when they woke up, until now.
  - Ask participants to rate their daily activities using their personal Pleasure Rating Scale.
  - Ask participants to tick the social interaction box on the activity log if the main task they were undertaking that hour involved social interaction – use explanation on the log if they are unsure.
- Mention to participants that being more specific about the activities they are doing may be more useful for them (e.g., instead of writing down “work”, it may be more helpful to be more specific like “staff meeting at work”).
- “Ok, now I’d like you to turn to the person next to you that you were talking to before and ask each other how you went during the practice, and whether you have any question or concerns about filling out the log.”
- “Does anyone have any questions?”

***CONDITION 1 – SKIP TO PROTOCOL ITEM 9***

**PROTOCOL ITEM 7: Guided Imagery to Begin Experiential Learning**

- Provide participants with an opportunity to have an experience of imagining how they will go about engaging in completing the Rating Positive Emotion Log.
- Ask participants to close their eyes (eyes can be kept open if participants do not feel comfortable having them closed) and imagine what they will be doing in the next day/next hour etc. Ask them to find the soonest time in their day when they think they will be able to fill out the log next. Then ask them to remember to fill out the activity log and picture themselves doing that. Identify situational triggers, specific time and location. Notice what is shifting in terms of thoughts, emotions, physiology and behaviour.
- Assist participants in noticing how completing the Rating Positive Emotion Log will fit into their life
- Assist participants in identifying their beliefs about the task and identify possible obstacles that may arise.
- Ask participants about how it felt imagining filling out the activity log. Identify changes in affect/emotion. Thank people who shared their experiences.

**Example**

- “Imagine yourself doing the task”
- “Imagine yourself leaving this room, so from 2pm to 3pm what will you be doing? Can you see yourself doing this task?”
- “Let’s assume you have taken 5 minutes to do this”. Close or leave your eyes open.
- “How did it feel imagining yourself filling out the Rating Positive Emotion Log?”
PROTOCOL ITEM 8: Situational Conceptualisation to Identify Beliefs and Situational Triggers

- Explore participants’ thoughts, feelings, physiology and behavioural responses related to the completion of the Activity Log.
  - Generally discuss this during guided imagery and again afterwards

Example

- “What kind of thoughts were going through your mind when you imagined yourself completing the log? Feeling? Body reactions?”
- “When you finish work, that is your trigger to complete the log”

Homework Assign

PROTOCOL ITEM 9: Ask Client to Summarize Rationale in Relation to Therapy Goals

Example

- “What do you think you will gain from completing the log?”
- “How do you think this activity is going to help?”
- “Can you tell me why it might be worth the effort to do all this?”

***IF IN CONDITIONS 2, 3 OR 4 ASK THE FOLLOWING, OTHERWISE SKIP TO NEXT SECTION:

- Ask participants to take out the Homework Assignment Form from their folders and make a note of their goal on the form (i.e., Learning Goal), which is what we talked about in pairs at the beginning of today’s meeting.

***CONDITION 1 – PARTIAL COMPLETION OF PROTOCOL ITEM 10***

PROTOCOL ITEM 10: Collaborate to Specify How the Task Will be Practically Possible (i.e., where, how often, and how long it will take)

- “Ok, now I would like you to take out the Between-Session Activity Form. We will be keeping a copy of this form but like the tracking positive emotions log, it will only have your ID number of it so we won’t know who it belongs to. You will also get to take a copy of the form home.”
- “The first thing I would like you to do is fill out today’s date which is …….. and the date of your second meeting, which will be ……..”
- “Then I would like you to, in your own words, complete the activity description”
- Ask participants individually when, where, how often and how long they think the task will take.
- Advise that if they could record as long as possible that would be great.

***CONDITION 4 - use this information as a starting point, along with the reminder timeslots form for the content that will be used in the reminders being sent***

Example

- “Thinking about it, _when_ do you think you can do the task?”
- “Thinking about it, _where_ do you think you can do the task?”
- “_How often_ do you think you will be doing the task?”
- “_How long_ do you think you need to put aside to do this?”

***CONDITION 1 – SKIP TO PROTOCOL ITEM 15***
# Between-Session Activity Form

**Today’s Date:** 

**Next Appointment Date:** 

**Session Number:**

## Activity Description:

**Learning Goal** (e.g., test idea/practice skill):

**When** (e.g., 11:45 am before lunch):

**Where** (e.g., in the bedroom/at work):

**How often** (e.g., times per day/hour/week):

**How long** (e.g., hours/minutes):

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PROTOCOL ITEM 13: Ask Client to Summarise Task and Obtain Rating of Readiness, Importance, and Confidence (renegotiate if <70%)

a) Summarise Task
   - “Can you tell me in your own words what the task is?”
   Ask participants to complete the Homework Assignment Form as we go through the next few items

b) Obtain Rating of Readiness
   - Ask participants how ready they are to do the task

c) Obtain Rating of Importance
   - “What would have to happen to make this more important to you?”
   - “What stops it from moving from X to 100?”

d) Obtain Rating of Confidence (if <70% renegotiate)
   - Participants need to be at 70% confident that they can complete the task, otherwise do not move on and renegotiate. Questions to ask:
     - “What would make you more confident about the task?”
     - “What would need to happen to take the score from X to 100?”
     - “What are the steps you need to take to feel confident to start?”

PROTOCOL ITEM 11: Consider Potential Difficulties (i.e., link to obstacles identified during review)

Example

- “Can you think of anything that might get in the way of you doing this?”
- “How would you get around this obstacle?”
## PROTOCOL ITEM 12: Emphasize Learning ‘Experiment’ Focus

- Advise participants that the week of completing the Rating Positive Emotion Log may be viewed as an experiment, an opportunity for them to go away and try to complete the task. Their experiences, any difficulties or obstacles encountered can be discussed when they return for the second meeting.
- Advise participants to come to the second group meeting even if they have not completed any, or only some of the log as this is all part of the learning process.

### Example

- “You are not being graded”
- “There are no right or wrong answers”
- “Any information you gather will be useful to help understand what activities are pleasurable for you”

## PROTOCOL ITEM 14: Make a Written Note of the Homework for the Client (or use Homework Form)

- Protocol Item 14 will be completed individually with each participant.

### CONDITION 4: Ask participants to fill in the Reminder Timeslots Form

- As you all know a condition of your participation in this study was that you own a mobile phone that can receive SMS text messages
- Does everyone have one?
- Ok, to help remind you to complete the rating positive emotions log, we will be sending everyone a daily SMS text message. But we would like you choose the time that you would like to receive the message at for the next seven days. This time can be between 9am and 5pm. This time can be the same for the next seven says or it can be different, it is really up to you.
- The SMS text message will be sent to you at the times you have requested, except when we are running sessions for the study. If we are running a session during the time you have requested then reminder will be sent to you as soon as the session we are running has ended, usually within 1 hour.
- So now we would like you to take some time to think about which times would be best for you to receive the reminder over the next seven days. It may be useful to refer back to the between session activity form where you wrote when you plan complete the log, and then base your reminder times around that.
- Once you have thought about it, please get out Form 7 the ‘reminder timeslots form’ and circle the times at which you would like to receive the reminders.

********

- Summarise – “Today we’ve spent some time putting together a scale for pleasurable emotions and learning how to complete a Rating Positive Emotion Log to record our activities and rate the pleasure you feel when undertaking an activity.”
- Ask participants to complete Form 6 the Group Questionnaire
- Participants advised that after the second meeting, we will be keeping the completed Rating Positive Emotion Log and should they want a copy for themselves that should make a copy before they attend the second meeting.
- Participants are then reminded they are required to attend a second meeting, day, date, time and venue information given.
- Remind participants to maintain confidentiality of the information disclosed during today’s group meeting.
- Advise participants that in the event that they may have experienced any unpleasant emotions or some form of emotional distress, assistance is available by contacting the chief investigator of the study Dr. Nikolaos Kazantzis, the La Trobe Counselling Service or Psychology Clinic. These contact details are provided on the Participant Information Sheet.
- Remind participants to take the Participant Information Sheet, Withdrawal of Consent Form, their Pleasure Rating Scale, the white copy of the Between Session Activity Form and the Rating Positive Emotion Log with them when they leave.
- Thank participants for their time today.
Meeting 2

- As participants come in and sit down hand them their materials folder and ask them to complete Form 8 the WHO-5, Form 9 the Positive Emotion Log Completion Strategy and Form 10 the HRS-II
- Welcome participants to the second meeting.
- Remind participants of the Group agreement
  - “In these groups meetings we agree to respect each other and not talk when others are talking. We agree to be mindful of how long we share, allowing others an opportunity to contribute. We agree to respect the anonymity of group members and maintain confidentiality of the information disclosed during these meetings.”

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Homework Review

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<tr>
<th>PROTOCOL ITEM 15: Discuss Non-Completion and Quantity and Quality of Completion</th>
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<tr>
<td>- Discuss with participants how they went with engaging in the task</td>
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<td>- Focus on learning not compliance</td>
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<td>- Ask about their experiences of engaging in the task</td>
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<td>- “How did people go with completing the task?”</td>
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<td>- “What did you get out of it?”</td>
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<td>- Ask about quantity and quality of task completion</td>
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<td>- “How much did people complete? All 7 days, 6 days, 2….?”</td>
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</table>
PROTOCOL ITEM 16: Provide Verbal Reinforcement for any Portion Carried Out

- Praise participants for any portion of the task completed or attempted
  - “It’s good to see that some people completed X days and others X days, that you all attempted to complete the log.”

PROTOCOL ITEM 17: Situational Conceptualisation to Identify Beliefs about the Consequences to Homework (i.e., synthesis of learning)

- Ask participants to identify a specific situation in which they completed the Rating Positive Emotion Log.
  - “Can people think of a specific situation in which they completed the log?”
    - “What image did you have as you did this?”
    - “How did you feel in your body?”
    - “What thoughts did you have?”
    - “What emotions did you have?”
- Discuss participants’ beliefs regarding the costs and benefits of engaging in the activity.
  - “What did you learn from completing the log?”
  - “Did you find out anything that was surprising?”

PROTOCOL ITEM 18: Use Individualised Conceptualisation to Make Sense of Non-Completion

- If mentioned in earlier discussions, use information from a participants’ individualised conceptualisation to make sense of why they may not have completed the task.

PROTOCOL ITEM 19: Problem-Solve Obstacles

- Discuss any obstacles encountered and collaboratively problem solve possible solutions
  - “Did anyone experience any obstacles in doing the task?”

PROTOCOL ITEM 20: Record Homework Completion in Session Notes

- A record of homework compliance can be obtained by asking participants to complete the Homework Rating Scale II.
• Take the *Rating Positive Emotion Log* from each participant
  - For those participants who require a copy for their own records, advise them to go with one of the facilitators at the end of the session to obtain a photocopy.
• Provide participants with **Form 11** the *Written Debrief Form*.
  - Remind participants that in the event that they may have experienced any unpleasant emotions or some form of emotional distress, assistance is available by contacting the chief investigator of the study Dr. Nikolaos Kazantzis, the La Trobe Counselling Service or Psychology Clinic. These contact details are provided on the Participant Information Sheet.
• Prize Draw
  - Ask participants to fill in **Form 12** the *Prize Draw Form* and inform them that it is voluntary.
  - Advise participants about the prize draw:
    “*You have the chance to go in to the draw to win one of 4 x $100 Coles/Myer vouchers. The winners will be randomly drawn on November 1st 2010 and notified by email.*”
• Thanks participants for their time
• Ask participants to put their hand up once they have completed the Prize Draw Entry Form so that you can come around and check that they have completed all the forms – then they are free to leave.

******

**References**

Appendix E

Homework Adherence and Competence Scale (HAACS) – Adherence Only (revised)
### HAACS: Homework Adherence and Competence Scale

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

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

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<tr>
<th>HOMEWORK REVIEW</th>
<th>Items 1-5 cover the therapist behaviors involved in reviewing homework from the previous session, and typically occurs early in the session.</th>
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<tr>
<td>1</td>
<td><strong>DID the therapist discuss the completion of previously assigned homework to any extent?</strong></td>
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<td></td>
<td><strong>[Yes] [No]</strong></td>
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<tr>
<td>2</td>
<td><strong>DID the therapist provide verbal reinforcement (i.e., praise) for any portion of the homework carried out?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>[Yes] [No]</strong></td>
</tr>
<tr>
<td>3</td>
<td><strong>WAS a situational conceptualization (e.g., thoughts, behaviors, emotions, physiology) used in reviewing previously assigned homework?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>[Yes] [No]</strong></td>
</tr>
<tr>
<td>4</td>
<td><strong>WAS an individualized conceptualization used to make sense of any portion of non-completed homework (i.e., linked non-completion to the client’s automatic thoughts, underlying assumptions and rules, or core beliefs)?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>[Yes] [No] [n/a]</strong></td>
</tr>
<tr>
<td>5</td>
<td><strong>DID the therapist attempt to problem solve practical obstacles to the homework?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>[Yes] [No]</strong></td>
</tr>
</tbody>
</table>

---

*Homework Adherence And Competence Scale © Copyright 2005-2006 by Nikolaos Kazantzis, Paul Wedge, and Keith D. Dobson. From the Team Research Project “Cognitive Behavior Therapy Homework Project” at Massey University.*
<table>
<thead>
<tr>
<th>HOMEWORK DESIGN</th>
<th>Items 6-14 cover the therapist behaviors involved in collaboratively deciding what homework will be carried out between sessions, and typically occurs throughout the session.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>WAS any new or revised homework discussed?</td>
</tr>
<tr>
<td></td>
<td>Note: This item asks about the therapist's use of the components of the &quot;guided discovery&quot; process. The guided discovery process has four sequential components which are:</td>
</tr>
<tr>
<td></td>
<td>i. Asking informational questions to uncover information outside the client's awareness,</td>
</tr>
<tr>
<td></td>
<td>ii. Listening emphatically and providing reflections,</td>
</tr>
<tr>
<td></td>
<td>iii. Summarizing the information discovered,</td>
</tr>
<tr>
<td></td>
<td>iv. Asking synthesizing or analytical questions which enable the client's own learning.</td>
</tr>
<tr>
<td>7</td>
<td>DID the therapist use any aspects of guided discovery to identify the client's coping strategies and beliefs related to the homework?</td>
</tr>
<tr>
<td>8</td>
<td>DID the therapist integrate a disorder-specific cognitive model with the individualized conceptualization in designing homework?</td>
</tr>
<tr>
<td>9</td>
<td>WERE homework tasks selected for completion before the next session?</td>
</tr>
<tr>
<td>10</td>
<td>DID the therapist present any rationale for the homework?</td>
</tr>
<tr>
<td>11</td>
<td>DID the therapist ask about the client's ability and perceived difficulty of the homework?</td>
</tr>
<tr>
<td>12</td>
<td>WAS ANY attempt made to facilitate in-session homework practice?</td>
</tr>
<tr>
<td>13</td>
<td>DID the therapist use guided imagery to begin experiential learning for the homework in session?</td>
</tr>
<tr>
<td>14</td>
<td>DID the therapist use a situational conceptualization to help identify the client's beliefs and triggers (i.e., emotional, behavioral, physiological) for carrying out the homework in specific situations?</td>
</tr>
</tbody>
</table>
### HOMEWORK ASSIGN

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAS there any attempt to summarize the rationale for the homework in relation to therapy goals?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>WAS there any attempt to specify when the homework will be practically integrated into the client's life?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>WAS there any attempt to specify where the homework will be practiced?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>WAS there any attempt to specify how often the homework will be practiced?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>WAS there any attempt to specify how long the homework will take to complete?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>WAS there any consideration of potential difficulties for completing the homework?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>WAS there ANY attempt to explain the outcome from the homework as having a learning ‘experiment’ focus?</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>WAS there ANY attempt to summarize the homework?</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
## Rating Positive Emotions Log

**Step 1:** On the log fill in the day and date you will be recording on. **Step 2:** Write the MAIN ACTIVITY you were doing in each timeslot. **Step 3:** In the box P (Pleasure Rating) note the rating of Pleasure you felt while undertaking this activity (0 to 100 or 1 to 10, ranging from “none” to “the most pleasure I have ever experienced”) using your pleasure rating scale. **Step 4:** Ask yourself how much pleasure/enjoyment do I get while doing this activity? **Step 5:** Tick the box SI (Social Interaction) if your activity involved spending most of the time interacting with another person (can be verbal or non-verbal communication; in-person or on the phone/internet). In the example shown, SI has been ticked as the person was in a university tutorial participating in a group activity. If you were in a busy bus with others you would not tick SI unless verbal/non-verbal interaction with others was the focus.

### Example

<table>
<thead>
<tr>
<th>Day: Date:</th>
<th>Day: Date:</th>
<th>Day: Date:</th>
<th>Day: Date:</th>
<th>Day: Date:</th>
<th>Day: Date:</th>
<th>Day: Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-7 A.M</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
</tr>
<tr>
<td>7-8 A.M</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
</tr>
<tr>
<td>8-9 A.M</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
</tr>
<tr>
<td>9-10 A.M</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
</tr>
<tr>
<td>10-11 A.M</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
</tr>
<tr>
<td>11-12 P.M</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
<td>SI</td>
</tr>
</tbody>
</table>

**Hints:** Start completing the chart today for the next seven days. Please include the day and date. Once you have completed one day simply continue with completing the following six days until the whole week is completed. Sometimes people forget to complete a day or part of a day. If this happens do not be discouraged and continue from the earliest missed set you can recall.

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Appendix G

Quality Rating Scale

QUALITY RATING SCALE

FOR THE

‘RATING POSITIVE EMOTIONS LOG’

Nikolaos Kazantzis
Clare Allan
Melanie Cresci
Linda Troselj

La Trove University
Melbourne, Australia

General Instructions:
This rating scale has been designed for use with the ‘Rating Positive Emotions Log’ used in The Positive Emotion Study. The Rating Positive Emotions log involves individuals recording the main activity they completed each hour of the day, rating the level of pleasure they received from the activity and indicating whether the activity involved social interaction. This activity is analogous to individuals rating their negative emotions in therapy. Given that many therapies include the monitoring of emotional states, this rating scale could be adapted to assess the quality with which similar recording tasks have been completed.

Instructions for Question 1:
Question one is to be completed by the individual that completed the Rating Positive Emotions Log (e.g., the participant or client).
Instructions:

Please circle the letter below that best represents the way you completed the Rating Positive Emotions Log over the past seven days. If you used more than one of the strategies represented below, please circle the letter that best represents the way you completed the majority of the Rating Positive Emotions Log.

- A: After each hour
- B: Completed chunks of 2-5 hours at a time
- C: At the end of each day
- D: Completed a whole day of recording at the start of the following day
- E: Completed the entire week all at once
- F: Didn’t complete at all

Instructions for Questions 2:

Question two is to be completed by the experimenter, clinician or researcher. Please circle the number (1, 2 or 3) that best corresponds to level of quality with which the Rating Positive Emotions log has been completed.

__2: Showed good breadth of use of the pleasure scale
- Low 1: Rated pleasure for all activities within the same range of 2 or 20 points
- Med 2: Rated pleasure for all activities within the same 5 or 50 points
- High 3: Used the entire scale eg. 1-10 or 1-100

Instructions for Questions 3:

Question three is to be completed by the experimenter, clinician or researchers. Please calculate the number of low, medium and high descriptions provided in the Rating Positive Emotions Log. Then calculate a percentage score (e.g., the total number of low activity descriptions, divided by the total number of activities recorded, multiplied by 100). Finally, please circle the number (1, 2 or 3) that best corresponds to level of quality with the majority of the Rating Positive Emotions Log has been completed.

___3: Provided adequate descriptions of activities
- Total___%_____ Low 1: A one word attribute e.g., ‘Work’
- Total___%_____ Med 2: Some detail beyond a one word attribute e.g., ‘Studying chemistry’ or ‘Watching neighbours’
- Total___%_____ High 3: High activity descriptions e.g., ‘Watching neighbours whilst eating dinner’
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