A thesis submitted to the University of Birmingham for the degree of

Doctor of Clinical Psychology

VOLUME I OF II

LITERATURE REVIEW and EMPIRICAL PAPER

Assessing the Suitability of Cognitive-Behavioural Therapy for Specialised Client Populations

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OVERVIEW

This thesis is submitted in partial fulfilment of the requirement for the degree of Doctor of Clinical Psychology at the School of Psychology, University of Birmingham. The thesis is comprised of two volumes. Volume I is composed of two parts: (1) a literature review concerning factors determining the suitability of cognitive-behavioural therapy (or, CBT) for adults with intellectual disabilities (prepared for submission to the Journal of Applied Research in Intellectual Disabilities) and, (2) an empirical paper detailing the development, validation and evaluation of a new method for assessing the suitability of CBT for older people with anxiety and/or depression (prepared for submission to the Behavioural and Cognitive Psychotherapy journal). A public domain briefing paper is also submitted as part of this volume.

Volume II is comprised of five clinical practice reports (or, CPRs). The first, a psychological models CPR, formulates the case of a 40 year-old woman with symptoms of depression from both psychodynamic and cognitive perspectives. The second, a single-case experimental design CPR, is concerned with the cognitive-behavioural formulation and treatment of obsessive-compulsive symptoms in a 45 year-old woman. The third, a service evaluation CPR, describes a consumer satisfaction survey that was conducted in a Clinical Psychology Service for Children and Young People. The fourth, a case study CPR, details working from a systemic perspective with a 49 year-old man with mild learning disabilities who was referred for anxiety relating to seizures. The fifth CPR, which was assessed by means of an oral presentation, is concerned with working from a narrative cognitive-behavioural perspective with a 75 year-old woman accessing inpatient mental health services due to psychotic experiences in the context of terminal physical health difficulties.

Throughout the two volumes, all names and identifying features, both of clients and services, have been changed or removed in order to ensure confidentiality.

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CHAPTER 1

Literature Review

What factors determine the suitability of cognitive-behavioural therapy for adults with intellectual disabilities? A review of the empirical literature[1]

[1] This paper was prepared for submission to the Journal of Applied Research in Intellectual Disabilities (see appendix A for guidance for authors)

1.1 ABSTRACT

Background: For any therapeutic approach, it is important to consider what factors determine its suitability for clients. As cognitive-behavioural therapy (or, CBT), is increasingly being investigated as a therapeutic intervention for adults with intellectual disabilities, this literature review considers the status of empirical evidence concerning factors that determine CBT suitability for this population.

Method: Using five electronic databases, searches were conducted to identify relevant empirical papers published between 1997 and 2010.

Results: Fifteen studies, of seventeen identified, were reviewed. Studies concerned either factors relating to CBT intervention responsiveness or the ability of participants to complete tasks thought necessary for CBT. Across the reviewed studies, several client and contextual factors of potential importance were identified. The veracity of these findings is considered with reference to study methodological issues.

Conclusions: Although a number of potentially important client and contextual factors have been identified in the literature, further investigations are needed to more clearly establish which of these relate to CBT intervention responsiveness.

Keywords: cognitive-behavioural therapy; intellectual disabilities; suitability; assessment; adults; literature review

1.2 BACKGROUND

1.2.1 The provision of cognitive-behavioural therapy for adults with intellectual disabilities

In cognitive-behavioural theories of mental health difficulties, thought processes are seen to mediate the affective, behavioural and physiological responses an individual experiences prior to, during and following certain situations (Trower, Jones, Dryden & Casey, 2011). Consequently, in cognitive-behavioural therapy (or, CBT), change is argued to occur through the identification and modification of unhelpful thinking patterns. Research suggests this approach can be effective for a range of adult mental health difficulties, including anxiety, depression, obsessive-compulsive disorder, phobias and low self-esteem (e.g. Roth & Fonagy, 2005). However, compared to intellectually able adults, the provision of CBT for adults with intellectual (or learning) disabilities has historically been poor (Stenfert Kroese, 1998), despite evidence of comparable if not greater rates of mental health difficulties within this population (Deb, Thomas & Bright, 2001; Kerker, Owens, Zigler & Horwitz, 2004). This disparity in CBT provision is likely due to a number of factors, including service organisation issues (Hatton & Taylor, 2005), difficulties assessing and identifying mental health problems in the context of an intellectual disability (Moss, 1995) and therapist beliefs and feelings about working with adults with intellectual disabilities (Bender, 1993; Lindsay, Neilson & Lawrenson, 1997). However, in more recent years, interest in CBT for this population has increased, both in the research literature

(for recent reviews, see Beail, 2003; Sturmey, 2004; Taylor, Lindsay & Willner, 2008; Willner, 2006, 2007, 2009) and in clinical practice (Royal College of Psychiatrists, 2004).

1.2.2 Determining the suitability of CBT for adults with intellectual disabilities

For any therapeutic approach, it is important to consider factors determining its suitability for clients and how these might be assessed by clinicians. To date, research regarding CBT suitability has largely concerned intellectually able adults, most notably in the work of Safran, Segal, Shaw & Vallis (1990; see also Safran, Segal, Vallis, Shaw & Samstag, 1993). These authors developed and validated a clinician-completed measure, the Suitability for Short-Term Cognitive Therapy (or, SSCT) interview and ratings procedure, which assesses and rates ten factors (including accessibility of automatic thoughts, awareness and differentiation of emotions and compatibility with the cognitive rationale) believed necessary for short-term CBT with an interpersonal focus. In a study of 42 clients who received CBT, mean pre-treatment ratings on the SSCT were found to correlate significantly with improvements on outcome measures and with both therapist and client ratings of therapy success. More recently, in a larger study of 113 clients receiving CBT for a range of mental health difficulties, Myhr, Talbot, Annable & Pinard (2007) found that mean SSCT scores were significantly correlated with treatment responsiveness and accounted for 20% of the variance in outcome data.

In the intellectual disabilities field, the issue of CBT suitability was first considered in detail by several authors contributing to the edited book *Cognitive-Behaviour Therapy*

for People with Learning Disabilities (Stenfert Kroese, Dagnan & Loumidis, 1997). Across the various clinical applications of CBT detailed in this text, three categories of suitability factors emerged, namely: (1) client factors, such as language comprehension and expression (Black, Cullen & Novaco, 1997; Loumidis & Hill, 1997; Reed, 1997; Williams & Jones, 1997), cognitive abilities, including memory, attention and speed of processing (Black et al., 1997; Jones, Miller, Williams & Goldthorp, 1997), motivation to engage in treatment, including sufficient self-esteem and self-efficacy (Black et al., 1997; Jones et al., 1997), and specific CBT skills, including the ability to identify thoughts, feelings and behaviours, understanding that responses to situations are mediated by cognitions, the ability to engage in collaborative empiricism and the ability to make use of self-report measures or other means of monitoring change (Black et al., 1997; Dagnan & Chadwick, 1997; Jones et al., 1997); (2) therapist factors, such as ability to adapt working to better meet the capabilities of individuals with intellectual disabilities (Stenfert Kroese, 1997) and the capacity to offer longer intervention periods and 'booster' sessions (Loumidis & Hill, 1997); and, (3) broader contextual factors, including whether conditions in the client's life facilitate the generalisation and maintenance of therapeutic gains (given that self-regulation difficulties may be present; Stenfert Kroese, 1997).

Of the authors contributing to Stenfert Kroese et al. (1997), Dagnan & Chadwick (1997) considered the issue of CBT suitability in most detail, and outlined findings relating to four client abilities felt necessary for this approach to be viable, namely: (1) identification of and differentiation between situations, beliefs and consequences (emotional and/or behavioural), (2) understanding that responses to situations are mediated by cognitions, (3) disputation or testing-out of beliefs, and (4) expression of

beliefs and consequences that can be quantified and used to detect change. In relation to the first two of these abilities, the authors found that of 29 individuals with mild to moderate intellectual disabilities 20% were able to identify appropriate mediating cognitions for recent situations in which they had felt sad or angry. Dagnan & Chadwick (1997) also outlined a more thorough assessment of CBT abilities and completed this with six participants. Results showed that all participants were able to pass a simple emotional recognition task (using happy and sad faces) and a test of situation-consequence linking (stating whether characters depicted in short stories would be happy or sad). However, on a further emotional recognition task, in which recognition from both faces and body postures was examined using ten-item picture arrays, performance was more varied (faces: mean 4.2/10, range 0 – 7; body postures: mean 5.0/10, range 1 – 7). Performance was also more varied on a cognitive mediation task (mean 3.7/6, range 1 – 6), in which participants were asked to state what they might be thinking given a scenario (e.g. *you see a group of your friends but they do not say hello*) and an emotional state (e.g. *happy*). Three participants were only able to give appropriate mediating thoughts when the valences of the emotion and the scenario were congruent, suggesting the use of a rule-based or intuitive approach rather than a clear understanding of cognitive mediation. Dagnan & Chadwick (1997) argued therefore that performance on trials where the valence of the situation and emotion were incongruent might act as a more definitive test of whether participants understand the mediating role of cognitions.

In regards to the third and fourth client abilities (disputation of beliefs and expression of beliefs and consequences in a quantifiable manner), Dagnan & Chadwick (1997) presented supporting case study material and also noted previous studies showing that

individuals with intellectual disabilities can make use of self-report measures gauging belief strength (Dagnan, Dennis & Wood, 1994; Dagnan & Ruddick, 1995).

Although the contributors to Stenfert Kroese et al. (1997) were the first to consider factors determining CBT suitability for adults with intellectual disabilities in detail, this was chiefly based on clinical practice rather than on empirical investigations (with the exception of Dagnan & Chadwick, 1997). Indeed, as was highlighted by Williams & Jones (1997) at the time ,"...there is, as yet, too little data to suggest for whom such techniques may work best and under what circumstances" (p.67). However, given the increased research interest in CBT for adults with intellectual disabilities since the publication of Stenfert Kroese et al. some 13 years ago, is this still the case? In order to address this question, a review of empirical investigations concerning factors determining the suitability of CBT for adults with intellectual disabilities was completed, encompassing studies published between 1997 and the end of 2010.

1.3 METHOD

Several search methods were employed to identify studies, published between 1997 and the end of 2010, which were either fully or partly concerned with the empirical examination of factors relating to CBT suitability for adults with intellectual disabilities. This search was not restricted to studies of a particular design as several methodologies were thought likely to generate findings relevant to the focus of this review. For example, the issue of CBT suitability for adults with intellectual disabilities could be addressed both through studies examining factors relating to CBT

treatment responsiveness as well as those investigating the ability of individuals from this client group to complete tasks thought necessary for CBT.

1.3.1 Search methods for identification of studies

Initially, searches were conducted of five electronic databases (Web of Science, PsycInfo, Medline, EMBASE and CINAHL) using the following keyword strategy: Topic=("mental* retard*" OR "learning difficult*" OR "learning disorder*" OR "learning disab*" OR "special need*" OR "intellect* disab*" OR "intellect* difficult*" OR "intellect* disorder*" OR "intellect* impair*" OR "learning impair*" OR "mental* impair*" OR "mental* disab*" OR "mental* disorder*") AND Topic=(CBT OR "cognitive behav* therap*" OR cognitive OR "cognitive-behav*" OR treat* OR interven*) AND Topic=(assess* AND (suit* OR approp*)) NOT Topic=(child* OR teen* OR adolescen* OR infant*). Searches were programmed to limit returns to results published between 1997 and the end of 2010. Reference lists of studies identified through these electronic searches were also examined. Three experts in the field of CBT for individuals with intellectual disabilities were also contacted and asked to identify any studies they felt would be appropriate for inclusion in the review.

1.4 RESULTS

1.4.1 Search results

Electronic database searches produced a total of 1461 returns, of which six were appropriate for inclusion in the review (Bruce, Collins, Langdon, Powlitch & Reynolds, 2010; Dagnan, Chadwick & Proudlove, 2000; Dagnan, Mellor & Jefferson, 2009; Esbensen & Benson, 2005; Joyce, Globe & Moody, 2006; Oathamshaw & Haddock, 2006). Through searching the reference lists of these papers, five additional studies were identified (Dagnan & Proudlove, 1997; Glenn, Bihm & Lammers, 2003; Jahoda et al., 2009; McKenzie, Matheson, McKaskie, Hamilton & Murray, 2000; Sams, Collins & Reynolds, 2006). Six additional studies were identified following contact with three experts in the field (Hagiliassis, Gulbenkoglu, di Marco, Young & Hudson, 2005; Rose, Loftus, Flint & Carey, 2005; Taylor, Novaco, Gillmer, Robertson & Thorne, 2005; Taylor, Novaco & Johnson, 2009; Willner, Brace & Phillips, 2005; Willner, Jones, Tams & Green, 2002). In total, 17 studies were identified for inclusion in the review. However, as the findings of Dagnan & Proudlove (1997) and Taylor et al. (2005) are presented and expanded upon in Dagnan et al. (2000) and Taylor et al. (2009), respectively, only these latter studies were considered in this review.

1.4.2 Review of included studies

Studies included in this review concerned either factors relating to CBT intervention responsiveness for adults with intellectual disabilities or the ability of this client group

to undertake tasks thought necessary for CBT. Studies in the latter category fell into six sub-categories, each concerning a different client ability. For each category, study findings are described and then summarised with reference to methodological considerations (including the reliability and validity of the measures and assessments used, the size and composition of participant samples and the means of statistical analysis employed).

1.4.2.1 Studies investigating factors relating to CBT intervention responsiveness in adults with intellectual disabilities

1.4.2.1.1 Summary of included studies

Details of the five studies included in this section of the review are presented in Tables 1.1a to 1.1c. Each study reported either a CBT-based anger management (Hagiliassis et al., 2005; Rose et al., 2005; Willner et al., 2002, 2005) or treatment (Taylor et al., 2009) programme for adults with intellectual disabilities and considered one or more factors relating to intervention responsiveness. Three studies used a randomised control trial (or, RCT) design (Hagiliassis et al., 2005; Willner et al., 2002, 2005), one a delayed wait-list control methodology (Rose et al., 2005) and one a treatment study design with no control or comparison group (Taylor et al., 2009). Four studies reported on community-based group CBT anger management interventions and one (Taylor et al., 2009) on individualised CBT anger treatment for forensic inpatients. All samples comprised of participants with clinically significant anger difficulties though varied in size (from 14 in Willner et al., 2002 to 85 in Rose et al., 2005), age range, gender composition and included intellectual disability range.

With the exception of Taylor et al. (2009), study samples were comprised of adults accessing community services (such as day services and community support teams) for individuals with intellectual disabilities.

All studies assessed the intellectual abilities of their participants using one or more established measure. Two studies (Willner et al., 2002; Taylor et al., 2009) assessed general intellectual functioning (using the Wechsler Adult Intelligence Scale – Revised (WAIS-R; Wechsler, 1981), the Wechsler Adult Intelligence Scale – Third Edition (WAIS-III; Wechsler, 1997), or the Wechsler Abbreviated Scale of Intelligence (WASI; Wechsler, 1999)), three (Hagiliassis et al., 2005; Rose et al., 2005; Willner et al., 2005) assessed receptive vocabulary (using the Peabody Picture Vocabulary Scale – Third Edition (PPVT-III; Dunn & Dunn, 1997), or the British Picture Vocabulary Scale (BPVS; Dunn, Dunn, Whetton & Pintillie, 1982)), and one (Hagiliassis et al., 2005) assessed non-verbal reasoning abilities (using Raven's Coloured Progressive Matrices (CPM; Raven, Raven & Court, 1998)).

All studies used established anger scales at pre- and post-intervention and at follow-up to measure treatment responsiveness. Three studies (Taylor et al., 2009; Willner et al., 2002, 2005) used the Provocation Index or Inventory (PI; Novaco, 1994, 2003), two (Rose et al., 2005; Willner et al., 2002) used the Anger Inventory (AI; Benson & Ivins, 1992), two (Hagiliassis et al., 2005; Taylor et al., 2009) used the Novaco Anger Scale (NAS; Novaco, 1994, 2003) one (Taylor et al., 2009) used the Trait Anger and Anger Expression Scale of the State-Trait Anger Expression Inventory (STAXI; Spielberger, 1996), one (Taylor et al., 2009) used the Ward Anger Rating Scale (WARS; Novaco, 1994) and one (Willner et al., 2005) used the Profile of Anger

Coping Skills (PACS; Willner et al., 2005). In one study (Hagiliassis et al., 2005), a quality of life measure (the Outcome Rating Scale (ORS; Miller & Duncan, 2000) was also used. Measures were completed either by clients (Hagiliassis et al., 2005; Rose et al., 2005; the NAS, STAXI and PI, as structured interviews, in Taylor et al., 2009), staff members (the WARS in Taylor et al., 2009; the PACS in Willner et al., 2005), or both (Willner et al., 2002; the PI in Willner et al., 2005).

Across studies, intervention programmes varied in duration from 18 x 1 hours (Willner et al., 2002; Taylor et al., 2009) to 16 x 2 hours (Rose et al., 2005). All studies used intervention programmes, designed or adapted for individuals with intellectual disabilities, based on Novaco's (1975, 1979, 1994) cognitive-behavioural model of anger management, which seeks to develop anger awareness (both of anger evoking situations and the physiological, behavioural and cognitive aspects of anger) and the use of coping strategies (such as relaxation, distraction and cognitive restructuring). In all studies, consideration was given to means of promoting adherence to treatment protocols, such as using fully scripted session plans (Hagiliassis et al., 2005), the provision of weekly peer supervision, completion of session reports and regular random reviews of therapists' treatment files (Taylor et al., 2009).

As shown in Tables 1.1a to 1.1e, all studies reported significant improvements (though to varying degrees) for participants in intervention groups compared to those in control conditions that were maintained at three to twelve month follow-up. These findings are not considered further here as they are not the primary focus of this

review (for a further discussion of the effectiveness of such interventions, see Willner, 2007).

Two studies investigated several factors potentially related to CBT intervention responsiveness by means of regression analysis. In Hagiliassis et al. (2005), which reported on a group CBT anger management intervention for adults with borderline to severe intellectual disabilities, performance on Raven's CPM was the only variable of five considered (the others being age, gender, primary mode of communication and PPVT-III score) found to significantly account for variance in anger score changes in the intervention group. Changes in anger scores were found to be negatively correlated with Raven's CPM performance, suggesting participants with greater difficulties in non-verbal reasoning abilities showed greater post-intervention improvement. In Rose et al.'s (2005) group CBT anger management study with adults with mild intellectual disabilities, variance in pre- to post-intervention improvement was significantly accounted for by BPVS (receptive vocabulary) score and accompaniment to sessions (with greater improvement noted for those with higher BPVS scores and those accompanied by a care worker) though not by client age, gender or therapist experience (whether the therapist leading the group attended was a clinical psychologist or a supervised nurse). However, these findings were not evident when pre-intervention to follow-up change scores were considered.

In the other studies included in this section, one or two factors potentially relating to CBT intervention responsiveness were examined. In Willner et al. (2002), which reported on a group CBT anger management intervention for adults with mild intellectual disabilities, participant full scale and verbal IQ scores (though not

performance IQ scores) were found to be significantly and positively correlated with a measure of overall improvement (calculated by averaging scores of client- and carer-rated anger measures). A further linear regression analysis concerning verbal IQ and change on outcome measures found that an improvement of approximately 1.7% on pre-intervention anger scores would be expected for each additional IQ point over 50 (those scoring at or below 50 would be expected to show no improvement). Willner et al. (2002) also noted that the four participants accompanied to sessions by a care worker showed significantly greater improvement that the three participants who were unaccompanied.

In Taylor et al. (2009)'s study of individual CBT anger treatment for adults with borderline to mild intellectual disabilities in a forensic inpatient setting, participant verbal IQ score (above or below 69) was entered as a between-participants factor in separate analyses conducted for each anger measure (three being self-report measures modified to be completed as structured interviews with clients, and one a staff-completed measure, each completed at baseline, pre- and post-intervention, and follow-up). For each of the measures tested, no significant main effects of verbal IQ grouping or interaction effects concerning this factor were found. Further analyses, correlating verbal IQ scores and change on each anger measure (both pre- to post-intervention and pre-intervention to follow-up change were calculated), demonstrated only a significant positive correlation to pre- to post-intervention change on the NAS cognitive sub-scale (which measures an individual's cognitive experiences of anger, such as anger justification, rumination, hostile attitude and suspicion). Comparisons were also conducted between higher and lower IQ groups for pre- to post-intervention and pre-intervention to follow-up change data, and demonstrated only a significantly

greater improvement on the NAS cognitive sub-scale for participants in the higher IQ grouping.

In Willner et al. (2005), which described a group CBT anger management for adults with intellectual disabilities, a modest positive but non-significant correlation was noted between improvements on participant PI ratings (completed by a key-worker) and BPVS score.

1.4.2.1.2 Summary of findings and methodological issues

Given that factors impacting on treatment responsiveness were not consistently examined across the five studies, it is difficult to draw overall conclusions. However, two studies were consistent in their findings that clients accompanied to sessions by carers showed greater treatment responsiveness than those who were not (Rose et al., 2005; Willner et al., 2002). Contradictory findings were noted regarding the impact of participant receptive vocabulary, with significantly improved outcomes for those scoring higher on this ability noted in one study (Rose et al., 2005) but not in others (Hagiliassis et al., 2005; Willner et al., 2005). With regard to the impact of participant IQ on outcome, the overall association between outcome and verbal IQ noted in Willner et al. (2002) was not found in Taylor et al. (2009). However, in the latter study participants in the higher IQ grouping did show significantly greater improvements on one measure, the NAS cognitive sub-scale, compared to those in the lower grouping.

As noted previously, the five studies varied in a number of respects (participants used, assessment and outcome measures used, format of intervention, methods of statistical analysis and so on) that may account for their divergent findings. For example, as noted by Taylor et al. (2009), verbal IQ effects may be less evident in one-to-one CBT working compared to group interventions (such as Willner et al., 2002) as the former allows for a more individualised approach that may be better able to overcome a client's cognitive difficulties. It is also likely that differences in the style of intervention delivery, such as a greater use of non-verbal materials, could account for effects of receptive vocabulary in some studies (Rose et al., 2005) but not others (Hagiliassis et al., 2005; Willner et al., 2005).

It is also important to note that although all studies discussed methods of promoting adherence to intervention protocols, none formally measured fidelity to CBT principles and practices (using, for example, the Cognitive Therapy Scale for Psychosis; Haddock et al., 2001). It is also unclear to what extent participants were able to engage in and benefited from all aspects of the intervention. In order to draw conclusions about factors determining CBT (rather than behavioural) suitability, it is important that all studies are compliant with CBT and gauge cognitive changes (as in Taylor et al., 2009, who considered NAS cognitive, behavioural and arousal score changes separately).

Table 1.1a: Summary of studies included in review investigating factors relating to CBT responsiveness in adults with intellectual disabilities

Author(s) and year	*Sample*	*Study description*	*Outcome measures*	*Study condition*	*N*	*Age (mean, SD, range)*	*Gender (% male)*	*Assessment of intellectual disability (measure, mean, SD, range)*	*Main findings and conclusions*
Willner et al. (2002)	Community	Group CBT anger management (9 x 2hrs) RCT with waiting list control	Anger Inventory (AI) (Benson & Ivins, 1992) Provocation Index (PI) (Novaco, 1994) Client- and carer-completed at pre- and post-intervention and at three month follow-up (intervention group only)	Intervention	7	31.4, 14.2, 18 - 57	57%	WAIS-R[1], WAIS-III[2] or WASI[3]; full scale IQ 63.9, 8.9, NS[4]	Participants in intervention group showed significant improvements on anger ratings (both client- and carer-completed) compared to control group post-intervention; intervention group showed significant improvements at follow-up compared to their post-intervention scores Significant positive correlation between outcome improvement and full scale and verbal IQ scores; significantly better outcomes for clients accompanied to sessions by a carer
				Control	7	30.4, 12.4, 19 - 55	71%	WAIS-R, WAIS-III or WASI full scale IQ 65.3, 9.3, NS	
Hagiliassis et al. (2005)	Community	Group CBT anger management (12 x 2hrs) RCT with waiting list control	Novaco Anger Scale (NAS) – Section A (Novaco, 1994) Outcome Rating Scale (Miller & Duncan, 2000) Client-completed at pre- and post- intervention and at four month follow-up	Intervention	14	44.9, 13.0, 28 – 74	50%	PPVT-III[5]; standard score 60.0, 14.3, 40 - 79 CPM[6]; age-equivalent score 6.9, 1.8, 5 – 11	Significant improvement on post-intervention NAS scores for intervention group compared to controls and their own pre-intervention scores; gains maintained for intervention group at follow-up (and significantly improved compared to their pre-intervention scores); no significant changes on ORS Significant negative correlation between improvement on NAS and CPM score; CPM score only variable to significantly account for variance in NAS improvement
				Control	16	43.6, 12.8, 26 - 73	60%	PPVT-III; standard score 56.8, 18.1, 40 - 97 CPM age-equivalent score 7.3, 2.5, 5 - 12	

1 Wechsler Adult Intelligence Scale – Revised (Wechsler, 1981)
2 Wechsler Adult Intelligence Scale – 3rd Edition (Wechsler, 1997)
3 Wechsler Abbreviated Scale of Intelligence (Wechsler, 1999)
4 NS indicates this information was not stated by the authors
5 Peabody Picture Vocabulary Scale – 3rd Edition (Dunn & Dunn, 1997)
6 Raven's Coloured Progressive Matrices (Raven, Raven & Court, 1998)

Table 1.1b: Summary of studies included in review investigating factors relating to CBT responsiveness in adults with intellectual disabilities

Author(s) and year	*Sample*	*Study description*	*Outcome measures*	*Study condition*	*N*	*Age (mean, SD, range)*	*Gender (% male)*	*Assessment of intellectual disability (measure, mean, SD, range)*	*Main findings and conclusions*
Rose et al. (2005)	Community	Group CBT anger management (16 x 2hrs) with waiting list control	Anger Inventory (AI) (Benson & Ivins, 1992) Client-completed pre- and post-intervention and at three-to-six month follow-up	Intervention	50	38.6, 11.8, 18 – 64	80%	BPVS[7]; raw score 72, 20.9, 24 – 113	Significant improvement on post-intervention AI scores for intervention group compared to controls Variance in pre- to post- improvement for intervention group significantly accounted for by BPVS score (greater improvements if BPVS score higher) and whether client accompanied to sessions by carer (greater improvements if client was accompanied); no variables significantly accounted for variance in pre-intervention to follow-up scores
				Control	36	34.7, 10.1, 17 - 49	86%	BPVS; raw score 72, 19.7, 24 - 107	
Willner et al. (2005)	Community	Group CBT anger management (12 x 2hrs) RCT with waiting list control	Provocation Index (PI) (Novaco, 1994) Profile of Anger Coping Skills (PACS) (Willner et al., 2005) Client- (PI) and key-worker (PI, PACS) completed pre- and post-intervention and at six month follow-up	Intervention	8	44.8, 13.0, 25 – 59	63%	BPVS (short-form); 14.1, 4.8, NS	Intervention group PI scores significantly improved at post-intervention (key-worker rated) and follow-up (client and key-worker rated) compared to control group; PACS scores significantly improved for intervention group at post-intervention and follow-up For pre- to post- improvements on PI (key-worker rated), modest positive but non-significant correlation with BPVS score
				Control	9	31.5, 9.1, 20 - 44	78%	BPVS (short-form); 15.1, 7.3, NS	

7 British Picture Vocabulary Scale (Dunn, Dunn, Whetton & Pintillie, 1982)

Table 1.1c: Summary of studies included in review investigating factors relating to CBT responsiveness in adults with intellectual disabilities

Author(s) and year	*Sample*	*Study description*	*Outcome measures*	*Study condition*	*N*	*Age (mean, SD, range)*	*Gender (% male)*	*Assessment of intellectual disability (measure, mean, SD, range)*	*Main findings and conclusions*
Taylor et al. (2009)	Inpatient - Forensic	Individual CBT anger treatment (18 x 1hrs), with no control or comparison condition	Novaco Anger Scale (NAS) (Novaco, 2003) Trait Anger and Anger Expression Scale of the State-Trait Anger Expression Inventory (STAXI; Spielberger, 1996) Provocation Inventory (PI) (Novaco, 2003) Ward Anger Rating Scale (WARS) (Novaco, 1994) NAS, STAXI and PI completed as structured interviews with clients, WARS carer-completed, completed at screen, pre- and post- intervention and at 12 month follow-up	n/a	83	2.4, 10.9, 19 - 62	81%	WAIS-III; mean verbal IQ 68.4, 5.7, 54 - 81	Significant post-intervention improvements on all measures that were maintained at 12 month follow-up Significant positive correlation between verbal IQ and anger change score (pre- to post-intervention) for NAS cognitive sub-scale; no other correlations for pre- to post-intervention or pre-intervention to follow-up change significant Higher (>69) verbal IQ group showed significantly greater pre- to post-intervention change on NAS cognitive sub-scale than lower (<69) group; no other comparisons significant (both for pre- to post- intervention and pre-intervention to follow-up change)

1.4.2.2 Studies investigating the ability of individuals with intellectual disabilities to complete tasks thought necessary for CBT

1.4.2.2.1 Summary of included studies

Details of the ten studies included in this section of the review are presented in Tables 1.2a to 1.2e. Each study investigated one or more client ability thought necessary for CBT, specifically: (1) emotional recognition and labelling (Dagnan et al., 2000, 2009; McKenzie et al., 2000; Joyce et al., 2006; Oathamshaw & Haddock, 2006; Sams et al., 2006), (2) linking of emotional states (consequences) to situations (antecedents) (Dagnan et al., 2000, 2009; Joyce et al., 2006; Oathamshaw & Haddock, 2006), (3) differentiating between thoughts, feelings and behaviours (Bruce et al., 2010; Sams et al., 2006), (4) understanding of cognitive mediation (Bruce et al., 2010; Dagnan et al., 2000, 2009; Joyce et al., 2006; Oathamshaw & Haddock, 2006), (5) collaborative engagement with a therapist (Jahoda et al., 2009), and (6) reliable and valid use of self-report measures (Glenn et al., 2003; Esbensen & Benson, 2005).
Two studies (Bruce et al., 2010; McKenzie et al., 2000) additionally considered whether performance on specific CBT abilities could be improved through training programmes, with Bruce et al. (2010) comparing such a programme with relaxation training using a RCT design. Consideration is first given to the overall characteristics of included studies, then to the specific client abilities assessed in them.

Overall, studies showed variability in sample size (from six in McKenzie et al., 2000, to 73 in Esbensen & Benson, 2005), age, gender composition and the range of participant intellectual disabilities included. With the exception of Oathamshaw &

Haddock (2006), whose sample included inpatients, all studies sampled adults in contact with community services for individuals with intellectual disabilities. In the majority of studies, it is not stated whether those included had clinically significant mental health difficulties (Bruce et al., 2010; Dagnan et al., 2000, 2009; Joyce et al., 2006; McKenzie et al., 2000; Sams et al., 2006). In Glenn et al. (2003) and Esbensen & Benson (2005), samples comprised both individuals with and without mental health diagnoses. In Jahoda et al. (2009) and Oathamshaw & Haddock (2006) samples were fully comprised of individuals accessing either community or inpatient mental health services for those with intellectual disabilities.

With the exception of McKenzie et al. (2000), all studies completed one or more established intellectual ability measure with their participants. Six studies (Bruce et al., 2010; Dagnan et al., 2000, 2009; Joyce et al., 2006; Oathamshaw & Haddock, 2006; Sams et al., 2006) used the BPVS, three (Bruce et al., 2010; Jahoda et al., 2009; Sams et al., 2006) used the WASI and one (Esbensen & Benson, 2005) used the PPVT-III. Glenn et al. (2003) reported IQ data for their sample but do not state the measure used.

1.4.2.2.1.1 Ability to recognise and/or label emotional states

Six studies examined emotional recognition and labelling abilities of adults with intellectual disabilities. Four (Dagnan et al., 2000, 2009; Oathamshaw & Haddock, 2006; Sams et al., 2006) considered only emotional recognition and assessed this ability using the Dagnan & Proudlove (1997) task. In this, participants match named emotional states to one of five presented facial expressions drawn from Symbols for

Makaton (Walker, 1985). As all emotions are tested, a maximum score of five is possible. As shown in Tables 1.2a to 1.2e, mean performances (and standard deviations) on this task varied from 2.3 (1.6) in Dagnan et al. (2009) to 3.4 (1.6) in Sams et al. (2006). In terms of participants obtaining maximum scores, 14.6% did so in Dagnan et al. (2000) compared to 44% in Sams et al. (2006). Both Dagnan et al. (2000) and Oathamshaw & Haddock (2006) identified a significant positive correlation between task scores and receptive vocabulary ability, whilst Sams et al. (2006) found significantly higher BPVS scores for participating achieving maximum scores compared to those making one or more error (no differences were found between these two groups, however, in terms of full scale, verbal or performance IQ).

In addition to examining emotional recognition, McKenzie et al. (2000) and Joyce et al. (2006) also examined the ability of participants to label emotional states. In McKenzie et al. (2000), a small sample of participants with moderate learning disabilities completed both recognition and labelling tasks (using line drawings as well as photographs with and without context) before and after a ten-hour group training programme designed to enhance emotional recognition skills. Results showed significant improvements in overall performance following training, suggesting this client ability can be enhanced through such programmes. In Joyce et al. (2006), participants completed recognition and labelling tasks (using photographic materials) assessing a broader range of 12 emotional states. Results showed significantly better performance on the recognition task (mean score: 4.4, SD 2.6) than the labelling task (mean score: 2.7, SD: 1.8).

1.4.2.2.1.2 Ability to link emotional states (consequences) to situations (antecedents)

Four studies investigated the ability of adults with intellectual disabilities to link emotional states to situations. All used, in full (Joyce et al., 2006) or in part (Dagnan et al., 2000, 2009; Oathamshaw & Haddock, 2006) the Reed & Clements (1989) assessment, which examines knowledge of happy and sad emotional states across four tasks (for example, stating whether a character in a given scenario is happy or sad). In order to pass this assessment, an errorless performance is required. Three studies reported pass rates for their participants (50% in Joyce et al., 2006, 72% in Dagnan et al., 2000, and 75% in Oathamshaw & Haddock, 2006) whilst Dagnan et al. (2009) reported a mean score of 4.7 out of 6 (SD 1.5). Comparing participants passing and failing this task, Dagnan et al. (2000), Joyce et al. (2006) and Oathamshaw & Haddock (2006) all found significantly higher receptive vocabulary scores for those passing whilst Dagnan et al. (2009) noted a significant positive correlation between task and BPVS scores. Joyce et al. (2006) also noted that passing participants had significantly higher CASP (Communication Assessment Profile for adults with a mental handicap; van der Gaag, 1988), emotional recognition and emotional naming scores than those failing. However, Dagnan et al. (2000) found no difference between passing and failing participants in terms of Dagnan & Proudlove (1997) emotional recognition scores.

Table 1.2a: Summary of review studies investigating the ability of adults with intellectual disabilities to undertake CBT tasks

Author(s) and year	*Sample*	*Clinical or non-clinical for mental health difficulties*	*Client abilities assessed and methods*	*N*	*Age (mean, SD, range)*	*Gender (% male)*	*Assessment of intellectual disability (measure, mean, SD, range)*	*Main findings and conclusions*
Dagnan et al. (2000)	Community	NS[1]	*Emotional recognition* (Dagnan & Proudlove (1997) emotional recognition task) *Ability to link emotional states (consequences) with situations (antecedents)* (part three of Reed & Clements (1989) assessment) *Ability to understand cognitive mediation* (Dagnan et al. (2000) If A and B, choose a C and If A and C, choose a B cognitive mediation tasks)	40	35.1, 9.5, NS	48%	BPVS[2]; raw score 64.0, 27.1, NS	*Emotional recognition*: mean score 2.7/5 (SD 1.6), significant positive correlation between score and BPVS *Antecedent-consequence linking*: 75% of participants passed (scoring 6/6); passing participants had significantly higher BPVS scores, no difference on emotional recognition task score *Cognitive mediation*: 10% passed (score >8) If A and B, choose a C task, 25% passed If A and C, choose a B task; significantly better BPVS scores for participants passing If A and B, choose a C; no difference on emotional recognition scores for those passing or failing tasks
McKenzie et al. (2000)	Community	NS	*Emotional recognition* (McKenzie et al. (2000) task); performance compared before and after emotional recognition training (10 x 1hr)	6	35.6, 10.5, 20 - 52	67%	NS	Significant improvement on emotional recognition task from group mean of 13.8 (SD 6.8) to 22.2 (SD 9.6) following intervention; significant improvements on identifying emotions from line drawings, identifying emotions from choice of six line drawings and identifying emotions from array of six photographs with context given

1 NS indicates this was not stated by the authors

2 British Picture Vocabulary Scale (Dunn, Dunn, Whetton & Pintillie, 1982)

Table 1.2b: Summary of review studies investigating the ability of adults with intellectual disabilities to undertake CBT tasks

Author(s) and year	*Sample*	*Clinical or non-clinical for mental health difficulties*	*Client abilities assessed and methods*	*N*	*Age (mean, SD, range)*	*Gender (% male)*	*Assessment of intellectual disability (measure, mean, SD, range)*	*Main findings and conclusions*
Glenn et al. (2003)	Community	Mixed	*Ability to make use of self-report measures in a reliable and valid manner* (completion of Beck Anxiety Inventory (BAI; Beck & Steer, 1990), Reynolds Child Depression Scale (RCDS: Reynolds, 1989), Automatic Thoughts Questionnaire (ATQ; Hollon & Kendall, 1980), Cognitions Checklist (CCL; Beck, Brown, Steer, Eidelson & Riskind, 1987); ATQ and CCL adapted so that a consistent 0-3 scale was used)	46	36.4, 9.2, 21 - 59	54%	NS; 66.1, 8.5, 44 - 83	Internal consistencies across scales high (0.92 – 0.97) Scores on all measures significantly correlated 79% of variance in depression scores accounted for by ATQ sub-scales 74% of variance in anxiety accounted for by CCL anxiety and depression sub-scales
Esbensen & Benson (2005)	Community	Mixed	*Ability to make use of self-report measures in a reliable and valid manner* (completion of Self-Report Depression Questionnaire (SRDQ; Reynolds & Baker, 1988), Children's Attributional Styles Questionnaire (CASQ; Seligman et al., 1984), Automatic Thoughts Questionnaire (ATQ; Hollon & Kendall, 1980), Cognitive Triad Inventory for Children (CTI-C; Kaslow, Stark, Printz, Livingston & Tsai, 1992), Hopelessness Scale for Children (HSC; Kazdin, Rodgers & Colbus, 1986), Piers-Harris Children's Self Concept Scale (PH-SCS; Piers & Harris, 1969)	73	40.6, 12.1, NS	NS	PPVT-III[3]; raw score 116.7, 29.1, 71 - 191	Good internal consistency for SRDQ, ATQ, CTI-C and PH-SCS (0.80 – 0.94), not for HSC and CASQ (0.39 – 0.51) Significant correlations between receptive vocabulary, ATQ, HSC, CASQ, CTI-C and PH-SCS (when partialling out these effects, depressed mood correlated with greater levels of automatic thoughts, less positive attributional styles, a negative cognitive triad, greater hopelessness and lower self-esteem)

3 Peabody Picture Vocabulary Scale – 3rd Edition (Dunn, Dunn & Williams, 1997)

Table 1.2c: Summary of review studies investigating the ability of adults with intellectual disabilities to undertake CBT tasks

Author(s) and year	*Sample*	*Clinical or non-clinical for mental health difficulties*	*Client abilities assessed and methods*	*N*	*Age (mean, SD, range)*	*Gender (% male)*	*Assessment of intellectual disability (measure, mean, SD, range)*	*Main findings and conclusions*
Joyce et al. (2006)	Community	NS	*Emotional recognition and naming* (Joyce et al., 2006 task) *Ability to link emotional states (consequences) with situations (antecedents)* (Reed & Clements (1989) assessment) *Ability to understand cognitive mediation* (Dagnan et al. (2000) If A and B, choose a C and If A and C, choose a B cognitive mediation tasks)	72[4]	40.0, 11.9, 21 - 81	50%	BPVS; score 12.9, 6.9, 2 – 30 (mean age equivalent 5 yrs 9 mths, range 1 yr 7 mths to 19 yrs)	*Emotional recognition and naming*: significantly better recognition (mean 4.4/12, SD 2.6) than naming (mean 2.7/12, SD 1.8) *Antecedent-consequence linking:* 50% of participants passed, participants passing had significantly higher scores on the BPVS, the CASP (Communication Assessment Profile for adults with a mental handicap; van der Gaag, 1988) and emotional recognition and naming tasks *Cognitive mediation*: 11.5% passed the If A and B, choose a C task, those passing had significantly higher scores on BPVS, CASP and the emotion naming task; 13.5% passed the If A and C, choose a B task, those passing had significant higher BPVS and CASP scores
Oathamshaw & Haddock (2006)	Community and inpatient	Clinical	*Emotional recognition* (Dagnan & Proudlove (1997) emotional recognition task) *Ability to link emotional states (consequences) with situations (antecedents)* (part three of Reed & Clements (1989) assessment) *Ability to distinguish between thoughts, feelings and behaviours* (Behaviour-Thought-Feeling Questionnaire, adapted from Greenberger & Padesky, 1985) *Ability to understand cognitive mediation* (Dagnan et al. (2000) If A and B, choose a C and If A and C, choose a B cognitive mediation tasks	50	43.0, NS, NS	54%	BPVS; median score 88, semi-interquartile range 64 – 99.8	*Emotional recognition*: Mean score 2.9 (SD 1.2), significant positive correlation of scores with BPVS scores *Antecedent-consequence linking*: 72% of participants passed, those passing had significantly higher BPVS scores *Thought, feeling, behaviour differentiation:* Higher pass rates on behaviour (66.7%) and feeling (52.1%) sub-scales, lower on thought sub-scale (18.8%) *Cognitive mediation*: Comparable pass rates (score >8) on the If A and B, choose a C (12%) and the If A and C, choose a B (10%) tasks; participants passing the If A and C, choose a B task had significantly higher BPVS scores

4 Data only reported for 52 participants as 20 failed to score on BPVS

Table 1.2d: Summary of review studies investigating the ability of adults with intellectual disabilities to undertake CBT tasks

Author(s) and year	*Sample*	*Clinical or non-clinical for mental health difficulties*	*Client abilities assessed and methods*	*N*	*Age (mean, SD, range)*	*Gender (% male)*	*Assessment of intellectual disability (measure, mean, SD, range)*	*Main findings and conclusions*
Sams et al. (2006)	Community	NS	*Emotional recognition* (Dagnan & Proudlove (1997) emotional recognition task) *Ability to distinguish between thoughts, feelings and behaviours* (Thought-Feeling-Behaviour task, Quakley et al., 2004, comparison of giving visual cues or not to participants)	59	NS, NS, 17 - 60	39%	WASI[5]; full scale IQ 58.0, NS, 50 – 72 BPVS; 85.4, 27.7, NS (age equivalent 8.4yrs, 3.3, NS)	*Emotional recognition*: Mean score 3.4 (SD 1.6), 44% of participants scored 5/5; participants scoring 5 showed significantly higher BPVS scores than those scoring <5, no difference on full scale, verbal or performance IQ scores *Thought, feeling, behaviour differentiation*: Mean score 9.8 (SD 3.7, range 5 – 18); age, BPVS and raw full scale IQ score all made significant contributions in accounting for variance in overall task score
Dagnan et al. (2009)	Community	NS	*Emotional recognition* (Dagnan & Proudlove (1997) emotional recognition task) *Ability to link emotional states (consequences) with situations (antecedents)* (part three of Reed & Clements (1989) assessment) *Ability to understand cognitive mediation* (Dagnan et al. (2000) If A and C, choose a B task, asked to generate thoughts rather than picking between two choices)	41	39.2, 11.7, 19 - 63	66%	BPVS; raw score 61.5, 26.6, 19 – 126	*Emotional recognition*: Mean score 2.3 (SD 1.6, range 0 -5), 14.6% of participants scored 5/5 *Antecedent-consequence linking*: Mean score 4.7 (SD 1.5), significant positive correlation between task score and BPVS score *Cognitive mediation*: Across the six task scenarios, % of participants providing an appropriate mediating cognition ranged from 30.6% to 40.5%, inappropriate cognitions (given the emotion) ranged from 0% to 23.7%; number of appropriate and inappropriate cognitions given significantly positively correlated with BPVS score; scores on the Reed & Clements task significantly positively correlated with number of inappropriate cognitions, but not appropriate cognitions

5 Wechsler Abbreviated Scale of Intelligence (Wechsler, 1999)

Table 1.2e: Summary of review studies investigating the ability of adults with intellectual disabilities to undertake CBT tasks

Author(s) and year	*Sample*	*Clinical or non-clinical for mental health difficulties*	*Client abilities assessed and methods*	*N*	*Age (mean, SD, range)*	*Gender (% male)*	*Assessment of intellectual disability (measure, mean, SD, range)*	*Main findings and conclusions*
Jahoda et al. (2009)	Community	Clinical	*Ability to engage in a collaborative manner with a therapist* (recordings of fourth and ninth CBT therapeutic sessions transcribed using Linell, Gustavsson & Juvonen (1988)'s initiative-response method of analysing power distribution in dialogue)	15	35.7, 9.3, 21 - 47	53%	WASI; full scale IQ 66.7, 9.0, 55 – 79	Results suggest that power was relatively equally distributed in dialogues between clients and therapists; no significant increase in power distribution over time No significant correlation between IQ score and number of fragmentation turns made by clients in first recorded session; significant negative correlation found for second recorded session
Bruce et al. (2010)[6]	Community	NS	*Ability to distinguish between thoughts, feelings and behaviours* (Thought-Feeling-Behaviour task, Quakley et al., 2004; Sams et al., 2006)	18	40.5, 13.8, NS[7]	44%	WASI; full scale IQ 56.4, 3.3, NS BPVS-II age equivalent 7.7, 3.1, NS	*Thought, feeling, behaviour differentiation*: Overall pre-intervention score of 8.7/18 (SD 3.2, range 4 – 14); no significant difference between groups on pre- and post-intervention scores *Cognitive mediation*: Overall pre-intervention score of 2.2/6 (SD 1.0, range 0 – 6); significant improvement post-intervention for CBT skills group, significantly better performance on original than new items at post-intervention test; % correct on new items (0.59) significantly better than pre-intervention original items (0.37), suggest generalisation
			Ability to understand cognitive mediation (Thought to Feeling Task, Doherr et al., 2005) Both tasks completed before and after random allocation to a 1hr CBT skills training session or relaxation session (new items included in both tasks post-intervention to assess generalisation)	16		50%	WASI; full scale IQ 57.1, 4.9, NS BPVS-II age equivalent 6.7, 2.9, NS	

6 In Bruce et al. (2010), separate values are reported for an intervention group (n = 18) and a control group (n = 16)
7 In Bruce et al. (2010), age information is only provided for the overall sample, not specific groups

1.4.2.2.1.3 Ability to distinguish between thoughts, feelings and behaviours

Three studies **(**Bruce et al., 2010; Oathamshaw & Haddock, 2006; Sams et al., 2006) examined to what extent adults with intellectual disabilities can differentiate between thoughts, feelings and behaviours. Participants in Oathamshaw & Haddock (2006) completed an adapted version of the Behaviour-Thought-Feeling Questionnaire (Greenberger & Padesky, 1985), in which 24 read statements are sorted into categories of thinking (e.g. *this is hard*), doing (e.g. *talk to a friend*) and feeling (e.g. *sad*). Results showed pass rates (significantly above chance) were better for behaviours (67%) and feelings (52%) than for thoughts (19%). Participants passing the behaviour and feeling sub-tests were found to have significantly higher BPVS scores than those failing, whilst no such difference was found on the thoughts sub-test.

In both Sams et al. (2006) and Bruce et al. (2010), participants completed a different form of assessment, namely an adaptation of the Thought/Feeling/Behaviour Discrimination Task (Quakley, Coker & Reynolds, 2004). In this, participants are read six short stories and asked to sort each one's component sentences (printed on separate cards) into boxes for 'thinking', 'feeling' and 'doing' sentences. In Sams et al. (2006) half of the participants completed this task with visual cues placed on the boxes to determine if this improved performance. In Bruce et al. (2010), this task was completed before and after participants received a one-hour training session either in CBT skills (focusing on differentiating between thoughts, feelings and behaviours and on linking thoughts and feelings) or relaxation, with four additional stories included in the post-training assessment in order to assess generalisation. Results were

comparable across studies, with mean scores of 9.8 (SD 3.7) in Sams et al. (2006) and 8.7 (SD 3.2) in Bruce et al., (2010). In Sams et al. (2006), visual cues were not found to significantly affect performance, whilst participant age, BPVS score and raw full scale IQ all made significant contributions to variance in overall task scores. In Bruce et al. (2010), pre- and post-training performances were found not to differ significantly.

1.4.2.2.1.4 Ability to understand the mediating role of cognitions

Five studies examined the ability of adults with intellectual disabilities to understand the mediating role of cognitions between situations and responses. Three of these (Dagnan et al., 2000; Joyce et al., 2006; Oathamshaw & Haddock, 2006) assessed this ability using the two cognitive mediation tasks of Dagnan et al. (2000). In these, participants are asked to both: (1) choose an emotion (happy or sad) given a verbally presented scenario and an evaluative belief (the If A and B, choose a C or, AB,C, task), and (2) choose an evaluate belief given a scenario and an emotion (the If A and C, choose a B, or AC,B, task). Five scenarios are tested twice, with the valence of the emotion or belief varied (positive or negative). As tested scenarios also vary in valence, this allows congruency between the situation and emotion or belief to also be examined. Dagnan et al. (2000) proposed an overall pass rate of eight on each task, and a pass rate of five on each congruency sub-task.

As shown in Tables 2a-2e, overall pass rates in these three studies ranged from 10% to 12% for the AB,C task and from 13.5% to 25% for the AC,B task. Statistical analyses in Dagnan et al. (2000) found that performance on these two tasks did not

differ significantly. Pass rates for congruent trials (for AB,C task: 19.2% to 37.5%; for AC,B task: 14% to 21.2%) tended to be higher than those for incongruent trials (for AB,C task: 2% to 3.8%; for AC,B task: 4% to 12.5%), and in Dagnan et al. (2000) performance was found to be significantly better for congruent than incongruent trials in the AB,C task.

All studies also investigated factors potentially mediating performance on these tasks, with findings suggesting significantly better performance (in certain tasks and conditions) for participants with higher receptive vocabulary scores (Dagnan et al., 2000, Joyce et al., 2006, Oathamshaw & Haddock, 2006), higher emotional labelling scores (Joyce et al., 2006) and higher scores on the CASP measure of communication skills (Joyce et al., 2006). In Dagnan et al. (2000), performance on the two cognitive mediation tasks and their conditions was also found to be significantly worse than that on the Reed & Clements (1989) emotional awareness assessment.

In Dagnan et al. (2009), participants were also verbally presented with scenarios and emotional consequences though were asked to generate thoughts given these situations and responses rather than choose from options provided by the examiner. Six scenarios were tested in total, with participant responses classified by two raters (with high levels of agreement) into seven response categories. Results across scenarios showed 'appropriate antecedent-consequence link' responses were the most common e.g. "they are having a joke" (35.5%), followed by 'no response' (18.7%), 'disagreeing with the given emotion' e.g. "sad – a lot of them about" (15.4%), 'restating the emotion' e.g. "happy" (12.8%), 'responding to the activating event' e.g. "laughing at me – always happens" (8.1%), 'unclassified' e.g. "my own room" (7.7%)

and ‘restating the activating event’ e.g. “it’s nice being happy” (1.8%). The number of ‘appropriate antecedent-consequence link’ and ‘responding to activating event’ responses were both found to be significantly and positively correlated with participant receptive vocabulary scores. However, of these two response categories, only the number of ‘responding to activating event’ responses was found to be positively and significantly correlated with performance on the Reed & Clement (1989) task.

In Bruce et al. (2010), the ability to understand cognitive mediation was examined using the assessment method proposed by Doherr, Reynolds, Wetherly & Evans (2005). In this, participants are verbally given a scenario and a thought. They are then asked to state how they would feel, given the situation and thought. Responses can be made verbally or by using one of four Makaton symbols (representing happy, sad, angry and worried). The visual cue of a stick person with a thought bubble is also used to convey what is meant by thinking. Bruce et al. (2010)’s participants completed this task before and after receiving either a CBT or relaxation skills training session (see above), with additional items introduced in the post-training assessment to gauge generalisation of learning. Overall, the mean pre-assessment score on this measure was 2.2. (SD 1.0, range 0 – 6). Following the intervention session, those participants who had received CBT skills training showed a significant improvement on task, and this showed some generalisation to novel assessment items.

1.4.2.2.1.5 Ability to engage in a collaborative manner with a therapist

One study, Jahoda et al. (2009), investigated the ability of adults with intellectual disabilities to establish and maintain a collaborative relationship with a therapist. Fifteen participants with borderline to mild intellectual disabilities, all of whom were receiving individualised CBT for depression, anxiety or anger difficulties, agreed to two (fourth and ninth) of their therapy sessions being recorded and analysed using the initiative-response method of Linell, Gustavsson & Juvonen (1988). Through this method of analysis, patterns of interaction and 'power' distribution in conversations can be quantified. Results demonstrated that in both therapy sessions (which showed high levels of adherence to CBT principles and practices, as assessed by the Cognitive Therapy Scale for Psychosis; Haddock et al., 2001) 'power' was relatively equally distributed between clients and therapists. In terms of interaction patterns, therapists asked significantly more questions than clients, who mainly used balance 'turns' (discussing what the other speaker has said, and providing additional information for them to comment on). Results also demonstrated that lower client IQ scores were significantly associated with a greater number of fragmentation 'turns' (where the turn does not link up to what has just been said by the preceding speaker) in the ninth session.

1.4.2.2.1.6 Ability to make use of self-report measures in a reliable and valid manner

As part of broader investigations concerning the cognitive correlates of anxiety and depression symptoms in adults with intellectual disabilities, two studies reported

findings relating to the ability of this client group to make use of self-report measures in a reliable and valid manner. In both studies, participants with borderline to moderate learning disabilities, some of whom had additional current mental health difficulties (15% in Glenn et al., 2003, 45% in Esbensen & Benson, 2005), completed a range of questionnaires assessing both mood and cognitive variables (see Table 1.2b for details). For the majority of measures used, internal consistencies were shown to be high, suggesting participants were able to use the measures in a reliable manner. Further, cognitive variables were found to predict mood scores (Glenn et al., 2003) and distinguish between those with or without a diagnosis of depression (Esbensen & Benson, 2005).

1.4.2.2.2 Summary of findings and methodological issues

The studies included in this section all investigated the extent to which adults with intellectual disabilities possess capabilities thought necessary for CBT. These investigations have identified a number of potentially important client abilities and means of examining these (some of which are shared across studies), and have shown that individuals in this population can complete these tasks with varying degrees of success. Where comparable methods of assessment and analysis have been used, it is possible to identify client abilities where performance is more consistent across studies (emotional recognition and differentiation of thoughts, feelings and behaviours) and those where it is more variable (antecedent-consequence linking and cognitive mediation). Two of the studies have also shown that performance on some of these tasks can be improved through training programmes (Bruce et al., 2010; McKenzie et al., 2000). However, differing methodologies, participant populations

(some clinical, others non-clinical) and methods of analysis make the drawing of further conclusions difficult at present.

It must also be noted that at present these client abilities can only be considered potentially important when assessing CBT suitability for adults with intellectual disabilities as no studies have examined whether they have a significant impact on CBT responsiveness (and, additionally, whether this impact is above and beyond that made by factors correlated with these abilities, such as receptive vocabulary).

1.5 DISCUSSION

In this paper, empirical investigations concerned with factors determining the suitability of CBT for adults with intellectual disabilities, published between 1997 and 2010, were identified and reviewed. Identified studies fell into one of two categories: those concerned with factors relating to CBT intervention responsiveness, and those assessing the extent to which adults with intellectual disabilities could undertake tasks thought necessary for CBT. In terms of studies investigating factors relating to CBT intervention responsiveness, findings were mixed concerning the role of receptive vocabulary and IQ scores in predicting outcome. However, there was agreement between two studies (Rose et al., 2005; Willner et al., 2002) on the benefits of having a care worker attending therapeutic sessions with the client. With regard to the second category of studies, results demonstrated that adults with intellectual disabilities can, though to varying degrees, undertake tasks thought necessary for CBT. These findings appeared to be more consistent for emotional recognition and

thought/feeling/behaviour discrimination tasks that those concerning antecedent-consequent linking and cognitive mediation.

Despite the progress that has been made in this area of study since it was originally considered in detail by Stenfert Kroese et al. (1997), future research appears necessary to address a number of issues. Firstly, although a number of tasks have been identified that purport to measure client abilities though necessary for CBT (such as emotional recognition and cognitive mediation), research needs to examine whether scores on such tasks actually relate to treatment outcomes for adults with intellectual disabilities. It would also be of interest to examine whether a relationship exists between performance on CBT ability tasks and the extent to which subsequent therapeutic sessions adhere to CBT principles and practices (this could be assessed using Haddock et al.'s (2001) CTS-Psy scale).

Work also needs to be conducted to more firmly establish the psychometric properties of the CBT ability tests described in this review. Once these tests are found to be reliable and valid, and linked to therapeutic outcome, they could be recommended for inclusion in normal assessment practice by therapists undertaking CBT work with adults with intellectual disabilities.

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CHAPTER 2

Empirical Paper

The Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS): Development, validation and evaluation of a new method of assessing the suitability of cognitive-behavioural therapy for older people with anxiety- and/or depression-related difficulties[2]

[2] This paper has been prepared for submission to the Behavioural and Cognitive Psychotherapy journal (see appendix B for guidance for authors)

2.1 ABSTRACT

Background: Cognitive-behavioural therapy is increasingly being used with older people for anxiety- and/or depression-related disorders. However, no formalised assessment procedures, specifically tailored to age-related issues, exist that could aid clinicians in judging the suitability of CBT for older individuals.

Method: Through focus groups conducted with staff using CBT in an older persons' mental health service, a new interview and ratings procedure, the Cognitive-Behavioural Therapy for Older People Suitability Scale (or, COG-OPSS) was developed. This measure was trialled by staff in the same service, with information collected pertaining to the validation and evaluation of the COG-OPSS.

Results: Eleven staff completed COG-OPSS assessments for 30 clients, a smaller sample size than had originally been envisaged. Although the COG-OPSS received broadly positive evaluations by staff, it was not shown to significantly predict whether clients received CBT or other interventions. Some tentative evidence for the construct validity of the COG-OPSS was found through correlations with a therapeutic alliance scale. There was no clear evidence that the COG-OPSS enhanced staff assessment practices.

Conclusions: Given the small sample size, it is difficult to draw clear conclusions as to the psychometric properties of the COG-OPSS and its clinical value at present. Further research with a larger, more varied sample is recommended.

Keywords: cognitive-behavioural therapy; older people; assessment; suitability; anxiety; depression

2.2 INTRODUCTION

2.2.1 Cognitive-behavioural therapy with older people experiencing mental health difficulties

As with other age groups, mental health difficulties such as anxiety and depression are apparent in individuals aged 65 years and over (e.g. Blazer, 1997; Beekman, Copeland & Prince, 1999). However, the provision of psychological therapies for this population has historically been poor, perhaps due in part to Freud's assertion that older people lack the mental plasticity to change and therefore benefit from psychotherapy (e.g. Lovestone, 1983). Research in more recent years has challenged this viewpoint (e.g. Wilson, Mottram & Vassilas, 2009), and recent UK government policies have stated that older people should have the same access to mental health services as younger adults (New Horizons; HM Government, 2009).

Of the psychological approaches investigated with older people, cognitive-behavioural therapy (or, CBT) has to date received the greatest interest in the research literature, with evidence suggesting it can be effective in reducing late-life anxiety and depression symptoms (e.g. Hendriks, Voshaar, Keijsers, Hoogduin & van Balkom, 2008; Laidlaw et al., 2008). Consideration has also been given to how cognitive-behavioural models of mental distress may be adapted in order to account for and accommodate age-related issues. For example, Laidlaw, Thompson, Dick-Siskin & Gallagher-Thompson (2003) proposed an adapted version of Beck's cognitive model of depression (Beck, Rush, Shaw & Emery, 1979) which, in addition to its existing components (early life experiences, core beliefs, conditional beliefs, activating events,

compensatory strategies and negative automatic thoughts) also included cohort beliefs (the shared beliefs and experiences of the client's generation), role investment (the importance and function of roles carried on or lost by clients as they age), health status (how physical health issues impact on the client's autonomy and independence), socio-cultural beliefs (beliefs concerning ageing in the client's culture and society and whether they accept or reject them) and intergenerational linkages (the client's relationships with individuals, especially family, from different generations, and to what extent these are supportive or stressful).

2.2.2 Assessing the suitability of CBT for older people with mental health difficulties

As with all psychological interventions, it is important to consider what factors determine the suitability of CBT for clients and how this might be best assessed. For example, Blenkiron (1999) proposed that CBT would be more likely to suit clients if they: (1) accepted that psychological factors may underpin their difficulties, (2) were motivated to engage in therapy and complete homework tasks, (3) were able to identify their emotions and link these to thoughts and behaviours, (4) were able to form human relationships and work collaboratively, (5) were able to identify and maintain their focus on specific difficulties, (6) showed a favourable response to the CBT rationale, and (7) could tolerate anxiety sufficiently in order to test out beliefs through behavioural experiments.

To date, empirical investigations into this area have largely been conducted with adults of working age, most notably in the work of Safran, Segal and colleagues

(Safran, Segal, Shaw & Vallis, 1990; Safran, Segal, Vallis, Shaw & Samstag, 1993). Based on existing literature and clinical practice, these authors devised a clinician-completed interview and rating procedure, the Suitability for Short-Term Cognitive Therapy (or, SSCT) measure, which considers ten factors (accessibility of automatic thoughts, awareness and differentiation of emotions, acceptance of personal responsibility for change, compatibility with the cognitive rationale, alliance potential (in- and out-of session), chronicity of problems, security operations, focality and general optimism/pessimism regarding therapy) thought necessary for short-term cognitive therapy with an interpersonal focus. The SSCT was initially trialled in a study of 42 clients presenting to a clinic offering short-term cognitive therapy for either anxiety- or depression-based disorders. Results showed that those accepted for treatment scored significantly higher on all but one (chronicity of problems) of the SSCT scales and that mean SSCT ratings were significantly correlated with improvements on outcome measures and with both therapist and client ratings of therapy success. Inter-rater reliability was also examined by having 11 SSCT interviews rated by three separate judges, with results showing high reliability for all scales (0.75 – 0.98) with the exception of focality (0.46). The construct validity of the measure was also considered by asking clients accepted into treatment to complete a measure of therapeutic alliance, the Working Alliance Inventory (or, WAI; Horvath & Greenberg, 1986), at the end of their third therapy session. Results showed scores on the WAI to only significantly correlate with the in-session alliance aspect of the SSCT, suggesting not only the validity of this part of the measure but also that the other scales were collecting information additional to that measured by a therapeutic alliance scale. These initial findings have more recently been supported in Myhr, Talbot, Annable & Pinard's (2007) study of 113 clients receiving CBT for a range of

mental health difficulties, in which mean SSCT scores were found to significantly correlate with treatment responsiveness and accounted for 20% of the variance in outcome data.

Although the SSCT has not been formally trialled with older individuals, Laidlaw and Thompson (2008) considered its appropriateness for this client group and concluded, due to age-related issues, that "if used rigidly, all older people would be considered very poor candidates for CBT" (p. 95).

2.2.3 The current study

Based on the evidence outline above, formalised means of assessing CBT suitability appear to have clinical value, especially in predicting treatment outcome. However, these means were designed and validated through studies of working age adults and may not be appropriate for use with older individuals. Therefore, the current study sought to develop, validate and evaluate a means of assessing the suitability of CBT for older people, focusing specifically on those presenting with anxiety- and/or depression-related difficulties. Specifically, the objectives of the current study were:

1. To conduct focus groups with staff using CBT in mental health services for older people in order to: (1) gather information on factors determining CBT suitability for this client group, and (2) consider the viability of using the Safran et al. (1990) SSCT measure with older individuals.
2. To, based on this information, devise a clinician-completed interview and ratings procedure assessing CBT suitability for older people.

3. To recruit staff and clients in order to trial, validate and evaluate this new interview and ratings procedure in a clinical setting.

2.3 STUDY 1: DEVELOPMENT OF THE NEW CBT SUITABILITY INTERVIEW AND RATINGS PROCEDURE

2.3.1 Design

In order to identify factors determining CBT suitability for older people, and to consider the viability of using the Safran et al. (1990) SSCT measure with this client group, focus groups were conducted with staff members using CBT in their work in an older persons' mental health service.

2.3.2 Participants

All staff using CBT in an older persons' mental health service in the Midlands of the UK were invited to attend a focus group on assessing CBT suitability for older people. Across two groups, a total of seven staff attended (three clinical psychologists, three occupational therapists and one staff nurse). Of these, six reported currently using CBT in their practice, with time of use ranging from 4 to 25 years.

2.3.3 Procedure

Prior to attending the focus groups, participants were provided with a summary of the topics that would be discussed as well as information on the Safran et al. (1990) SSCT measure. In each group, which lasted two hours, participants were invited to discuss (1) the factors that they felt, in their experience, were important when deciding whether CBT was a suitable intervention for an older person, (2) the factors contained within the Safran et al. (1990) SSCT measure and whether they felt these to be viable for older people, and (3) whether there were any factors they would add to the SSCT measure. Details of the information and questions given by the author to focus group participants are included in appendices C and D. In each focus group, participants agreed upon a list of summary points that they were happy to be taken forward by the author in developing the new suitability measure.

2.3.4 Results

Across the two focus groups, the following summary points emerged:

- Participants identified client cognitive abilities (such as memory, attention and comprehension), physical health difficulties (such as vision and hearing impairments), mindedness to a psychological or CBT explanation of difficulties and motivation to engage in therapy as the key factors they routinely considered when assessing the suitability of CBT for older people.
- Participants identified that the accessibility of automatic thoughts, awareness and differentiation of emotions, compatibility with the cognitive rationale and alliance

potential (both in- and out-of-session) were aspects of the Safran et al. (1990) SSCT measure that were important and viable for use with older people. However, they felt that these could only be fully assessed through a longer period of assessment (more than the one hour suggested by Safran et al., 1990) that included time to socialise older people to the CBT rationale. The participants also felt that the chronicity of problems aspect of the SSCT was important to include, but that this should be amended to reflect whether these difficulties have consistently been evident or whether there have been periods of improvement (either spontaneously or through intervention).

- Participants identified that client physical health difficulties and cognitive abilities should be included as part of an assessment of CBT suitability. It was also felt that two other factors should be included: (1) to what extent the client's difficulties were a product of systemic factors, such as family issues, and (2) to what extent the client saw their difficulties as problematic and how motivated they were to engage in therapy.
- If the measure is to be available to a range of professionals with varying experiences of CBT, it should be relatively structured with prompt questions and examples given.

As it was felt the Safran et al. (1990) SSCT measure could not be readily adapted to meet these points, a new suitability interview and ratings procedure, called the Cognitive-Behavioural Therapy for Older People Suitability Scale (or, COG-OPSS) was devised (see appendices E and F). This procedure was designed to assess and rate ten CBT suitability factors, specifically:

1. Ability to identify beliefs/thoughts: the extent to which the client is able to identify (and report) their beliefs, thoughts, assumptions and so on, especially in relation to their anxiety- and/or depression-related difficulties.

2. Ability to identify emotions/feelings: the extent to which the client is able to identify (and report) how they are feeling, both in situations associated with their anxiety and/or depression difficulties as well as more generally.

3. Mindedness to CBT explanation of difficulties: the extent to which the client identifies with and accepts a cognitive-behavioural explanation of psychological difficulties (that is, that how they feel in a given situation is linked to what they are thinking about it).

4. Willingness to explore the relationship between thinking and feelings/behaviours: the extent to which the client is willing to explore the relationship between their thinking and feelings and behaviours (including given that doing so may result in distress or discomfort).

5. Therapeutic relationship: the extent to which the client appears able to form open, trusting and durable relationships with others, feels comfortable and safe in these relationships and can use them to discuss/explore difficulties and problems.

6. Interpersonal context: the extent to which the interpersonal context of a client (that is, the relationships they are in, both with family, friends, other professionals and so on) play a part in causing and/or maintaining the client's difficulties.

7. Duration and course of difficulties: the length of time the client has been experiencing the difficulties with anxiety and/or depression and the extent to which they have been shown to be improvable (either spontaneously or through intervention).

8. Physical health, disability and mobility: the extent to which the client has physical health, disability or mobility issues that would negatively impact on CBT working and could not be adapted for by the therapist.

9. Cognitive abilities: the extent to which the client has issues with cognitive abilities (such as memory, attention and comprehension) that cannot be adapted for by a therapist and would consequently negatively impact on any CBT intervention offered.

10. Readiness to change: the extent to which the client sees the anxiety and/or depression difficulties as a problem and how motivated they are to make changes in relation to these.

As can been seen in appendix F, each scale consists of a description of the factor under consideration, suggestions of information to consider when completing the scale, and a 1 to 5 rating scale (with higher scores indicating greater CBT suitability), with descriptive anchors given for points 1, 3 and 5. General introductory instructions were also devised to orient raters to using the measure. Given that focus group participants felt the measure should be accessible to a range of professionals with varying experiences in assessing CBT suitability, an interview schedule (see appendix E) was also devised as an optional aid clinicians to gather information relevant to the ten suitability factors. Prompt questions and examples are included in this interview, as is an exercise to help socialise clients to a CBT understanding of mental health difficulties.

2.4 STUDY 2: VALIDATION AND EVALUATION OF THE COG-OPSS

2.4.1 Design

In order to collect preliminary data to validate and evaluate the COG-OPSS, a second study was undertaken in the older person's mental health service previously described. In this, staff members, who as part of their clinical responsibilities assess clients for the suitability of psychological therapies, were invited to use the measure as part of their practice with two to three clients and provide feedback on this. As a total client sample of 50 was required, it was envisaged that 15 to 20 staff members would need to be recruited. Prior to undertaking the research, ethics approval was sought and obtained from Coventry & Warwickshire Research Ethics Committee (part of the NHS National Research Ethics Service; see appendix G), the University of Birmingham Research and Commercial Services and the Research and Development Department of the NHS Trust to which the older persons' mental health service belonged. The research was also supported by the management of the older persons' mental health service, who agreed to staff using clinical time to take part in the study.

2.4.2 Participants

Staff members in the older persons' mental health service were invited to take part in the second phase of the research through introductory sessions on the study, posters and e-mails. All interested staff members were provided with an information sheet regarding the study (appendix H). Of the 52 staff members who registered an interest in the study, 22 (42%) consented to take part (see appendix I for consent form). This

sample comprised of 10 clinical psychologists (nine qualified, one in training), seven nurses (four community psychiatric nurses or, CPNs, three staff nurses), four psychiatrists and one occupational therapist. Once a staff member consented to take part in the research, they met with the study lead (the author) for between 30 minutes to an hour to be trained in using the COG-OPSS and in completing the additional study measures.

2.4.3 Procedure

2.4.3.1 Original research protocol

The stages of the original research protocol were as follows:

Completion of staff pre- and post-study questionnaires: In order to evaluate whether participation in the study (especially using the COG-OPSS) influenced assessment practices, staff were asked to complete a questionnaire at the beginning and end of their involvement in the study (see appendices J and K). In both questionnaires, staff were asked to consider their normal practice of assessing the suitability of psychological therapies and to rate (on a 0 - 100 scale) each of the ten COG-OPSS factors in terms of (1) how often included them (0 = never, 100 = always), (2) how helpful they felt it was to include them (0 = not at all helpful, 100 = very helpful), and (3) how confident they felt in assessing them (0 = not at all confident, 100 = very confident). In the post-study questionnaire, staff were additionally asked to rate the COG-OPSS in terms of (1) how clear and easy the instructions were to follow, (2) the sufficiency of the training they received, (3) how helpful the measure was in

establishing a rapport with clients, and (4) how useful the measure was in their practice. Space was also provided for additional feedback on experiences of using the COG-OPSS.

Recruitment of client participants: Each participating staff member was asked to identify and recruit two to three clients to complete the COG-OPSS with. Clients were eligible to take part if they were aged 65 years or over, were presenting with anxiety- and/or depression-related difficulties, and did not have cognitive difficulties (such as dementia) as a main complaint. Clients could either be approached directly by staff or by using a pre-prepared study invitation letter (see appendix M). Clients were provided with a study information sheet (see appendix L) by staff and given a minimum of 24 hours before consent was sought (see appendix N for consent form). Once consent had been taken, the client's GP was informed of their participation in the study (see appendix O).

Completion of COG-OPSS and other measures with clients: Once consent had been taken, staff members were asked to complete the following with clients in one to two assessment sessions:

1. ***COG-OPSS interview schedule***: the use of this was at the discretion of staff as some felt able to collect the information required without this aid.
2. ***Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983)***: This is a client-completed measure, designed to assess the presence and severity of anxiety and depression symptoms whilst minimising the influence of any co-occurring medical difficulties (appendix P). For each of the fourteen statements given (seven relating to anxiety, seven to depression), clients choose one of four options to indicate

how much the statement has applied for them in the past week. Separate scores are calculated for anxiety and depression symptoms, and each of these can be placed into one of four severity categories (normal: 0 – 7, mild: 8 – 10, moderate: 11 – 15, severe: 16 – 21). Studies with older individuals have demonstrated greater validity for the depression sub-scale (e.g. Flint & Rifat, 1996; Kenn, Wood, Kucyj, Wattis & Cunane, 1987) than the anxiety sub-scale (e.g. Davies, Burn, McKenzie, Bothwell & Wattis, 1993). The measure was used in this study to establish the levels of anxiety and depression symptoms in clients participating in the study.

3. ***Adapted Session Rating Scale***: This is a client-completed measure (see appendix Q), adapted from Duncan et al.'s (2003) SRS, and was used in order to gauge client experiences of the assessment process. Specifically, clients were asked to rate the assessment (on a scale of 0 – 100) on four aspects: relationship with the assessor, the goals and topics of the assessment, the approach of the assessor and their feelings at the end of the assessment.

4. ***Video-recording of sessions***: In order to assess the inter-rater reliability and the construct validity of the COG-OPSS, staff were asked to seek additional consent from a sub-set of clients (15 – 20 in total) for the assessment session(s) to be video-recorded. These video-recordings were then to be viewed separately by two independent raters (both clinical psychologists) who would both complete the COG-OPSS ratings scales as well as a judgement of CBT suitability based on clinical experience (see appendix R).

Completion of COG-OPSS and other measures after seeing client: Having assessed the client, staff were asked to complete the following measures:

1. ***The COG-OPSS ratings scales***

2. Health of the Nation Outcome Scales for Elderly People (HoNOS 65+; Burns et al., 1999): This is a clinician-completed assessment, designed as an outcome measure, in which clients are rated (from 0, no problem, to 4, severe problem) on 12 aspects (behavioural disturbance, non-accidental self injury, problem drinking or drug use, cognitive problems, problems related to physical illness or disability, problems associated with hallucinations and/or delusions or false beliefs, problems associated with depressive symptoms, other mental and behavioural problems, problems with social or supportive relationships, problems with activities of daily living, overall problems with living conditions and problems with work and leisure activities). The HoNOS 65+ has satisfactory levels of reliability and validity. It was included in this study as it is routinely used by staff in the older persons' mental health service in which the research took place and provided further information to describe participating clients.

3. Agnew Relationship Measure – Short Form 12 Therapist Version (Cahill et al., submitted): This measure (see appendix S), adapted from the Agnew Relationship Measure (Agnew-Davies, Stiles, Hardy, Barkham & Shapiro, 1998), assesses the client-therapist alliance from the therapist's (or assessor's) perspective. Based on therapist ratings (on a 1, strongly disagree, to 7, strongly agree scale) on the 12 items given, core alliance and openness (feeling free to disclose personal material without fear of censure or embarrassment) scores are produced. Cahill et al. (submitted) report the ARM-12 to have adequate psychometric properties. This measure was included in this study to provide a means of testing the construct validity of the COG-OPSS therapeutic relationship sub-scale.

4. Outcomes and demographics sheet: Having completed the above assessments, staff were asked to complete a outcomes and demographics sheet

(appendix T) in which they reported: (1) what psychological provision (if any) the client had been offered and whether this was accepted, (2) how helpful, on a scale of 0 to 100, they had found the COG-OPSS in judging the suitability of CBT for the client and how helpful it had been in deciding what to do after the assessment, and (3) demographic information on the client, including age, gender, ethnicity and presenting difficulties.

2.4.3.2 Amended research protocol

Although sufficient staff numbers were recruited under the original research protocol, only two COG-OPSS were completed with clients after five months. Feedback from staff suggested this was due to: (1) clients, who were often new to the service, not feeling able to consider research participation given their current mental health difficulties, and (2) the demands of the study on staff given their other work commitments. Consequently, a revised protocol was submitted to and approved by both Coventry & Warwickshire REC and the NHS Trust's Research and Development Department (appendix U). In this, staff were asked to complete the COG-OPSS ratings scales (and the HoNOS 65+, ARM-12 and outcomes and demographics sheet; see appendix X for the compacted COG-OPSS study booklet used) based on the information they collected with clients through their routine assessment method and not to undertake research activities that would require client consent. Consequently, staff were no longer required to use the COG-OPSS assessment schedule, complete the HADS and adapted SRS with clients or seek consent to video-recording a sub-sample of their assessment appointments. Due to these amendments to the original protocol, it was not possible in this study to assess the inter-rater reliability of the

COG-OPSS. As part of the new protocol, amended staff information and consent sheets were also used (see appendices V and W).

2.4.4 Results

2.4.4.1 Staff and client characteristics

Of the 22 staff participating in the study, 11 (six qualified and one training clinical psychologists, two psychiatrists, one CPN and one staff nurse) returned one or more COG-OPSS forms. Of staff members returning COG-OPSS forms, seven reported undertaking CBT training in addition to their professional qualifications (one accredited, four non-accredited, one diploma level).

In total, participating staff completed COG-OPSS forms for 30 clients. The characteristics of this client sample, as well as mean scores on the HoNOS 65+ and the COG-OPSS, are presented in Table 2.1. As can be seen, the client sample had a mean age of 74.4 years, was 40% male and 96.7% British White in ethnicity. In terms of presenting mental health difficulties, 5 (16.7%) were reported to be experiencing anxiety, 0 depression, 10 (33.3%) anxiety and depression, 0 anxiety in the context of other issues, 8 (26.7%) depression in the context of other issues (e.g. psychosis, alcohol abuse), 5 (16.7%) anxiety and depression in the context of other issues (e.g. bereavement, enduring physical health complaints) and 2 (6.7%) other difficulties (e.g. carer stress).

Table 2.1: Client sample characteristics

Client variable	*Descriptive statistics*	
Age	74.4 (M) 6.8 (SD) 66 – 87 (range)	
Gender	Male 12 (40%) Female 18 (60%)	
Ethnicity	British White 29 (96.7%) British Pakistani 1 (3.3%)	
Presenting difficulties	5 (16.7%) anxiety 0 (0%) depression 10 (33.3%) anxiety, depression 0 (0%) anxiety, other 8 (26.7%) depression, other (e.g. psychosis, alcohol abuse) 5 (16.7%) anxiety, depression, other (e.g. bereavement, physical health difficulties) 2 (6.7%) other (e.g. carer stress)	
HoNOS 65+ scores	1. Behavioural disturbance	0.70 (M), 1.12 (SD), 0 – 3 (R)
	2. Non-accidental self injury	0.20 (M), 0.66 (SD), 0 – 3 (R)
	3. Problem drinking / drug use	0.37 (M), 0.93 (SD), 0 – 3 (R)
	4. Cognitive problems	0.50 (M), 0.78 (SD), 0 – 3 (R)
	5. Physical illness / disability problems	1.23 (M), 1.07 (SD), 0 – 3 (R)
	6. Hallucinations and/or delusions or false beliefs	0.23 (M), 0.73 (SD), 0 – 3 (R)
	7. Depressive symptoms	2.03 (M), 1.03 (SD), 0 – 3 (R)
	8. Other mental and behavioural problems	1.73 (M), 1.14 (SD), 0 – 3 (R)
	9. Social / supportive relationships problems	1.03 (M), 1.22 (SD), 0 – 3 (R)
	10. Problems with activities of daily living	0.80 (M), 1.06 (SD), 0 – 4 (R)
	11. Problems with living conditions	0.50 (M), 0.78 (SD), 0 – 3 (R)
	12. Problems with work and leisure activities	0.93 (M), 1.20 (SD), 0 – 4 (R)
	Mean HoNOS 65+ score	0.86 (M), 0.48 (SD), 0.17 – 1.83 (R)
COG-OPSS scores	1. Ability to identify beliefs	3.40 (M), 1.10 (SD), 2 – 5 (R)
	2. Ability to identify emotions	3.70 (M), 0.79 (SD), 2 – 5 (R)
	3. Mindedness to CBT explanation of difficulties	3.07 (M), 1.20 (SD), 1 – 5 (R)
	4. Willingness to explore belief-consequence relationships	3.07 (M), 1.05 (SD), 1 – 5 (R)
	5. Therapeutic relationship	3.57 (M), 1.14 (SD), 1 – 5 (R)
	6. Interpersonal context	3.23 (M), 1.07 (SD), 2 – 5 (R)
	7. Duration and course of difficulties	3.17 (M), 1.18 (SD), 1 – 5 (R)
	8. Physical health, disability and mobility	3.93 (M), 1.14 (SD), 2 – 5 (R)
	9. Cognitive abilities	4.37 (M), 0.85 (SD), 2 – 5 (R)
	10. Readiness to change	3.37 (M), 1.16 (SD), 1 – 5 (R)
	Mean COG-OPSS score	3.49 (M), 0.73 (SD), 2.20 – 4.80 (R)

2.4.4.2 Outcomes for clients following assessment

The outcomes for clients following assessment are shown in Table 2.2. As can be seen, 29 clients were offered or referred on for one or more forms of further psychological input. Nine were offered (six, all accepted) or referred on (three, all accepted) further psychological assessment whilst 22 were offered (18, 16 accepted, 1 did not accept, 1 undecided) or referred on (four, all accepted) a specific psychological intervention (nine individual CBT, three group CBT, nine individual other and one group other).

Table 2.2: Outcomes for clients following assessment

Outcome	*Individual or group intervention*	*CBT or other intervention*	*Client response*	*Number (and %) of clients*
Referred on for further psychological assessment	n/a	n/a	Accepted Declined Undecided	3 (10%) 0 0
Offered further psychological assessment by assessing clinician	n/a	n/a	Accepted Declined Undecided	6 (20%) 0 0
Referred on for psychological intervention	Individual	CBT	Accepted Declined Undecided	3 (10%) 0 0
		Other	Accepted Declined Undecided	0 0 0
	Group	CBT	Accepted Declined Undecided	0 0 0
		Other	Accepted Declined Undecided	1 (3%) 0 0
Offered psychological intervention by assessing clinician	Individual	CBT	Accepted Declined Undecided	6 (20%) 0 0
		Other	Accepted Declined Undecided	7 (23%) 1 (3%) 1 (3%)
	Group	CBT	Accepted Declined Undecided	3 (10%) 0 0
		Other	Accepted Declined Undecided	1 (3%) 0 0
No further psychological input offered	n/a	n/a	n/a	1 (3%)

As only one client was not offered or referred on for further psychological input, it was not possible to test the predictive validity of the COG-OPSS as in Safran et al. (1993), in which comparisons were made between clients accepted and not accepted for treatment. However, as shown in Table 2.2, numbers permitted analyses relating to the type of intervention (CBT or other) clients were offered or referred on for. As shown in Table 2.3, initial comparisons (using parametric or non-parametric tests as appropriate), with *p* values uncorrected for multiple testing, demonstrated that clients offered or referred on for CBT interventions were rated significantly higher on the ability to identify emotions (Mann-Whitney U = 32.0, Z = -1.980, $p = 0.048$), mindedness to CBT rationale (Mann-Whitney U = 26.0, Z = -2.351, $p = 0.019$), willingness to explore belief-consequence relationships (t (20) = 2.944, $p = 0.008$), therapeutic relationship (Mann-Whitney U = 28.5, Z = -2.169, $p = 0.03$), and readiness to change (t (20) = 2.513, $p = 0.021$) than those offered or referred on for 'other' interventions. Mean COG-OPSS scores were also significantly higher for the CBT group compared to the 'other' intervention group (t (20) = 2.085, $p = 0.05$). However, none of these comparisons achieved significance when a Bonferroni corrected 0.005 significance level was applied.

Table 2.3: Comparisons between clients offered or referred on for CBT or 'other' interventions

COG-OPSS	*Clients offered or referred on for CBT intervention*	*Clients offered or referred on for a 'other' intervention*
Ability to Identify Beliefs	3.75 (1.14)	3.30 (0.95)
Ability to Identify Emotions	4.08 (0.67)	3.40 (0.84)*
Mindedness to CBT Rationale	3.75 (1.06)	2.60 (1.07)*
Willingness to Explore Belief – Consequence Relationships	3.75 (0.97)	2.60 (0.84)**
Therapeutic Relationship	4.25 (0.87)	3.20 (1.14)*
Interpersonal Context	3.33 (1.23)	3.20 (0.91)
Duration and Course of Difficulties	3.33 (1.07)	3.10 (1.52)
Physical Health, Disability and Mobility	4.00 (1.21)	3.60 (1.07)
Cognitive Abilities	4.25 (0.97)	4.60 (0.52)
Readiness to Change	4.00 (0.95)	2.90 (1.10)*
Mean COG-OPSS score	3.85 (0.66)	3.25 (0.69)**

Comparisons significant at: * 0.05 level ** 0.01 level *** Bonferroni corrected 0.005 level

To further consider the predictive validity of the COG-OPSS, a binary logistic regression was conducted with outcome (CBT, other) as the dependent variable and age, gender and mean COG-OPSS score as predictor variables (scores on specific COG-OPSS scales were not considered due to the small sample size). The resulting full model (and consequently any of its component predictor variables) was not found

to significantly predict intervention offered or referred on for (omnibus χ^2 (3) = 4.455, p = 0.216).

2.4.4.3 Relationship between ARM-12 and COG-OPSS scores

As a preliminary test of the construct validity of the COG-OPSS, mean and individual scale ratings were correlated with scores on the core alliance and openness sub-scales of the ARM-12. Results are shown in Table 2.4, with correlations significant at the Bonferroni corrected 0.0025 level emboldened. In terms of ARM-12 core alliance scores, significant and positive correlations were noted with seven COG-OPSS ratings (ability to identify beliefs, ability to identify emotions, mindedness to CBT rationale, willingness to explore belief-consequence relationships, therapeutic relationship, readiness to change and mean COG-OPSS score) at the 0.0025 level and one (interpersonal context) at the 0.05 level. With regard to ARM-12 openness scores, significant and positive correlations were noted with one COG-OPSS rating (therapeutic relationship) at the 0.0025 level, four (ability to identify emotions, mindedness to CBT rationale, willingness to explore belief-consequence relationships, and mean COG-OPSS score) at the 0.01 level and one (readiness to change) at the 0.05 level. These findings differ from the pattern of those in Safran et al. (1990, 1993) and possible reasons for this are considered in the Discussion. However, it is interesting to note that both ARM-12 scores were only correlated at the 0.0025 level with the therapeutic relationship COG-OPSS scale.

Table 2.4: Relationship between COG-OPSS and ARM-12 scores

COG-OPSS	*Agnew Relationship Measure – Short Form 12 (ARM-12)*	
	Core Alliance	*Openness*
Ability to Identify Beliefs	**0.536*** **	0.296
Ability to Identify Emotions	**0.634*** **	0.467**
Mindedness to CBT Rationale	**0.642*** **	0.522**
Willingness to Explore Belief – Consequence Relationships	**0.556*** **	0.531**
Therapeutic Relationship	**0.706*** **	**0.649*** **
Interpersonal Context	0.379*	0.358
Duration and Course of Difficulties	0.242	0.067
Physical Health, Disability and Mobility	0.297	0.166
Cognitive Abilities	0.279	0.241
Readiness to Change	**0.685*** **	0.387*
Mean COG-OPSS score	**0.715*** **	0.525**

Correlation significant at: * 0.05 level ** 0.01 level *** Bonferroni corrected 0.0025 level

2.4.4.4 Pre- and post- study staff questionnaire ratings

Nine staff completed both the pre- and post-study questionnaires, with mean pre- and post-participation ratings for each COG-OPSS factor in terms of use in assessment, helpfulness in assessing and confidence in assessing shown in Table 2.5.

Table 2.5: Comparisons between staff member scores on pre- and post-study questionnaires

COG-OPSS scale	*Use in assessment (0 = never, 100 = always)*		*Helpfulness in including in assessment (0 = not at all helpful, 100 = very helpful)*		*Confidence in assessment (0 = not at all confident, 100 = very confident)*	
	Pre	*Post*	*Pre*	*Post*	*Pre*	*Post*
Ability to Identify Beliefs	82.2 (19.9)	81.1 (18.3)	92.2 (12.0)	88.9 (13.6)	85.6 (10.1)	91.1 (11.7)*
Ability to Identify Emotions	70.0 (27.8)	67.8 (25.4)	78.8 (23.1)	78.9 (22.0)	77.8 (12.0)	82.2 (10.9)*
Mindedness to CBT Rationale	77.8 (19.2)	82.2 (17.9)	82.2 (21.1)	82.2 (17.2)	83.3 (15.8)	83.3 (12.2)
Willingness to Explore Belief – Consequence Relationships	72.2 (21.7)	75.6 (19.4)	81.1 (28.5)	82.2 (21.7)	77.8 (14.8)	81.1 (17.6)
Therapeutic Relationship	88.9 (15.4)	90.0 (13.2)	95.6 (7.3)	96.7 (5.0)	90.0 (10.0)	91.1 (10.5)
Interpersonal Context	92.2 (8.3)	91.1 (11.7)	95.6 (7.3)	96.7 (7.1)	91.1 (7.8)	87.8 (13.0)
Duration and Course of Difficulties	92.2 (9.7)	91.1 (16.9)	96.7 (7.1)	94.4 (10.1)	95.6 (5.3)	97.8 (4.4)
Physical Health, Disability and Mobility	83.3 (20.6)	83.3 (19.4)	90.0 (20.0)	88.9 (16.9)	84.4 (18.1)	86.7 (15.8)
Cognitive Abilities	87.8 (16.4)	88.9 (13.6)	93.3 (16.6)	90.0 (17.3)	82.2 (17.2)	85.6 (15.9)
Readiness to Change	90.0 (13.2)	90.0 (17.3)	97.8 (6.7)	97.8 (4.4)	86.7 (12.2)	85.6 (23.5)
Mean score	83.7 (11.4)	84.1 (11.4)	90.3 (11.5)	89.7 (10.8)	85.4 (9.5)	87.2 (10.2)

Comparisons significant at: * 0.05 level ** 0.01 level *** Bonferroni corrected 0.001

Comparisons between pre- and post-study ratings demonstrated significantly higher post-study ratings in confidence in assessing for ability to identify beliefs (Wilcoxon Z = -2.236, p = 0.025) and ability to identify feelings (t (8) = -2.530, p = 0.035) at the 0.05 level. However, neither of these met significance at the Bonferroni corrected 0.001 level. Generally, it is perhaps important to note that staff ratings of practice were on average quite high even before the start of the study, which may have made it difficult to detect changes.

2.4.4.5 Evaluation of the COG-OPSS

2.4.4.5.1 Staff ratings of COG-OPSS helpfulness

Staff ratings in terms of COG-OPSS helpfulness in judging CBT suitability and making post-assessment decisions are presented in Table 2.6. These were not found to differ significantly (t (29) = 1.385, p = 0.177). On average, staff ratings on these two questions were positive though quite varied (in both cases, ranging from 10 to 100).

Table 2.6: Staff COG-OPSS helpfulness ratings for determining CBT suitability and making post-assessment decisions

Evaluation questions	*Helpfulness rating (0 = not at all helpful, 100 = very helpful)*			
	Mode	*Mean*	*SD*	*Range*
Overall, how helpful was the COG-OPSS to you when deciding whether or not cognitive-behavioural therapy (CBT) was suitable for this client?	70	66.3	21.4	10 – 100
How helpful was the COG-OPSS to you in deciding what to do after the assessment?	50	62.7	24.1	10 – 100

2.4.4.5.2 Staff evaluation ratings of the COG-OPSS

Evaluation ratings of the COG-OPSS given by the nine staff completing the post-study questionnaire are presented in Table 2.7. In terms of ease of use and training received, staff gave higher and more consistent ratings. With regard to establishing a rapport and forming a useful part of practice, average ratings were lower and more varied. Comparisons between ratings, with an uncorrected significance level, demonstrated significant differences between scores on questions 1 and 3 (Wilcoxon Z = -2.371, $p = 0.018$), 1 and 4 (Wilcoxon Z = -2.214, $p = 0.027$), 2 and 3 (t (8) = 3.411, $p = 0.009$) and 3 and 4 (t (8) = -2.887, $p = 0.02$). However, none of these comparisons achieved significance at the Bonferroni corrected 0.008 level.

Table 2.7: Staff ratings on COG-OPSS evaluation questions

Evaluation questions	*Rating (0 = not at all true, 100 = very true)*			
	Mode	*Mean*	*SD*	*Range*
The instructions given in the COG-OPSS were clear and easy to follow.	100	91.1	9.3	80 – 100
I received sufficient training about using the COG-OPSS.	100	90.0	11.2	70 – 100
The COG-OPSS helped me in establishing a rapport with clients.	50	54.4	32.8	10 – 100
I feel the COG-OPSS formed a useful part of my practice.	100	71.1	30.2	20 – 100

2.4.4.5.3 Additional feedback given by staff

Five staff members provided additional feedback on using the COG-OPSS, which is reproduced verbatim in Table 2.8. As can be seen, all comments were broadly positive, especially the feedback given by a CPN and a psychiatrist. The other three comments, all from clinical psychologists, were also broadly positive though highlighted some issues that merit further consideration. One clinical psychologist commented that the measure may be more helpful for less experienced psychological practitioners, whilst another stated that the factors detailed in the COG-OPSS were those that they already included in their normal practice. Another also expressed concern at the measure's specific focus on CBT, and how it may be more helpful to consider means of assessing psychological therapy suitability more generally. All of these points are considered in more detail in the Discussion.

Table 2.8: Verbatim feedback given by staff on using the COG-OPSS

"I think this is a useable and effective aid to assessment and a tool for offering a comprehensive and holistic CBT approach from the outset. I think it will make planning easier and measuring outcomes better" (CPN)
"I feel that the COG-OPSS would definitely help us to assess the suitability for CBT and also looks at important areas like forming a trusting, durable relationship with the therapist" (Psychiatrist)
"The descriptions of the items on the suitability scale were a little repetitive but very clear and made it easy to rate. I'm concerned about the focus purely on CBT rather than enabling colleagues to understand appropriateness for psychological therapy more broadly - it may reinforce the view that all we do is CBT rather than broadening others views and educating them in what psychology do and who would be appropriate" (Clinical Psychologist)
"The COG-OPSS made explicit what I think I do implicit anyway, in that it was helpful and it was reassuring" (Clinical Psychologist)
"I think it would be very useful for less experienced psychological practitioners. It was a helpful prompt to explore a wide range of areas as part of my assessment than I might routinely cover" (Clinical Psychologist)

2.5 DISCUSSION

In this study, the development, validation and evaluation of a new method for assessing the suitability of CBT for older people with anxiety and/or depression difficulties, the COG-OPSS, is described. This interview and ratings procedure was developed with reference to the work of Safran et al. (1990, 1993) and to information gathered through focus groups with staff using CBT in an older persons' mental health service. Staff in the same service were then invited to trial the COG-OPSS as part of their practice, to collect information to help establish its psychometric properties (specifically, predictive validity, construct validity and inter-rater reliability) and to evaluate the helpfulness of the measure. Staff were also asked to complete pre- and post-study measures to determine whether participation in the research impacted on their practice. Thirty COG-OPSS rating scales were completed by 11 staff, and nine staff members completed both the pre- and post-study questionnaires. However, due to amendments made to the research protocol during the study, it was not possible to collect information pertaining to the inter-rater reliability of the COG-OPSS.

As only one client in the sample was not offered or referred on for any further psychological input, it was not possible to compare clients accepted or not accepted for CBT (or psychological therapy more generally) on COG-OPSS as was done in Safran et al. (1993) using their SSCT measure. However, it was possible to compare clients in terms of the type of therapeutic input they were offered or referred on for (CBT or 'other'). Initial comparisons, using an uncorrected significance level, demonstrated that clients offered or referred on for CBT interventions were rated significantly more highly on the ability to identify emotions, mindedness to CBT rationale, willingness to explore belief-consequence relationships, therapeutic relationship, and readiness to change COG-OPSS suitability scales

compared to those offered ‘other’ interventions. Mean COG-OPSS scores were also found to be significantly higher for ‘CBT’ clients compared to ‘other’ clients. However, these comparisons failed to maintain their significance when *p* values were corrected for multiple testing. Mean COG-OPSS scores were also not found to significantly predict the type of therapeutic intervention offered to clients (CBT or other) when entered with age and gender into a binary logistic regression analysis. Based on these findings, the COG-OPSS did not appear to have sufficient predictive validity, though these results may in part be due to the small sample size used.

With regard to construct validity, ratings on several COG-OPSS suitability scales were found to correlate significantly and positively with the two component scales of a therapeutic alliance measure, the ARM-12. Several of these correlations (ARM-12 core alliance sub-scale with ability to identify beliefs, ability to identify emotions, mindedness to CBT rationale, willingness to explore belief-consequence relationships, therapeutic relationship, readiness to change and mean COG-OPSS rating, and ARM-12 openness sub-scale with therapeutic relationship) maintained their significance even after corrections were made for multiple testing. These findings differ to the pattern of results noted by Safran et al. (1993), who reported scores on a client-completed therapeutic alliance measure, the WAI, were only significantly corrected with the alliance potential (in-session evidence) aspect of their SSCT. These findings may suggest that further work is needed to improve the construct validity of the COG-OPSS suitability scales, though perhaps encouraging only ratings on the therapeutic relationship scale were found to be significantly correlated with both ARM-12 sub-scales at the corrected significance level. Disparate findings between this study and Safran et al. (1993) may also result from several factors, including the use of different therapeutic alliance measures, different measure completers (the assessor in this study, the client in Safran et al.,

1993) and different times of completion (at assessment in this study, after the third post-assessment therapy session in Safran et al., 1993).

In terms of staff evaluations of the COG-OPSS, ratings were more consistently positive for ease of use and training though more variable with regard to rapport building and forming a useful part of practice. Ratings in terms of helpfulness for judging CBT suitability and in making post-assessment decisions were again positive on average though showed substantial variability. In terms of pre- and post-study ratings concerning assessment of the factors contained within the COG-OPSS, confidence in two areas (ability to identify beliefs and ability to identify feelings) was found to be significantly higher post-study though this result failed to meet the set corrected significance level. The lack of further significant pre- to post-study changes may be due to the high pre-study ratings observed, which may be reflective of the fact that a large number of participants were qualified clinical psychologists. The additional feedback given by staff members was again in general positive though a number of issues regarding the COG-OPSS were raised. For example, the comments of two respondents suggested that the COG-OPSS was perhaps less helpful for more experienced psychological practitioners as it covered factors they already considered in their normal assessment practice. In additional, one respondent expressed concern at the CBT focus of the COG-OPSS, and suggested that the measure should be concerned with appropriateness for psychological therapies more broadly.

This study has a number of methodological limitations that would require addressing in future research. Firstly, although every effort was made to recruit adequate numbers of client participants, the sample size was small and consisted almost exclusively of participants who were offered or referred on for some further psychological input. This restricted the statistical

analyses that could be conducted and may have meant those that were undertaken lacked sufficient 'power' to detect differences and effects. Also, given the limited time frame of the study, it was only possible to consider the measure's predictive validity in terms of more immediate effects (i.e. what type of psychological therapy was offered or referred on for) rather than longer-term effects, such as treatment outcomes (as was investigated in Safran et al., 1990, 1993; Myhr et al., 2007). It is also important to note that data was not collected concerning a number of factors that may have mediated post-assessment decisions by assessors, such as service capacity and (in the case of psychological practitioners) their preferred mode(s) of therapy.

In terms of clinical practice, there is as yet no definitive evidence to recommend the use of the COG-OPSS by clinicians working with older people. However, given the small sample size used here, it is arguable the measure has yet to be trialled and evaluated in a sufficiently rigorous manner. Therefore, further research with a larger and more varied sample of client participants is required in order to establish whether the COG-OPSS has sufficient psychometric properties and is of clinical utility. As part of this, future research may need to cover a longer time period such that treatment outcome data can also be used to evaluate the predictive validity of the COG-OPSS. Future research should also consider where measures such as the COG-OPSS are best placed in services i.e. should they be used more generically or should they be used more specifically by psychological practitioners? Given the in-depth nature of the COG-OPSS, it may be beneficial for a more streamlined form of the measure to be devised to be used more generically e.g. in introductory assessments for the service or in outpatient clinics. Alternatively, other measures (such as the Psychological Mindedness Scale; Conte et al., 1990) could be used to help initially identify clients for whom psychological therapies may be appropriate, who could then be referred on for a more

detailed COG-OPSS assessment. It may also be helpful for future research to consider whether the scope of the COG-OPSS should be broadened so that, in addition to assessing suitability of CBT, other psychological therapies could be considered.

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CHAPTER 3

Public Domain Briefing Paper

PUBLIC DOMAIN BRIEFING PAPER

THE COGNITIVE-BEHAVIOURAL THERAPY FOR OLDER PEOPLE SUITABILITY SCALE (COG-OPSS): DEVELOPMENT AND PRELIMINARY VALIDATION AND EVALUATION OF A NEW METHOD FOR ASSESSING THE SUITABILITY OF COGNITIVE-BEHAVIOURAL THERAPY FOR OLDER PEOPLE WITH ANXIETY- AND/OR DEPRESSION-RELATED DIFFICULTIES

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3.1 OUTLINE

This study was completed by Jon Williamson and presented as part of a thesis submitted to the School of Psychology, University of Birmingham, for the qualification of Doctor of Clinical Psychology. The study describes the development and preliminary validation and evaluation of a new clinician-completed scale designed to assess how suitable cognitive-behavioural therapy (or, CBT) is for an older person experiencing anxiety- and/or depression-related difficulties. The measure is called the Cognitive-Behavioural Therapy for Older People Suitability Scale (or, COG-OPSS).

3.2 BACKGROUND

What is cognitive-behavioural therapy?

Cognitive-behavioural therapy (or, CBT) is a form of psychological treatment which sees the emotional and behavioural difficulties individuals experience in certain situations as resulting from 'unhelpful' thinking patterns (Trower, Jones, Dryden & Casey, 2011). Therefore, in CBT therapists work together with clients to identify and modify 'unhelpful' thinking patterns. CBT is a well researched treatment, with evidence suggesting it can be effective for a range of mental health difficulties (Roth & Fonagy, 2005) for individuals across the life span.

Why develop a clinician-rated measure assessing the suitability of CBT for older people experiencing anxiety- and/or depression-related difficulties?

Despite historical claims that older people (those aged 65 years and over) were unable to benefit from psychological therapies, more recent research has suggested that such treatments, including CBT, can be effective in addressing a range of mental health issues such as anxiety- and depression-related difficulties (e.g. Laidlaw, Thompson, Dick-Siskin & Gallagher-Thompson, 2003; Woods & Roth, 2005). However, CBT is but one of a range of therapies that could potentially benefit an older person and it is important to have assessment measures in place to help clients get access to the therapy that best meets their needs. One such measure is the Suitability for Short-Term Cognitive Therapy (or, SSCT) interview and ratings procedure, devised by Safran and colleagues (Safran, Segal, Shaw & Vallis, 1990; Safran, Segal, Vallis, Shaw & Samstag, 1993), which assesses ten factors thought to

determine the suitability of CBT for adults of working age. Research using this measure suggests it can help identify those who go on to receive CBT and can also predict how individuals will respond to CBT (Safran et al., 1990, 1993; Myhr, Talbot, Annable & Pinard, 2007). Such an assessment procedure could also be potentially useful for mental health professionals working with older people though would most likely need to be tailored to take into account age-related issues.

3.3 AIMS OF THE STUDY

The aims of this study were:

- To develop, through focus groups with clinicians using CBT with older people, a clinician-completed interview and ratings procedure, based on that by Safran et al. (1990), to assess the suitability of CBT for older people with anxiety- and/or depression-related difficulties.
- To trial the new measure in an older persons' mental health service and for data to be collected on the measure's reliability (does it produce consistent results) and validity (does it measure what it is supposed to measure).
- To assess if using the new measure has an effect on staff practices, and to get feedback from staff on their experiences of using the new measure.

3.4 PARTICIPANTS

Seven members of staff (including clinical psychologists, nurses and occupational therapists) from an older persons' mental health service, six of whom reported current use of CBT with clients, participated in the focus groups. Twenty two staff (including nurses, clinical

psychologists and psychiatrists) from the same service consented to trialling the new measure, the COG-OPSS, with two to three of their clients. In total, eleven staff members completed COG-OPSS rating scales (and additional measures, outlined below) for 30 clients with anxiety- and/or depression-related difficulties. The client sample had a mean age of 74.4 years, was 40% male and 96.7% White British in ethnicity.

3.5 METHOD

Using information gathered through the focus groups, the COG-OPSS interview and ratings procedure was devised. This procedure, based in part on Safran et al.'s SSCT measure, was designed to assess ten factors relating to CBT suitability (including the ability to identify beliefs, the ability to identify to identify feelings and how minded the client is to a CBT explanation of their difficulties) through a detailed interview with the client. Members of staff participating in the research were asked to recruit two to three clients to trial the COG-OPSS with, and to collect information that would help assess the reliability and validity of this measure. Staff were also asked to complete questionnaires at the start and end of the study that assessed the impact of using the COG-OPSS on their practice and also sought feedback on their experiences of using this measure. However, due to difficulties associated with client recruitment, alterations to the study were made five months into the research, with staff no longer required to complete certain measures with clients.

3.6 FINDINGS

A total of 30 COG-OPSS were completed for clients by 11 staff members. Nine staff members also completed both the pre- and post-study questionnaires and provided feedback

on their experiences of using the COG-OPSS. Client recruitment numbers were substantially lower than the number desired (50).

Reliability and validity of the COG-OPSS

The reliability of the COG-OPSS could not be assessed as the means of achieving this (the video-recording and rating of a sub-set of assessments) was removed in the changes made to the study. Some findings suggested the COG-OPSS might distinguish between those offered or referred on for CBT compared to other therapies but these results did not meet the stringent criteria for statistical significance used. Scores on a staff-completed questionnaire, measuring the therapeutic alliance between them and their client, were associated with ratings on several of the COG-OPSS suitability scales, most notably that concerning therapeutic relationship. This may provide some tentative evidence that this part of the COG-OPSS is measuring what is it supposed to measure.

Staff evaluations of the COG-OPSS and impact on their practice

There was some variability in how helpful staff found using the COG-OPSS in judging the suitability of CBT for clients and in making decisions after their assessment. Staff evaluations were consistently positive concerning the ease of use of the COG-OPSS and the training they received in relation to it. However, evaluations were more variable in terms of whether the COG-OPSS helped establish a rapport with clients and whether it formed a useful part of their practice. No changes in terms of staff assessment practices having used the COG-OPSS were found to meet the criteria for statistical significance used.

3.7 STUDY LIMITATIONS

Given the small client sample size, it was not possible to perform certain statistical tests and those that were performed may have been 'underpowered' (that is, they may have lacked the 'power' needed to detect differences or effects in the sample). All but one of the clients sampled were offered or referred on for further psychological assessment or intervention, so it was not possible to determine whether the COG-OPSS can reliably predict which clients go on to receive additional psychological input or not. Due to changes made to the research protocol, it was also not possible to assess how reliable a measure the COG-OPSS is.

3.8 CLINICAL IMPLICATIONS AND FUTURE RESEARCH

There is no clear evidence at present to recommend the use of the COG-OPSS in clinical practice though it may, through further testing with a larger client sample, prove to be of use to staff working with older people. Also, although the COG-OPSS was designed specifically to assess the suitability of CBT for older people, it may also be helpful to examine whether it is helpful in determining the appropriateness of other psychological therapies for clients (and, if not, what adaptations would be required to the measure to achieve this). As the COG-OPSS is quite an in-depth measure, it may also be helpful to consider whether a complimentary streamlined form could be developed for use by staff.

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APPENDIX A: GUIDELINES FOR AUTHORS – JOURNAL OF APPLIED RESEARCH IN INTELLECTUAL DISABILITIES

APPENDIX B: GUIDELINES FOR AUTHORS – BEHAVIOURAL AND COGNITIVE PSYCHOTHERAPY JOURNAL

APPENDIX C: FOCUS GROUP FRAMEWORK

Timetable

30 minutes	Discussion of factors influencing CBT suitability for older people
25 minutes	Discussion of Safran et al. SSCT, aspects 1 to 5 (5 minutes each)
15 minutes	Break
25 minutes	Discussion of Safran et al. SSCT, aspects 6 to 10 (5 minutes each)
25 minutes	Discussion of other factors to include in new assessment measure, summing up of main points, what happens next with the study

Introductions

The aims of this focus group are twofold. Firstly, the discussions will focus on what factors you think influence the suitability of cognitive-behavioural therapy (CBT) for an older person with mental health difficulties. Secondly, the discussions will focus on a specific means of assessing CBT suitability with adults of working age, the Safran et al. Suitability for Short-Term Cognitive Therapy (SSCT) interview, and whether this could be used with older persons.

Part 1: Discussion and exploration of factors influencing suitability of CBT for an older person (approx. duration 25 minutes)

1. What factors do you think are important when deciding whether cognitive-behavioural therapy (CBT) would be suitable for an older person?
2. Does that factor make CBT more or less suitable? Why do you think that is?
3. Is that experience/opinion shared by others?
4. How would CBT with an older person change because of that factor? What ways might there be around any problems resulting from that factor?
5. What other factors do you think are important when deciding whether CBT would be suitable for an older person?

Closing question:

Before we finish this part of the discussion, is there anything we have missed? Is there anything anyone else would like to say on this matter?

Summing up of main points from Part 1 of the focus group

Part 2: Discussion and exploration of Safran et al. SSCT interview protocol as a means of assessing suitability of CBT for older persons

In this second part of the group, we are going to focus the discussion on a specific way of assessing CBT suitability, the Suitability for Short-Term Cognitive Therapy (SSCT) interview by Safran et al. (1990). As you will know from the information you received prior to today, this interview suggests 10 suitability criteria to consider when assessing whether

CBT is suitable for a client. To date, the measure has been used with adults of working age. I'd like the discussions to focus on each suitability criteria for a few minutes, thinking about whether this would be appropriate to use with older persons.

The first criterion is the client's ability to access and articulate the automatic thoughts and dysfunctional beliefs that experience in problematic situations.

Would it be appropriate to use this criterion when assessing CBT suitability with older persons? Why is it appropriate? Why is it inappropriate?

Is this opinion shared by others in the group?

What changes, if any, would you make to this criterion when working with older persons? Would you remove this criterion completely?

The second criterion is the client's ability to be aware of and differentiate between different emotional states...

The third criterion is the client's acceptance of personal responsibility for change...

The fourth criterion is the extent to which the client understands and accepts the cognitive rational for emotional distress...

The fifth criterion is the client's ability and potential to form a therapeutic alliance based on in-session evidence...

The sixth criterion is the client's ability and potential to form a therapeutic alliance, this time using out-of-session evidence...

The seventh criterion is the chronicity or duration of the client's problems...

The eighth criterion is the extent to which security operations on the part of the client prevent the exploration of the client's difficulties...

The ninth criterion is the extent to which the client can work with a problem-oriented focus...

And finally, the tenth criterion is the extent to which the client feels hopeful about the therapeutic process...

After all suitability criteria have been addressed:

Are there any suitability criteria not already mentioned that you feel should be added to the measure when working with older persons? What is this criterion and why would you include it?

Closing question:

Before we finish this section of the focus group, is there anything we have missed? Is there anything else anyone would like to say on this matter?

APPENDIX D: INFORMATION SHEET ON THE SAFRAN ET AL. (1990) SSCT MEASURE FOR FOCUS GROUP PARTICIPANTS

Safran & Segal's (1990) Suitability for Short-Term Cognitive Therapy Interview

The Suitability for Short-Term Cognitive Therapy (SSCT) interview was devised by Safran & Segal (1990) as a means of assessing the extent to which an individual is suitable for short-term cognitive therapy. The interview protocol specifies ten suitability dimensions (see below) on which individuals are given a rating (on a nine point scale) based on the information obtained during their assessment. The interview does not specify the exact questions the interviewer should ask or a specific structure to follow. Instead, the interviewer should feel free to move back and forth among the areas as they see fit and can choose which questions to use from those suggested by the authors. It is suggested that prior to the interview the interviewer has some background details on the client and their difficulties and use the one-hour interview time to elicit the information needed to rate clients on the ten suitability criteria. To date, the SSCT has been used on adults of working age.

The ten suitability criteria, and possible means of assessing each of them, are listed in the table below:

No.	Suitability Criteria	Means of Assessing
1.	*Accessibility of Automatic Thoughts* The ease with which the client accesses and articulates the automatic thoughts and dysfunctional beliefs they have in problematic situations.	Ask the client to describe a specific problem situation and ask questions such as *"what were you thinking in that situation?"* or *"do you recall what was going on in your mind?"*
2.	*Awareness and Differentiation of Emotions* The client's ability to be become aware of and label different emotional states and to notice changes in emotions, both in the present and in retrospect.	Once the client has described a specific problematic situation, probe questions such as *"do you remember what you were feeling in that situation?"*, *"what was that feeling like?"* and *"how is that different from the way you normally feel?"*
3.	*Acceptance of Personal Responsibility for Change* The extent to which clients see themselves as playing a role in their own recovery.	Use probe questions such as *"what is your understanding of the role that the therapist (or the client) plays in therapy?"*
4.	*Compatibility with Cognitive Rationale* The extent to which the client understands and accepts the cognitive conceptualisation of emotional distress.	Use probe questions such as *"how do you understand your difficulties?"*, *"what do you think causes your difficulties?"* or *"what is your understanding of how cognitive-behavioural therapy works?"*
5.	*Alliance Potential (In-Session Evidence)* The client's potential to form a therapeutic alliance.	Therapists rate this criterion based largely on how they 'feel' being in the room with the client, and may consider factors such as amount of eye contact, tone of voice, body posture, verbalisations and overall degree of openness. Probe questions can be used, such as *"how are you feeling about our interview today?"* or *"how does it feel talking about your difficulties to someone?"*
6.	*Alliance Potential (Out-of-Session Evidence)* The client's potential to form a therapeutic alliance.	Ask the client about current or previous meaningful and intimate relationships. Probe questions such as *"have you ever been able to confide in someone?"* or *"tell me about some of the meaningful relationships in your life"* can be used. Consider asking about parents, siblings, friends, spouses, partners and so on.

7.	*Chronicity* The duration of the client's problems.	Ask questions about the onset, history and course of the client's difficulties.
8.	*Security Operations* The extent to which psychological processes and behaviours, designed to maintain self-esteem and reduce anxiety, prevent the exploration of the client's difficulties.	Consider whether any of the following are evidenced by the client: attempts to control the interview, tangential talking that makes it difficult to deal with any one subject in depth, changing the topic, dealing with topics in an overly rational way and so on.
9.	*Focality* The extent to which the client can work with a problem-oriented focus i.e. can they focus on one particular situation or issue as required.	Consider whether the client can focus on particular problems or situations or whether they want to work on everything at once, cannot talk about a situation without bringing in tangential information from other situations and so on.
10.	*General Optimism/Pessimism about Therapy* The extent to which the client feels hopeful about the possibility of therapy leading to change in their life.	Ask the client to what extent they feel hopeful about the therapeutic process, whether they feel they might benefit from it and so on.

For each suitability criterion, the client is given a rating on a nine point scale ranging from 0 to 5 with half points used. These rating scales are anchored so that 5 indicates the best prognosis and 1 indicates the worst prognosis. An example of one of the rating scales used is given below:

Accessibility of Automatic Thoughts

Instructions to Raters

In rating this item, *two* dimensions are considered:

a. The *ease* with which the patient accesses and articulates automatic thoughts and dysfunctional beliefs. This necessitates some consideration of the *quantity* and *quality* of probing by the therapist.
b. The *level* of self-reference reflected in the automatic thoughts the patient reports.

Score '1' when the patient is unable to gain access to any automatic thoughts (that is, is unaware of "self talk," does not report "mental pictures," and does not see the relationship between his or her own thinking and emotions).
Score '5' when the patient spontaneously reports automatic thoughts that appear to be core or central to the patient's conception of self.
Score '2' to '4' depending on the level of automatic thoughts reported. For example, a rating of '2' reflects automatic thoughts reported that are judged to be less core, less central than a rating of '4.'

0 Do *not* rate. Insufficient information.
1 Patient appears to be completely unable to gain access to automatic thoughts.
2 Patient is able to gain access to one or two automatic thoughts.
3 Patient is able to gain access to some automatic thoughts.
4 Patient is able to gain access to a number of important automatic thoughts.
5 Patient *readily* gains access to central automatic thoughts.

APPENDIX E: COGNITIVE-BEHAVIOURAL THERAPY FOR OLDER PEOPLE SUITABILITY SCALE (COG-OPSS) – ASSESSMENT SCHEDULE

Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS)

Assessment Schedule

Client's Name:	Date of Birth:

Introduction to the COG-OPSS

- The Cognitive-Behavioural Therapy for Older People Suitability Scale (or, COG-OPSS) is a means of assessing to the extent to which cognitive-behavioural therapy (or, CBT) is suitable for older individuals experiencing difficulties with anxiety and/or depression.
- The COG-OPSS is made up of ten suitability scales, each measuring a different factor thought to influence the suitability of CBT for an older person.
- For each suitability scale, a rating of 1 (CBT less likely to be suitable) to 5 (CBT more likely to be suitable) can be given. On each scale, descriptions are given for what would be required for a score of 1, 3 or 5 to be given. However, scores of 2 or 4 can also be given if it is felt this best reflects the information collected on the client.

Instructions for Use

- The COG-OPSS Assessment Schedule is a suggested format for an interview with a client that would support the interviewer/assessor in collecting the information they need to make ratings on the ten COG-OPSS suitability scales.
- The Assessment Schedule is made up of seven areas: (1) details of presenting difficulties, (2) history of difficulties, (3) the client's understanding of the difficulties, (4) the interpersonal context of the difficulties, (5) therapeutic relationship potential, (6) physical health, disability and mobility issues, and (7) cognitive abilities. These are presented in a suggested order to follow.
- For each section, areas of focus and suggested questions are given.
- A worksheet is also provided to help explore the client's ability to make connections between their beliefs and their symptoms of anxiety and/or depression.
- Some areas rely on gathering information by verbal questioning whilst others (specifically Therapeutic Relationship and Cognitive Abilities) rely more on observing how the client presents during the assessment.

- Please note that the Assessment Schedule is only a suggested means of collecting information relevant to assessing CBT suitability – it does not have to be followed rigidly and not all questions need be asked. You only need ask enough questions to get the information you need to make a rating of the COG-OPSS suitability scales.
- The COG-OPSS assessment should take place over no more than two 60 minute appointments. Ratings on the suitability scales should be made as soon as possible after these appointments have ended.

Suggested Introduction for Clients

"Thank you for meeting with me today. We are meeting today because I got a referral from [referrer's name, profession etc.] saying [summarise referral]. I would like to talk with you to find out more about you and the difficulties you're experiencing. As you know, we will be using a new means of assessment today and filling in some questionnaires. If you have any questions about what we're doing today, please let me know as we go along."

Details of Presenting Difficulties

❑ **Broad focus**	To gain details on the client's presenting difficulties anxiety and/or depression
❑ **This section will help in collecting information relevant to these suitability scales:**	• Ability to Identify Beliefs/Thoughts • Ability to Identify Emotions/Feelings • Readiness to Change

❑ **Specific areas of focus and suggested questions**

"Let's start by thinking about why you were referred..."

❑ **Client's understanding of the referral** • What is the client's understanding of why they've been referred? • What do they think of the referral? • Do they see the referral issue(s) as a difficulty?	

❑ **Description of difficulties** • What things does the client feel they are having difficulties with? Consider: - Behaviour e.g. lowered activity levels, social withdrawal, avoidance of situations - Feelings e.g. worry (anxiety), irritability, sad, tearful, worthlessness, numbness, guilt - Physical e.g. sleeping, appetite, energy levels, tension, aches - Cognitive e.g. difficulties concentrating, paying attention, remembering things, indecisiveness • Do the difficulties stop them from doing things they'd like to be doing? What are these?	

❑ **Situations (antecedents)** • When do the difficulties occur e.g. time, day • Where do they occur e.g. at home, out • What is the client doing when they occur • Who is the client with when they occur	

❑ **Feelings/physical changes (consequences)** • How does the client feel in these situations e.g. worried, anxious, scared, sad, tearful irritable • What changes do they notice in their body at the time - e.g. anxiety: breathlessness, rapid heartbeat, sweating, dizziness, trembling, 'butterflies in stomach' - e.g. depression: lack of energy, sighing, aches and pains	

❑ **Feelings/physical changes (consequences) continued** • Are there situations in which the feelings are particularly strong? • How are feelings in these situations different from other times (e.g. if they happen when the client is out shopping, how is this different from when they are at home)	

❑ **Behaviour of clients, others (consequences)** • What exactly does the client do when the difficulties happen? • What exactly do they do to make the difficulties less? • Does the client use any medications or other substances (e.g. alcohol, drugs, legal and/or illegal) to manage the difficulties? • How long can the client tolerate the difficulties before doing something about them? e.g. *"When you are feeling worried when out shopping, how long can you stick with it?"* • What do others do e.g. family, friends, carers when the difficulties happen?	

❑ **Thoughts/cognitions (beliefs)** • What thoughts/beliefs/mental images/pictures etc. occur when the client is in these situations? • "Can you say what things you're thinking about (or 'what goes through your mind/head' or 'what you say to yourself') just before [the difficulties] happen?" • Give general examples of thoughts that might make people worried or upset e.g. - <u>anxiety</u>: "Something terrible is going to happen", "I can't cope" "I'll make a fool of myself" - <u>depression</u>: "I'm useless", "Nobody cares about me", "Things are never going to get better"	

❑ **Readiness to change** • Does the client want things to be different? • Do they believe things can be different? • *"How would your life be better if [the difficulties] were less? Would there be a downside to [the difficulties] being less?"*	

Duration and Course of Difficulties

❑ **Broad focus**	To gain details on the history of the difficulties
❑ **This section will help in collecting information relevant to these suitability scales:**	• Duration and Course of Difficulties

❑ **Specific areas of focus and suggested questions**

"Let's think a bit more about [the difficulties] you've been telling me about. When did you notice [the difficulties] starting to happen?"

❑ **Onset of difficulties** • When did the difficulties begin? • What was happening around that time? Consider: - Changes in or loss of roles of value to client e.g. retiring from employment - Onset or worsening of physical health changes (and impact, if any, of these on activities, independence, autonomy) - Changes in client's family: - bereavements - changes in health of family members - changes in relationships between family members e.g. divorce, re-marriage - actions of family members that client is worried by or disapproves of - Changes in client's other social networks - Changes in or loss of activities of value to client	

❑ **Duration of difficulties** • How long have the difficulties been apparent? Weeks, months, years? • Has the client experienced similar difficulties in the past? If so, when was this, how long did these difficulties last? • Have they always been present? • *"Do you remember a time when the difficulties weren't there?"*	

❑ **Course of difficulties** • Have the difficulties been consistent? • Have there been times when the difficulties were better? What was happening at these times? • Have there been previous attempts to address the difficulties e.g. by the client themselves, with professionals, with others such as family, friends? If yes, did the difficulties show any change?	

Client's Understanding of Difficulties

❑ **Broad focus**	To gain details on how the client understands the difficulties with anxiety and/or depression they're experiencing
❑ **This section will help in collecting information relevant to these suitability scales:**	• Mindedness to CBT Explanation of Difficulties • Willingness to Explore Relationship between Thinking and Feelings/Behaviours

❑ **Specific areas of focus and suggested questions**

"Let's think a bit more about why the difficulties might be happening. Why do you think they are happening?"

❑ **Client's understanding/explanation of difficulties** • Why does the client think the difficulties are happening? • How do they understand them? • Do they see the difficulties as being related to getting older? • What are the client's views about ageing? Positive? Not as positive?	

❑ **Client's mindedness to medical approach** • To what degree does the client see their difficulties from a medical perspective? • Is this the only perspective they see their difficulties from? *"Some people would say tablets are the only way to make difficulties like yours better...what do you think?"*	

❑ **Client's mindedness to CBT approach** • Does the client see a link between how they think and how they feel? *"Are there certain things you tend to be thinking about when you feel...?"* *"Do you think there is a link between what you think about and how you feel?"* *"If you thought less about...do you think you'd feel different?"* • If the client finds it difficult to make links between their beliefs and feelings (and actions), how do they react to being taken through the Cat-Burglar Worksheet? (appendix 1) • How does the client react when given an explanation of how CBT would explain how their difficulties? (appendix 2)	

❑ **Client's mindedness to CBT approach continued** • Does the client acknowledge that there could be evidence for and against the beliefs linked to their anxiety and/or depression *"You said that you think that...what's the evidence for that? What's the evidence against it?"* • How does the client respond when it is suggested that beliefs are things that can tested out? • How would they feel about doing things to test out these beliefs e.g. talking about evidence for and against the belief with a therapist, or trying out activities they think would be difficult? • Discuss with the client how testing out beliefs can sometimes be difficult (e.g. can bring about feelings of worry or upset), how would they feel about that? Is it something they could accept? • Are there times in the past that the client has faced challenges? How did they overcome these?	

Interpersonal Context

❑ **Broad focus**	To gain details on the various interpersonal contexts (relationships, family etc.) in which the difficulties with anxiety and/or depression occur and how these relate to the difficulties
❑ **This section will help in collecting information relevant to these suitability scales:**	• Interpersonal Context

❑ **Specific areas of focus and suggested questions**

❑ **Details of client's current living arrangements, family, friends, other professionals involved** • *"Can you tell me a bit about where you live and who you live with?"* • Who is in the client's family, who do they see? • Are there any current issues/difficulties in the family? How does the client feel about these? • Does the client have one or more friends? How often do they see them? • What roles does the client play in their family, network of friends etc., do they find these roles rewarding or stressful? • Are there any other professionals currently working with the client? Does the client view these inputs as helpful or not?	

❑ **How do others see the difficulties** • "What would (e.g. your partner/son/daughter) say about the difficulties? Why would they say they are happening?" • "What would they say needs to happen for the difficulties to get better? Do you agree with them?"	

❑ **How do others respond when the difficulties happen** • "What does (e.g. your partner/son/daughter) do when the difficulties happen?" • "What does (e.g. your partner/son/daughter) do to make the difficulties better? Do they do anything to make the difficulties worse?" • "If the difficulties got better, how do you think things would be different e.g. between you and your partner/son/daughter, in your family?"	

Therapeutic Relationship

❑ **Broad focus**	To gain information to assess the extent to which the client appears able to form open, trusting and durable relationships with others, feels comfortable and safe in these relationships, and can use relationships to discuss/explore difficulties and problems.
❑ **This section will help in collecting information relevant to these suitability scales:**	• Therapeutic Relationship

❑ **Specific areas of focus and suggested questions**

❑ **Client's current experiences of relationships** • Has the client talked to family/friends/others about the difficulties? How did they find this? • Are there people in the client's life that they can confide in, that they trust? • Does the client feel it's appropriate to discuss personal issues, like [the difficulties] with others, including professionals? *"We've talked about some more personal/private things today...how has that been for you?"*	

❑ **Client's previous experiences of relationships** • Has the client been able to confide in others in the past? • If so, when did this happen and was it helpful or not to them? • What does the client remember of their earlier relationships e.g. with their parents, did they feel loved, safe, did they feel they could trust them? • Did the client experience any losses in relationships when they were younger?	

❑ **Client's presentation during the assessment(s)** • Does the client make eye contact? • Does the client appear 'friendly' and 'warm' towards you? • Do they appear relaxed or not? • How does the client respond to questions (especially more personal ones) e.g. openly or more guarded?	* These are not questions to ask directly to the client, answers should be based on how the client presents during the assessment*

Physical Health, Disability and Mobility

❑ **Broad focus**	To gain details on any issues with physical health, disability and mobility the client has and whether these would impact on any CBT intervention work
❑ **This section will help in collecting information relevant to these suitability scales:**	• Physical Health, Disability and Mobility • Ability to Identify Beliefs/Thoughts

❑ **Specific areas of focus and suggested questions**

"Let's have a think about your physical health..."

❑ **Details of issues with physical health, disability and mobility** • Details of any issues with physical health, disability and mobility • Are these recent or more longstanding? • Does the client have any issues with pain? If so, how often do these happen? How severe is the pain? • Does the client have any difficulties with seeing and/or hearing? To what extent are these corrected for (e.g. by glasses, hearing aid)?	

❑ **Impact of physical health, disability and mobility issues on client's life** • What impact do the physical health, disability and mobility issues have on the client's life? • What do they make it difficult for the client to do e.g. activities, reading? • How distracting are these physical health, disability and mobility issues for the client? *e.g. "Does the pain make it difficult to focus on other things?"*	

❑ **Client's beliefs/thoughts about physical health, disability and mobility issues** • What does it mean to the client to have these difficulties with physical health, disability and mobility? • Does the client feel they are coping with these difficulties? How do they feel they do this? • What does the client think about these physical health, disability and mobility issues e.g. to they think or worry about them getting worse, about how others see them?	

Cognitive Abilities

❑ **Broad focus**	The extent to which any issues with cognitive abilities (including memory, attention and comprehension) could impact on CBT working.
❑ **This section will help in collecting information relevant to these suitability scales:**	• Cognitive Abilities

❑ Specific areas of focus and suggested questions

These questions are largely to be answered through observing the client rather than direct questioning

❑ **Memory** • Does the client remember what is said to them during the assessment e.g. questions asked? • Do things like repetition of material, prompting help with remembering?	

❑ **Attention** • Can the client maintain their focus of attention or are they easily distracted? • How easily can their attention be brought back to the conversation or topic, what seems to help this happen?	

❑ **Comprehension** • Does the client seem to grasp and understand what is said to them? • What seems to help them understand e.g. shorter, simpler sentences, repeating information, using more concrete language and examples, presenting materials in different forms e.g. verbal, written, pictures? • Does the client require long periods of time to respond to questions? Do the client's responses seem appropriate/correct after these periods? • How does the client find information given to them in written form e.g. can they understand it?	

❑ **Orientation** • Does the client appear oriented in terms of time and place? • Can they say what today's date is? • Can they say where they are?	

“Although I’ve asked a lot of questions I may have not asked about things that are important to you and that would help me understand things better. Are there some things I’ve not asked about that you think it’s important for me to know?”

Appendices

Appendix 1 – Cat/Burglar Worksheet

This worksheet is designed to be used when exploring with the client how they understand their difficulties and to what extent they are minded to a cognitive-behavioural explanation of psychological distress. The client is shown and read aloud each scenario in turn and asked to complete the "How You'd Feel" and "What You'd Do" boxes. The interviewer can then explore with the client what aspects are the same e.g. the event and what are different e.g. the thoughts, feelings and behaviours. The client can be asked what made the difference e.g. what thing led to these two different outcomes and guided to the answer that it was what the client thought that made the difference. This framework can then, if appropriate, be applied to an example difficulty the client is currently experiencing.

Appendix 2 - Explanation of the role of a psychological therapist and cognitive-behavioural therapy

"There are many different professionals and ways to help people who are feeling anxious or depressed. One professional you might have heard of, psychiatrists, often use a medical approach – they prescribe medications they think will help the person feel better. There are other professionals called psychological therapists - they don't prescribe medications and instead use talking therapies to try to help people feel better. One of these therapies is called cognitive-behavioural therapy or CBT. CBT says that thinking plays a big part in feeling anxious or depressed. For example, if a person thinks it's not safe to be out after dark, they might feel anxious about going out in the evening and instead stay at home. CBT is not like a medication and cannot just be given to a person without them doing anything. Instead, in CBT the client or patient plays a very active part, working with the therapist to help change the ways of thinking that make them feel anxious or depressed. As part of this, the client or patient might do tasks like keeping a diary of the things they think, feel and do in certain situations".

Appendix 1 Continued

Cat-Burglar Worksheet

Situation	Thinking	How You'd Feel	What You'd Do
It's night-time. You're in bed. You hear a noise from another room.	 "It's just the cat"		

Situation	Thinking	How You'd Feel	What You'd Do
It's night-time. You're in bed. You hear a noise from another room.	 "It's a burglar"		

APPENDIX F: COG-OPSS SUITABILITY SCALES

Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS)

Suitability Scales

Client's Name:	Date of Birth:

Please complete ratings on each of the ten suitability scales.

Suitability Summary Profile for Client

Suitability Scale	Rating				
	CBT Less Likely to be Suitable				CBT More Likely to be Suitable
1.Ability to Identify Beliefs/Thoughts	1	2	3	4	5
2. Ability to Identify Feelings/Emotions	1	2	3	4	5
3. Mindedness to CBT Explanation of Difficulties	1	2	3	4	5
4. Willingness to Explore Relationship between Thinking and Feelings/Behaviours	1	2	3	4	5
5. Therapeutic Relationship	1	2	3	4	5
6. Interpersonal Context	1	2	3	4	5
7. Duration and Course of Difficulties	1	2	3	4	5
8. Physical Health, Disability and Mobility Issues	1	2	3	4	5
9. Cognitive Abilities	1	2	3	4	5
10. Readiness to Change	1	2	3	4	5

Suitability Scales

1. Ability to Identify Beliefs/Thoughts

What This Scale Measures: The extent to which the client is able to identify (and report) what they are thinking (their beliefs, thoughts, attitudes, mental images and pictures, what they 'say to themselves', what 'goes through their head' and so on), especially in relation to their anxiety and/or depression symptoms but also more generally. Clients may show this awareness in several different ways e.g. through speech, writing, drawing.

When Scoring on This Scale Consider:

- To what extent the client can say what they're thinking about when they become anxious or depressed (can they report any beliefs, thoughts, attitudes, mental images and pictures? Can they what they 'say to themselves' or what 'goes through their head'?) Thinking that may be linked to the client's anxiety and/or depression symptoms could include beliefs concerning: how they client sees themselves, how they think others see them, what they think is going to happen in a situation (e.g. that they might not cope), what they think the future holds for them, the client's physical and/or mental health, how they view mental health difficulties, changes in roles (e.g. employment) of value to client, issues with family, friends and so on and views on what it means to become older.
- To what extent the client seems able to identify or 'tune in' to their thinking in relation to other matters e.g. what they were thinking before the assessment appointments.

5 (CBT more likely to be suitable)	The client shows a good ability to identify (and report) what they are thinking (being able to report more than two beliefs and thoughts), especially in relation to their anxiety and/or depression symptoms and perhaps also more generally. This may occur spontaneously or though occasional prompting by the interviewer/assessor.
4	
3	The client shows some ability to identify (and report) what they are thinking, being able to report one or two beliefs or thoughts in relation to their anxiety and/or depression. They may also be able to report some of their thinking more generally (e.g. in relation to matters other than their anxiety and/or depression difficulties). More than occasional prompting is required by the interviewer/assessor for this to occur.
2	
1 (CBT less likely to be suitable)	The client shows no ability to identify (and report) what they are thinking, being unable to report any beliefs or thoughts in relation to their anxiety and/or depression symptoms. The client may deny that they think anything when the anxiety and/or depression symptoms happen, saying that it is the situation(s) they are in that causes the difficulties. This is despite the interviewer/assessor providing the client with several opportunities to help them identify their thoughts and beliefs (e.g. giving examples of common thoughts associated with anxiety and/or depression symptoms). The client also finds it difficult to report their thinking in relation to other matters (those not relating to anxiety and/or depression symptoms).

2. Ability to Identify Emotions/Feelings

What This Scale Measures: The extent to which the client is able to identify (and report) how they are feeling (what emotions they are experiencing e.g. happiness, sadness, anger, fear, worry and so on), both in situations associated with their difficulties with anxiety and/or depression as well as more generally. This includes their ability to differentiate between different emotional experiences (in terms of the type of feelings and their strength/intensity).

When Scoring on This Scale Consider:

- The extent to which the client can describe their emotions and feelings, both more generally and in association with their anxiety and/or depression symptoms; how these feelings are different to those experienced at other times; the extent to which the client can identify changes in the intensity (or strength) of their emotions and feelings, both generally and in relation to the difficulties; the client's emotional awareness both within the session (can the client identify how they feel when certain issues or topics are discussed in the session) and outside of it (the client's reports of feelings towards previous or current events).

5 (CBT more likely to be suitable)	The client shows a good level of emotional awareness, being able to identify how they feel (including the type of feeling and the strength of the feeling) especially in relation to their anxiety and/or depression symptoms e.g. how they feel when they are in certain situations or when they think about certain things. The client also shows a good general ability to identify how they feel in relation to other matters in their life. This ability may be evident both in the assessment appointments and outside of them. This emotional awareness occurs either spontaneously or through occasional prompting by the interviewer/assessor.
4	
3	The client shows some emotional awareness, and can report one or two examples of how they feel (including the type of feeling and its strength), especially in relation to their anxiety and/or depression symptoms e.g. how they feel when in certain situations or when they think about certain things. The client requires more than occasional prompting from the interviewer for this to occur.
2	
1 (CBT less likely to be suitable)	The client shows no emotional awareness, being unable to say how they feel (including type and strength of feeling) both generally and in relation to their anxiety and/or depression difficulties. This is despite several attempts by the interviewer/assessor to elicit the client's feelings. This lack of emotional awareness is evidence both within and outside of the assessment session(s).

3. Mindedness to CBT Explanation of Difficulties

What This Scale Measures: The extent to which the client identifies with and accepts a cognitive-behavioural explanation of psychological difficulties (i.e. that how they feel in a given situation is linked to what they are thinking about).

When Scoring on This Scale Consider:

- The extent to which the client can make links between their thoughts regarding a given event and their subsequent feelings and behaviours; how the client responds when given an explanation of a CBT way of working e.g. using the definition of a cognitive-behavioural therapist and using the cat-burglar worksheet; the extent to which the client sees value in therapeutic work that would work from the assumption their thinking determines their feelings and behaviours; the client's own views and beliefs concerning their current mental health difficulties and how they see these improving or resolving; the extent to which the client subscribes to other explanations for their mental health difficulties e.g. a medical account.

5 (CBT more likely to be suitable)	The client appears to clearly relate to a cognitive-behavioural explanation (seeing it as an important part, along perhaps with other factors e.g. medical) of their difficulties, seeing a link between how they think and how they feel and behave. The client may also report seeing the logic in therapeutic tasks working from a CBT perspective e.g. testing out beliefs by discussion, behavioural tasks etc.
4	
3	The client appears to relate to some degree to a cognitive-behavioural explanation and can sometimes see the link between how they think and how they feel and behave. The client appears at times to favour alternative explanations of their difficulties but they are prepared to consider a CBT account alongside these. The client sees some logic or sense in therapeutic tasks working from a CBT perspective.
2	
1 (CBT less likely to be suitable)	The client does not accept a cognitive-behavioural explanation of psychological distress and cannot see any relevance of this to their current difficulties. This is despite attempts by the interviewer to socialise the client to the cognitive-behavioural way of working e.g. explaining the way a cognitive-behavioural therapist works or using the cat-burglar worksheet. The client may strongly adhere to another explanation e.g. a medical account and cannot see any sense or logic in undertaking any tasks or discussions that would examine the links between their thoughts, feelings and behaviours.

4. Willingness to Explore Relationship Between Thinking and Feelings/Behaviours

What This Scale Measures: The extent to which the client is willing to explore the relationship between their thinking and feelings and behaviours, including given that doing so may result in distress or discomfort.

When Scoring on This Scale Consider:

- To what extent the client sees their thinking as something 'to be tested out' and examined; to what extent the client acknowledges that there might be different ways of looking at how they think about things; what the client feels could be the potential benefits/costs of exploring the relationship between thinking and feeling and behaviour.
- To what extent the client is willing to explore how their thinking impacts on their feelings and behaviour, even if this might result in them becoming distressed or upset; more generally, how the client responds when distressing or discomforting topics are raised in the assessment (e.g. how long can the client stay with the topic, are certain topics avoided); to what extent does the client currently place and keep themselves in situations that provoke distress and discomfort; how has the client dealt with other adversities or hardships in their lives; what beliefs or thoughts does the client have about themselves in terms of coping (i.e. do they see themselves as someone who can cope with difficult situations).

5 (CBT more likely to be suitable)	The client appears willing to and sees value in exploring the relationship between their thinking and feeling and behaviour, even if this might result in distress or discomfort. The client is able to discuss distressing or discomforting topics (or shows little avoidance of these if raised by others) and shows resiliency when faced with psychological distress or discomfort (e.g. they may report placing and keeping themselves in situations they currently find distressing or discomforting).
4	
3	The client shows some willingness and sees some value in exploring the relationship between their thinking and feeling and behaviour. The client appears able to tolerate some distress and discomfort though avoids certain topics, tasks and activities. The client shows some resiliency when faced with psychological distress or discomfort, such as being able to keep themselves in distressing situations for a brief period.
2	
1 (CBT less likely to be suitable)	The client appears unwilling to and sees no value in exploring the relationship between their thinking and feeling and behaviour. The client is unable to talk about distressing issues for even a brief period of time and avoids these if raised by others. In their day-to-day life the client avoids any situation provoking distress or discomfort.

5. Therapeutic Relationship

What This Scale Measures: The extent to which the client appears able to form open, trusting and durable relationships with others, feels comfortable and safe in these relationships, and can use relationships to discuss/explore difficulties and problems.

When Scoring on This Scale Consider:

- The client's current and past (especially those in childhood) relationships (e.g. partner, spouse, family, friends, carers, other professionals and so on) and whether the client feels these relationships are/were: loving, caring, supportive, trusting, reliable and durable (i.e. the relationship endured arguments, disagreements and so on), a place where the client felt 'heard' and understood and a place to discuss difficulties they were having (not necessarily those concerning mental health); the client's presentation during the assessment e.g. their 'warmth', eye contact, body posture, the extent to which they are open or guarded when asked questions, especially those of a more personal nature.

5 (CBT more likely to be suitable)	There is evidence that the client has experienced and /or continues to experience trusting, supportive and enduring relationships with others. The client has had positive experiences of discussing difficulties with others and sees relationships as a way of exploring difficulties or problems they are experiencing. In the interview, the client appears to talk openly, and there is a good sense of rapport between the client and the therapist e.g. eye contact is made, 'warmth', the client appears to feel heard and understood by the therapist.
4	
3	There is evidence that to some degree the client's relationships with others (past and/or current) have been trusting, supportive and enduring. The client may have had both positive and negative experiences of confiding in others and at times appears reluctant to use relationships to explore difficulties (this may be due to feelings of mistrust, concerns that they won't be 'heard' and so on). In the interview, the client appears guarded at times though there is some evidence of rapport between the client and therapist e.g. some eye contact, some sense of 'warmth' and so on.
2	
1 (CBT less likely to be suitable)	There is no evidence that the client has experienced or experiences trusting, supportive and enduring relationships with others. The client may have little to no experience of confiding in others or if they have describe these in negative terms. The client does not see relationships as an appropriate forum to discuss difficulties and appears generally guarded and mistrustful of the therapist during the interview. There is little sense of rapport between the client and the therapist, as shown by poor eye contact, a lack of 'warmth' and so on.

6. Interpersonal Context

What This Scale Measures: The extent to which the interpersonal context of a client (that is, the relationships they are a part of, both personal e.g. family, friends, and professional e.g. other services or organisations working with the client) plays a part in causing and/or maintaining the client's difficulties, and how compatible the client's interpersonal context would be were a CBT intervention offered to the client.

When Scoring on This Scale Consider:

- The current relationships, both personal and professional, the client is involved in; the extent to which the client's difficulties may be caused and/or maintained by these relationships (this could be because others feel they are actually helping the client or because the client's difficulties benefit the relationship in some way e.g. focusing on the difficulties draws attention away from other difficulties); how supportive these relationships have been if previous therapeutic work has been carried out with the client and/or would be if CBT work was carried out with the client.

5 (CBT more likely to be suitable)	The interpersonal context of the client (e.g. the relationships , both personal and professional, the client is involved in) appears to play little to no role in causing and/or maintaining the client's difficulties; if a CBT intervention was offered to the client, it is not felt that the interpersonal context of the client would be disruptive to this.
4	
3	There is some evidence that the interpersonal context of the client (e.g. the relationships, both personal and professional, the client is involved in) is playing a role in causing and/or maintaining the client's difficulties; if a CBT intervention was offered to the client, it is felt that the interpersonal context of the client could at times be disruptive but not significantly.
2	
1 (CBT less likely to be suitable)	There is evidence that the interpersonal context of the client (e.g. relationships, both personal and professional, the client is in) would be very disruptive and detrimental to any CBT working. These relationships appear to play a very significant role in causing and/or maintaining the difficulties and it is felt that any attempts to bring about change through working with the client would be counteracted and met with significant resistance by others.

7. Duration and Course of Difficulties

What This Scale Measures: The length of time the client has been experiencing the difficulties with anxiety and/or depression and the extent to which they have been shown to be improvable (this could be spontaneously or through some form of intervention e.g. medical, psychological, family support).

When Scoring on This Scale Consider:

- How long the difficulties have been apparent as a proportion of the client's life; to what extent there have been periods of symptom improvement or remission (either spontaneously or due to intervention); if the difficulties are longstanding, are they constant in severity or is this changing with time (e.g. do the difficulties seem to be decreasing over time, increasing over time, or staying constant); to what extent the difficulties have impacted on the client's life, and how long has this impact been apparent.

5 (CBT more likely to be suitable)	The client's difficulties have a relatively recent onset (e.g. the last few years) and have not been apparent previously. Alternatively, if the difficulties have been apparent previously they have been short-lived (either spontaneously improving or responding well to intervention) and have only had a minimal impact on the client's life overall.
4	
3	The client's difficulties have been apparent beyond their recent past (e.g. more than the last few years) and have had a moderate impact at times during the client's life. The difficulties have shown some improvement, either spontaneously or through intervention.
2	
1 (CBT less likely to be suitable)	The client's difficulties have been apparent for most of their life and have had a significant and longstanding impact on the client's life. The difficulties have shown little to no improvement during this time, either spontaneously or in response to interventions.

8. Physical Health, Disability and Mobility

What This Scale Measures: The extent to which the client has issues with their physical health, disability and mobility that would negatively impact on CBT working and could not be adapted for by the therapist.

When Scoring on This Scale Consider:

- Whether the client has any issues with physical health (including difficulties with pain), disability (including sight and hearing issues) or mobility that would impact on CBT working; whether these issues could be accommodated for by modifications to working (e.g. for individuals with sight difficulties, printing materials in larger fonts) or by other means (e.g. the use of glasses or a hearing aid).

5 (CBT more likely to be suitable)	It is felt that the client's issues (if any) with physical health, disability and mobility would impact minimally on CBT working. Any impacts on working can be readily accommodated either by adaptations by the therapist e.g. printing materials in larger fonts for those with sight difficulties or by other interventions e.g. the client's use of glasses or a hearing aid. It is also felt that any physical health, disability or mobility issues would not distract the client significantly during any sessions (e.g. if the client has issues with pain, these do not significantly distract them from discussions with others).
4	
3	It is felt that the client's issues with physical health, disability and mobility would impact to some degree on CBT working. Whilst adaptations would not fully accommodate for these issues (e.g. materials are still difficult to read even in larger fonts, glasses and hearing aids only partially correct sensory difficulties) it is still felt that with these modifications CBT work could still take place. The client's physical health, disability or mobility issues may prove distracting at times during sessions but are not very disruptive.
2	
1 (CBT less likely to be suitable)	It is felt that the client's issues with physical health, disability and mobility would be very disruptive to any CBT working and could not be accommodated for by modifications. For example, the client may have: severe pain issues that makes it very difficult for them to focus on therapeutic work or severe sensory impairments that would make it very difficult to communicate information.

9. Cognitive Abilities

What This Scale Measures: The extent to which the client has issues with cognitive abilities (such as memory, attention and comprehension) t hat cannot be adapted for by a therapist and would consequently negatively impact on any CBT intervention offered to the client.

When Scoring on This Scale Consider:

- The presentation of the client during the assessment, including: the extent to which the client was able to maintain their concentration (and if it did wander how readily it could be brought back to the issue of focus); the extent to which the client could learn and recall information provided to them during the assessment (and if difficulties arose, whether repetition of information or prompting was beneficial); the extent to which the client was able to grasp the meaning of what was being said (and if there were difficulties, whether repeating or rephrasing information helped); the extent to which the client responded to questions in a timely manner (or if the client appeared to have difficulties processing information promptly, whether allowing more time improved responding).

5 (CBT more likely to be suitable)	No issues are apparent concerning the client's cognitive abilities or if issues are apparent these are only minimal and/or can readily be accommodated for by the individual working with the client e.g. using more frequent recaps, allowing more time for information to be processed.
4	
3	Some issues with cognitive abilities are apparent and these have some impact on working with the client e.g. concentration wanders and a little difficult to bring back. Whilst modifications to CBT working (e.g. using more frequent recaps) may not fully address these issues it is felt that they are sufficient to allow some work with the client to occur e.g. with the modifications, the client is able to remember some of the information discussed and focus on some of the conversation.
2	
1 (CBT less likely to be suitable)	The client's cognitive abilities appear to be significantly impaired (e.g. learning of new information very difficult, concentration lost very easily and difficult to bring back, comprehension/understanding poor even when repeated, rephrased etc.). It is felt that any therapist would find it very difficult to adapt a CBT intervention to reduce the impact these cognitive issues would have on it.

10. Readiness to Change

What This Scale Measures: The extent to which the client sees the difficulties with anxiety and/or depression as a problem and how motivated they are to make changes in relation to these difficulties.

When Scoring on This Scale Consider:

- The extent to which the client sees the difficulties with anxiety and/or depression as a problem; to what extent the client wants things to be different regarding the anxiety and/or depression (i.e. to what extent they'd like to feel less anxious or depressed); how important is it for the client for things to be different regarding their anxiety and/or depression; to what extent does the client feel that changes regarding their difficulties with anxiety and/or depression are possible and achievable; to what extent does the client feel they would benefit were the difficulties with anxiety and/or depression to be lessened; do the difficulties provide the client with any gains or benefits and how prepared are they to have these reduced.

5 (CBT more likely to be suitable)	The client views the difficulties they are experiencing as a problem and something that they wish to be different. The client is willing to engage in tasks and activities to bring about change and may already have started to take actions to bring about change themselves or with the support of others e.g. trying to build up their tolerance of situations they find anxiety provoking.
4	
3	The client views the difficulties they are experiencing as a problem and identifies that change would result in more benefits than costs. However, the costs are still apparent in the client's thinking at times and as a result they are only somewhat willing to engage in tasks and activities to bring about change.
2	
1 (CBT less likely to be suitable)	The client does not view the difficulties they are experiencing as a problem and consequently feels there is no need for anything to change. Alternatively, the client acknowledges that the difficulties are a problem but strongly feels that change is not possible and/or that the costs of making changing far outweigh the benefits. The client does not see any value in undertaking any tasks/actions to bring about change regarding their anxiety and/or depression.

APPENDIX G: ETHICS APPROVAL LETTER

NHS
Coventry & Warwickshire Research Ethics Committee
Prospect House
Fishing Line Road
Enfield
Redditch
B97 6EW

Telephone: 01527 582531
Facsimile:

15 September 2010

Dr. Jon Williamson
School of Psychology
University of Birmingham
Edgbaston, Birmingham
B152TT

Dear Dr. Williamson

Study Title:	**The Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS): Development, Validation and Evaluation of a New Method for Assessing the Suitability of Cognitive-Behavioural Therapy for Older People with Anxiety and/or Depression**
REC reference number:	**10/H1211/22**
Protocol number:	**RG_10-124**

Thank you for your letter of 13 August 2010, responding to the Committee's request for further information on the above research and revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research

governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Investigator CV		21 June 2010
Protocol	v1	15 May 2010
CV Academic Supervisor		21 June 2010
Letter to Chair from Birmingham & Solihull Mental Health NHS Foundation Trust		13 August 2010
REC application		29 June 2010
Covering Letter		29 June 2010
Summary/Synopsis	v1	15 May 2010
Letter from Sponsor		22 June 2010
Interview Schedules/Topic Guides	v1	15 May 2010
Questionnaire: HADS Questionnaire		
Questionnaire: Pre-Study Questionnaire	v1	15 May 2010
Letter of invitation to participant	v1	15 May 2010
Letter of invitation to participant	v1	15 May 2010
GP/Consultant Information Sheets	v1	15 May 2010
Response to Request for Further Information		
Participant Information Sheet: Professional Participant Information Sheet	2	13 August 2010
Participant Information Sheet: Client Participant Information Sheet	2	13 August 2010
Participant Consent Form: Professional Participant	v1	15 May 2010
Participant Consent Form: Client Participant	v1	15 May 2010
Questionnaire: ARM-12		
Questionnaire: Post-Study Questionnaire	v1	15 May 2010
Questionnaire: Adapted Session Rating Scale	v1	15 May 2010
Questionnaire: Client Information & Outcome	v1	15 May 2010
Questionnaire: Suitability rating for video recordings	v1	15 May 2010
Questionnaire: Inter-rater reliability video scoring sheet	v1	15 May 2010
Evidence of insurance or indemnity		01 August 2009

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H1211/22	**Please quote this number on all correspondence**

Yours sincerely

Anne McCullough

Dr Helen Brittain
Chair

Email: anne.mccullough@westmidlands.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Dr. Brendan W. Laverty*

APPENDIX H: MEMBER OF STAFF INFORMATION SHEET

Member of Staff Information Sheet Version 2: 13th August 2010

Study Title: The Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS): Development, Validation and Evaluation of a New Method for Assessing the Suitability of Cognitive-Behavioural Therapy for Older People with Anxiety and/or Depression

Researcher: Jon Williamson, Project Chief Investigator and Trainee Clinical Psychologist

You are being invited to take part in a research study. This research is being conducted as part of my Doctorate in Clinical Psychology at the University of Birmingham. The study has been reviewed and given ethical approval by Coventry and Warwickshire Research Ethics Committee. Before you decide whether or not you wish to take part, please read this information sheet and if appropriate discuss it colleagues (e.g. manager or supervisor). You can also ask us if there is anything that is not clear or if you would like more information on the project.

The purpose of the study

The aim of the study is to develop an assessment tool and evaluate its use by mental health professionals who deliver psychological therapies to older people. Specifically, this tool aims to help professionals in deciding to what extent a particular form of psychological treatment, cognitive-behavioural therapy (CBT), is suitable for older people with anxiety and/or depression.

Why have I been chosen?

We are asking mental health professionals working within the Mental Health Services for Older People (part of XXXX) to take part in the study. Overall, the study is looking for these professionals to recruit approximately 50 clients with anxiety and/or depression to take part in the study. Of course, participation in the project is entirely voluntary and participating individuals can withdraw at any time without giving a reason.

What will be asked of me if I take part?

If you agree to participate in the study, you will be asked to complete a new interview-style assessment, the Cognitive-Behavioural Therapy for Older People Suitability Scale (or, COG-OPSS), with clients referred to the Mental Health Services for Older People who are being considered for psychological input. The COG-OPSS is a semi-structured interview assessment measure, developed through focus groups with mental health professionals working with older people, that has been designed to collect information thought to be pertinent to assessing the suitability of CBT for an older person, including

awareness of thoughts/cognitions, awareness/differentiation of emotions, cognitive functioning and physical health, disability and mobility issues.

You will also be asked to complete with participating clients a measure of anxiety and depression symptoms, the Hospital Anxiety and Depression Scale. Participating clients will also complete a brief evaluation measure of the assessment measure. You will also be asked to complete your own evaluation measures for the COG-OPSS, looking at whether using it has been helpful or not in your practice. In terms of using the COG-OPSS with clients, this should take no more than one to two 60 minute appointments.

We will also ask for a small number of clients (approximately 15) to have their assessment appointments videotaped to permit inter-rater reliability values for the measure to be completed.

The data from the assessments performed will be put into a database and analysed together with data from the other participants in the study. All data will be anonymised. The results of the study will be written up for a doctoral thesis as well as for publication. The findings may also be presented at conferences.

What are the possible side effects or risks of taking part?

In terms of working with clients, the COG-OPSS is not thought to ask any questions that differ substantially from those that would be asked in standard assessment appointments. However, scoring the COG-OPSS and completing the evaluation measures will require some additional time on the part of participating professionals. However, if you participate in the project you will be asked to complete the COG-OPSS instead of your standard assessment method – you will not be expected to do both with a client participating in the research.

What are the possible benefits of taking part?

At the moment, there are no formal assessment tools for mental health professionals to help them decide how suitable cognitive-behavioural therapy is for an older person. It is hoped that this study will lead to the development of such a tool which therefore may benefit future older persons accessing services. In terms of more immediate benefits, completing the interview may help you and the client you are working with in thinking about their difficulties and possible ways of addressing these. For those videotaping assessment sessions, professionals may wish to additionally use these in supervision for professional development.

To thank professionals for participating, the names of those taking part will be entered into a draw for two £25 shopping vouchers. You can opt out of this draw should you wish to.

How long does the research study last?

This research study lasts for 1 year, from September 2010 to September 2011.

Will my taking part in the study be kept confidential?

Yes, all information collected as part of this research, including questionnaires, notes from interviews and videotape recordings will be kept in a locked filing cabinet in the School of Psychology at the University of Birmingham. Any information from or about you will have your name and any other identifying features removed so that you cannot be recognised from it. This means that your anonymity will be preserved at all times during and after the study time period.

Who should I contact if I have further questions or concerns?

If you have any questions about the study, please feel free to contact either:

Jon Williamson – Chief Project Investigator and Trainee Clinical Psychologist
Telephone: XXXX
Post: XXXX
XXXX
E-Mail: XXXX

Jan Oyebode – Academic Supervisor and Consultant Clinical Psychologist
Telephone: XXXX
Post: XXXX
XXXX
E-Mail: XXXX

Susan Adams – Principal Investigator and Clinical Psychologist
Telephone: XXXX
Post: XXXX
E-Mail: XXXX

Alternatively, if you have any complaints about the conduct of the research you can contact:

XXXX – Consultant Clinical Psychologist
Telephone: XXXX
Post: XXXX
XXXX
E-Mail: XXXX

Thank you for taking the time to read this information sheet. This copy is for you to keep.

APPENDIX I: MEMBER OF STAFF CONSENT FORM

Member of Staff Consent Form **Version 1: 15th May 2010**

Study Title: The Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS): Development, Validation and Evaluation of a New Method for Assessing the Suitability of Cognitive-Behavioural Therapy for Older People with Anxiety and/or Depression

Researcher: Jon Williamson

	Please initial box
1. I confirm that I have understood the information sheet dated 13th August 2010 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research, without giving any reason.	☐
3. I understand that I will be asked to video record some of my work for this project and agree to this.	☐
4. I understand that the GP of participating clients will be contacted to inform them of their participation in the study.	☐
5. I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data.	☐
6. I understand that all information about me will be kept in a confidential way and destroyed in line with the University's policies.	☐
7. I understand that the findings of this project will be written up for publication in scientific journals and may be presented at conferences in the UK and abroad. However, my anonymity will be protected at all times.	☐
8. I agree to take part in the above study.	☐

.....	.....	.....
Name of member of staff	Date	Signature
.....	.....	.....
Name of witness	Date	Signature
.....	.....	.....
Name of researcher	Date	Signature

Would you like to receive a written summary of the findings of this research study?

❑ Yes ❑ No

If Yes, please give the address to which you would like this summary sending:

Address: _____

_____

_____

Postcode: _____

Would you like to be entered into the draw held for participating professionals at the end of the study (two prizes of £25 shopping vouchers)?

❑ Yes ❑ No

Vouchers will be sent to the postal address stated above.

APPENDIX J: MEMBER OF STAFF PRE-STUDY QUESTIONNAIRE

Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS)

Pre-Study Questionnaire for Members of Staff

This questionnaire asks you about your current practice when assessing the suitability of psychological therapies, such as cognitive-behavioural therapy (or CBT), for older people with anxiety and/or depression.

Please complete this questionnaire once before you start using the COG-OPSS for your clients.

Your Name: _____

Your Professional Role: _____

Details of your Qualifications and Training:

Please tick and give details for as many as apply:

- ❑ Accredited CBT Training — Details: _____
- ❑ Non-accredited CBT Training — Details: _____
- ❑ Diploma in CBT Training — Details: _____
- ❑ Other e.g. DClinPsy, Psychiatry — Details: _____
- ❑ No qualifications or training in CBT

1. At present, to what extent do you normally include the following when assessing suitability of psychological therapies, such as CBT, for older people with anxiety and/or depression?

	Never										Always
A client's awareness of their thoughts and beliefs, especially those relating to their anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100
A client's awareness of and ability to differentiate between their emotions	0	10	20	30	40	50	60	70	80	90	100
The client's mindedness to a CBT approach (to what extent the client sees a link between their thinking and their feelings and behaviour)	0	10	20	30	40	50	60	70	80	90	100
How willing a client is to test out the relationship between their thinking and their feelings and behaviour, even if this is at times distressing	0	10	20	30	40	50	60	70	80	90	100
The likelihood that the client will be able to form an open, trusting and durable relationship with a therapist	0	10	20	30	40	50	60	70	80	90	100
The interpersonal context to the client's difficulties (relationships, family, friends, other professionals involved) and the extent to which this might play a part in the client's difficulties	0	10	20	30	40	50	60	70	80	90	100
The duration and course of the client's difficulties with anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100
The extent to which issues with physical health, disability and mobility could impact on a psychological therapy, like CBT	0	10	20	30	40	50	60	70	80	90	100
The extent to which any issues with cognitive capacities, including memory, attention and comprehension, could impact on a psychological therapy, like CBT	0	10	20	30	40	50	60	70	80	90	100
The client's readiness to address their difficulties with anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100

2. At present, how helpful do you think it is to include each of the following when you normally assess the suitability of psychological therapies, such as CBT, for older people with anxiety and/or depression?

	Not at all helpful										Very helpful
A client's awareness of their thoughts and beliefs, especially those relating to their anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100
A client's awareness of and ability to differentiate between their emotions	0	10	20	30	40	50	60	70	80	90	100
The client's mindedness to a CBT approach (to what extent the client sees a link between their thinking and their feelings and behaviour)	0	10	20	30	40	50	60	70	80	90	100
How willing a client is to test out the relationship between their thinking and their feelings and behaviour, even if this is at times distressing	0	10	20	30	40	50	60	70	80	90	100
The likelihood that the client will be able to form an open, trusting and durable relationship with a therapist	0	10	20	30	40	50	60	70	80	90	100
The interpersonal context to the client's difficulties (relationships, family, friends, other professionals involved) and the extent to which this might play a part in the client's difficulties	0	10	20	30	40	50	60	70	80	90	100
The duration and course of the client's difficulties with anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100
The extent to which issues with physical health, disability and mobility could impact on a psychological therapy, like CBT	0	10	20	30	40	50	60	70	80	90	100
The extent to which any issues with cognitive capacities, including memory, attention and comprehension, could impact on a psychological therapy, like CBT	0	10	20	30	40	50	60	70	80	90	100
The client's readiness to address their difficulties with anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100

3. At present, how confident do you feel in assessing each of the following when conducting your normal assessment of the suitability of psychological therapies, such as CBT, for older people with anxiety and/or depression?

	Not at all confident										Very confident
A client's awareness of their thoughts and beliefs, especially those relating to their anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100
A client's awareness of and ability to differentiate between their emotions	0	10	20	30	40	50	60	70	80	90	100
The client's mindedness to a CBT approach (to what extent the client sees a link between their thinking and their feelings and behaviour)	0	10	20	30	40	50	60	70	80	90	100
How willing a client is to test out the relationship between their thinking and their feelings and behaviour, even if this is at times distressing	0	10	20	30	40	50	60	70	80	90	100
The likelihood that the client will be able to form an open, trusting and durable relationship with a therapist	0	10	20	30	40	50	60	70	80	90	100
The interpersonal context to the client's difficulties (relationships, family, friends, other professionals involved) and the extent to which this might play a part in the client's difficulties	0	10	20	30	40	50	60	70	80	90	100
The duration and course of the client's difficulties with anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100
The extent to which issues with physical health, disability and mobility could impact on a psychological therapy, like CBT	0	10	20	30	40	50	60	70	80	90	100
The extent to which any issues with cognitive capacities, including memory, attention and comprehension, could impact on a psychological therapy, like CBT	0	10	20	30	40	50	60	70	80	90	100
The client's readiness to address their difficulties with anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100

End of Questionnaire – Thank You

APPENDIX K: MEMBER OF STAFF POST-STUDY QUESTIONNAIRE

Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS)

Post-Study Questionnaire for Members of Staff

This questionnaire asks you about your current practice when assessing the suitability of psychological therapies, such as cognitive-behavioural therapy (or CBT), for older people with anxiety and/or depression.

Please complete this questionnaire once at the end of your involvement in the study (that is, after you have tried using the COG-OPSS with your clients).

Your Name: _____

Your Professional Role: _____

Details of your Qualifications and Training:

Please tick and give details for as many as apply:

- ❑ Accredited CBT Training — Details: _____
- ❑ Non-accredited CBT Training — Details: _____
- ❑ Diploma in CBT Training — Details: _____
- ❑ Other e.g. DClinPsy, Psychiatry — Details: _____
- ❑ No qualifications or training in CBT

How many clients did you use the COG-OPSS with? _____

1. At present, to what extent do you normally include the following when assessing suitability of psychological therapies, such as CBT, for older people with anxiety and/or depression?

	Never										Always
A client's awareness of their thoughts and beliefs, especially those relating to their anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100
A client's awareness of and ability to differentiate between their emotions	0	10	20	30	40	50	60	70	80	90	100
The client's mindedness to a CBT approach (to what extent the client sees a link between their thinking and their feelings and behaviour)	0	10	20	30	40	50	60	70	80	90	100
How willing a client is to test out the relationship between their thinking and their feelings and behaviour, even if this is at times distressing	0	10	20	30	40	50	60	70	80	90	100
The likelihood that the client will be able to form an open, trusting and durable relationship with a therapist	0	10	20	30	40	50	60	70	80	90	100
The interpersonal context to the client's difficulties (relationships, family, friends, other professionals involved) and the extent to which this might play a part in the client's difficulties	0	10	20	30	40	50	60	70	80	90	100
The duration and course of the client's difficulties with anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100
The extent to which issues with physical health, disability and mobility could impact on a psychological therapy, like CBT	0	10	20	30	40	50	60	70	80	90	100
The extent to which any issues with cognitive capacities, including memory, attention and comprehension, could impact on a psychological therapy, like CBT	0	10	20	30	40	50	60	70	80	90	100
The client's readiness to address their difficulties with anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100

2. At present, how helpful do you think it is to include each of the following when you normally assess the suitability of psychological therapies, such as CBT, for older people with anxiety and/or depression?

	Not at all helpful										Very helpful
A client's awareness of their thoughts and beliefs, especially those relating to their anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100
A client's awareness of and ability to differentiate between their emotions	0	10	20	30	40	50	60	70	80	90	100
The client's mindedness to a CBT approach (to what extent the client sees a link between their thinking and their feelings and behaviour)	0	10	20	30	40	50	60	70	80	90	100
How willing a client is to test out the relationship between their thinking and their feelings and behaviour, even if this is at times distressing	0	10	20	30	40	50	60	70	80	90	100
The likelihood that the client will be able to form an open, trusting and durable relationship with a therapist	0	10	20	30	40	50	60	70	80	90	100
The interpersonal context to the client's difficulties (relationships, family, friends, other professionals involved) and the extent to which this might play a part in the client's difficulties	0	10	20	30	40	50	60	70	80	90	100
The duration and course of the client's difficulties with anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100
The extent to which issues with physical health, disability and mobility could impact on a psychological therapy, like CBT	0	10	20	30	40	50	60	70	80	90	100
The extent to which any issues with cognitive capacities, including memory, attention and comprehension, could impact on a psychological therapy, like CBT	0	10	20	30	40	50	60	70	80	90	100
The client's readiness to address their difficulties with anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100

3. At present, how confident do you feel in assessing each of the following when conducting your normal assessment of the suitability of psychological therapies, such as CBT, for older people with anxiety and/or depression?

	Not at all confident										Very confident
A client's awareness of their thoughts and beliefs, especially those relating to their anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100
A client's awareness of and ability to differentiate between their emotions	0	10	20	30	40	50	60	70	80	90	100
The client's mindedness to a CBT approach (to what extent the client sees a link between their thinking and their feelings and behaviour)	0	10	20	30	40	50	60	70	80	90	100
How willing a client is to test out the relationship between their thinking and their feelings and behaviour, even if this is at times distressing	0	10	20	30	40	50	60	70	80	90	100
The likelihood that the client will be able to form an open, trusting and durable relationship with a therapist	0	10	20	30	40	50	60	70	80	90	100
The interpersonal context to the client's difficulties (relationships, family, friends, other professionals involved) and the extent to which this might play a part in the client's difficulties	0	10	20	30	40	50	60	70	80	90	100
The duration and course of the client's difficulties with anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100
The extent to which issues with physical health, disability and mobility could impact on a psychological therapy, like CBT	0	10	20	30	40	50	60	70	80	90	100
The extent to which any issues with cognitive capacities, including memory, attention and comprehension, could impact on a psychological therapy, like CBT	0	10	20	30	40	50	60	70	80	90	100
The client's readiness to address their difficulties with anxiety and/or depression	0	10	20	30	40	50	60	70	80	90	100

4. Thinking about your experiences of using the COG-OPSS, please answer the following questions.

	Not at all true										Very true
The instructions given in the COG-OPSS were clear and easy to follow.	0	10	20	30	40	50	60	70	80	90	100
I received sufficient training about using the COG-OPSS.	0	10	20	30	40	50	60	70	80	90	100
The COG-OPSS helped me in establishing a rapport with clients.	0	10	20	30	40	50	60	70	80	90	100
I feel the COG-OPSS formed a useful part of my practice.	0	10	20	30	40	50	60	70	80	90	100

5. Is there any other feedback on using the COG-OPSS you would like to provide?

_____

_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

End of Questionnaire – Thank You

APPENDIX L: CLIENT INFORMATION SHEET

Client Participant Information Sheet Version 2: 13th August 2010

Study Title: The Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS): Development, Validation and Evaluation of a New Method for Assessing the Suitability of Cognitive-Behavioural Therapy for Older People with Anxiety and/or Depression

Researcher: Jon Williamson, Project Chief Investigator and Trainee Clinical Psychologist

You are being invited to take part in a research study. This research is being conducted as part of my Doctorate in Clinical Psychology at the University of Birmingham. The study has been reviewed and given ethical approval by Coventry and Warwickshire Research Ethics Committee. Before you decide whether or not you wish to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read this information sheet carefully and discuss it with others if you wish. You can also ask us if there is anything that is not clear or if you would like more information.

The purpose of the study

The aim of the study is to develop an assessment tool and evaluate its use by mental health professionals working with older people. Specifically, this tool aims to help professionals in deciding to what extent a particular form of psychological treatment, cognitive-behavioural therapy (CBT), is suitable for older people with anxiety and/or depression.

Why have I been chosen?

We are asking individuals referred to the Mental Health Services for Older People (part of XXXX) with anxiety and/or depressive difficulties to take part in the study. Overall, the study is looking to recruit approximately 50 participants.

Do I have to take part?

No, involvement in this study is entirely voluntary. If you decide not to take part this will not affect the standard of health care you receive now or in the future. If you do decide to take part, you are still free to withdraw from the study at any time without giving a reason.

What will happen to me if I take part?

If you agree to take part in the study, you will first be asked to complete an interview-style assessment. This will consist of a series of questions concerning the difficulties that lead to you seeing a mental health professional. You will also be asked to complete a questionnaire that measures anxiety and

depressive symptoms. You will also be asked to complete a brief evaluation of the interview measure that was used. These three tasks will be completed over one to two 60 minute appointments.

We will also ask a small number of people (approximately 15) to have their assessment appointments videotaped. This is to aid in the evaluation of the new assessment tool.

The data from the assessments performed will be put into a database and analysed together with data from the other participants in the study. All data will be anonymised. The results of the study will be written up for a doctoral thesis as well as for publication. The findings may also be presented at conferences.

What are the possible side effects or risks of taking part?

Some of the questions you are asked may cover issues that are sensitive and/or distressing to you. If you feel too uncomfortable, you can skip questions or stop the assessment if you wish.

What are the possible benefits of taking part?

At the moment, there are no formal assessment tools for mental health professionals to help them decide how suitable cognitive-behavioural therapy is for an older person. It is hoped that this study will lead to the development of such a tool which therefore may benefit future older persons. In terms of more immediate benefits, completing the interview may help you and the professional you are working with in thinking about your difficulties and possible ways of addressing these.

What will happen when the research study stops?

This research study lasts for 1 year from September 2010 to September 2011. There will be no change to your care or to services when the study stops.

Will my taking part in the study be kept confidential?

Yes, all information collected as part of this research, including questionnaires, notes from interviews and videotape recordings will be kept in a locked filing cabinet in the School of Psychology at the University of Birmingham. Any information from or about you will have your name, address and any other identifying features removed so that you cannot be recognised from it. This means that your anonymity will be preserved at all times during and after the study time period.

Who should I contact if I have further questions or concerns?

If you have any questions about the study, please feel free to contact either:

Jon Williamson – Chief Project Investigator and Trainee Clinical Psychologist
Telephone: XXXX
Post: XXXX
XXXX
E-Mail: XXXX

Jan Oyebode – Academic Supervisor and Consultant Clinical Psychologist
Telephone: XXXX
Post: XXXX
XXXX
E-Mail: XXXX

Alternatively, if you have any complaints about the conduct of the research you can contact:

XXXX – Consultant Clinical Psychologist
Telephone: XXXX
Post: XXXX
XXXX
E-Mail: XXXX

Patient Advice and Liaison Service (PALS)
Telephone: XXXX (24 hours)
Post: XXXX
XXXX
XXXX
E-Mail: XXXX

Thank you for taking the time to read this information sheet. This copy is for you to keep.

APPENDIX M: CLIENT INVITATION LETTER TEMPLATE

Address Line 1
Address Line 2
Address Line 3
Address Line 4

Telephone:
E-Mail:

Date:

Client Name
Address Line 1
Address Line 2
Address Line 3
Address Line 4

Dear [client's name],

Re: Invitation to take part in a research study

I would like to invite you to take part in a research study. The study is being run in Mental Health Services for Older People by Jon Williamson, a Trainee Clinical Psychologist from the University of Birmingham who is doing this research as part of his Doctorate in Clinical Psychology.

This research study is concerned with the development, use and evaluation of a new means of assessing how suitable a particular form of psychological therapy, cognitive-behavioural therapy (or CBT) is for older individuals with anxiety and/or depression. As part of this, the research is looking for individuals currently under the care of Mental Health Services for Older People to be assessed with this new measure and to provide some feedback on it.

I have enclosed an information sheet about the research study for you to look at.

Please let me stress that it is entirely up to you whether you choose to take part in the study or not. If you choose not to take part, this will not affect the standard of care you receive in any way.

Please take some time to read the information I've enclosed and discuss it with others if you like. I will contact you nearer the time of your assessment appointment to see if you want to attend and whether you'd like to take part in Jon's research study. If you have any questions in the meantime about the project, you can either contact myself on the above number or speak to Jon, whose contact details are on the information sheet provided.

Yours sincerely

APPENDIX N: CLIENT CONSENT FORM

Client Participant Consent Form **Version 1: 15th May 2010**

Study Title: The Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS): Development, Validation and Evaluation of a New Method for Assessing the Suitability of Cognitive-Behavioural Therapy for Older People with Anxiety and/or Depression

Researcher: Jon Williamson

	Please initial box
1. I confirm that I have understood the information sheet dated 13th August 2010 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research, without giving any reason, without my medical/social care or legal rights being affected.	☐
3. I understand that my interview may be video-recorded and agree to this.	☐
4. I give permission for the researcher to inform my GP of my participation in the study.	☐
5. I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. Parts of the data may also be made available to the NHS team responsible for me but only if any previously undisclosed issues or risk to me or others safety should be disclosed.	☐
6. I understand that all information about me will be kept in a confidential way and destroyed in line with the University's policies.	☐
7. I understand that the findings of this project will be written up for publication in scientific journals and may be presented at conferences in the UK and abroad. However, my anonymity will be protected at all times.	☐
8. I agree to take part in the above study.	☐

.....	.....	.....
Name of member of staff	Date	Signature
.....	.....	.....
Name of witness	Date	Signature
.....	.....	.....
Name of researcher	Date	Signature

Would you like to receive a written summary of the findings of this research study?

❑ Yes ❑ No

If Yes, please give the address to which you would like this summary sending:

Address: _____

_____

_____

Postcode: _____

APPENDIX O: CLIENT GP LETTER TEMPLATE

School of Psychology
University of Birmingham
Edgbaston
Birmingham
West Midlands
B15 2TT

Dr. Jon Williamson BSc (Hons) PhD
Telephone: XXXX
E-Mail: XXXX

[Date]

Dear Dr. [GP's name],

Re: [Client's name] Date of Birth: [Client's date of birth]
[Client's address]
NHS No.: [Client's NHS No.]

I am currently conducting a research project in conjunction with mental health professionals with Mental Health Services for Older People, part of XXXX. The aim of this research is to develop, validate and evaluate a new means of assessing whether cognitive-behavioural therapy is suited to older people with anxiety and/or depression.

Your patient, [client's name], has given their consent to take part in the study and for me to inform you of their participation. Individuals participating in the study are asked to complete an interview-style assessment as well as a questionnaire designed to measure symptoms of anxiety and depression. Participants will also be asked to complete a brief evaluation questionnaire on how they found the assessment interview. Apart from completing these assessments, participants will receive routine treatment at the discretion of those professionals who are involved in their care.

I have enclosed a copy of the information sheet given to your patient for your own reference. Should you have any further questions, please contact me using the above details.

Yours sincerely,

Jon Williamson
Trainee Clinical Psychologist and Project Chief Investigator

APPENDIX P: HOSPITAL ANXIETY AND DEPRESSION SCALE (HADS)

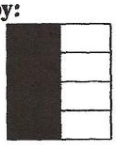
THE HOSPITAL AND ANXIETY DEPRESSION SCALE (HADS)

Name ..... **Date** .....

This questionnaire is designed to help us to know how you feel. Read each item and place a firm tick (✓) in the box opposite the reply which comes closest to how you have been feeling in the past week. Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought-out response. ***Please ✓ only one box in each section***

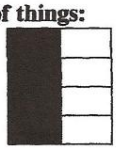
I feel tense or 'wound up':
- Most of the time .....
- A lot of the time .....
- Time to time, occasionally .....
- Not at all .....

I still enjoy the things I used to enjoy:
- Definitely as much .....
- Not quite so much .....
- Only a little .....
- Hardly at all .....



I get a sort of frightened feeling as if something awful is about to happen:
- Very definitely and quite badly ...
- Yes, but not too badly .....
- A little, but it doesn't worry me
- Not at all .....

I can laugh and see the funny side of things:
- As much as I always could .....
- Not quite so much now .....
- Definitely not so much now .....
- Not at all .....



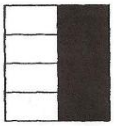
Worrying thoughts go through my mind:
- A great deal of the time .....
- A lot of the time .....
- From time to time, but not too often
- Only occasionally .....

I feel cheerful:
- Not at all .....
- Not often .....
- Sometimes .....
- Most of the time .....

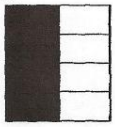
I can sit at ease and feel relaxed:
- Definitely .....
- Usually .....
- Not often .....
- Not at all .....

I feel as if I am slowed down:
- Nearly all the time .....
- Very often .....
- Sometimes .....
- Not at all .....

I get a sort of frightened feeling like 'butterflies' in the stomach:
- Not at all .....
- Occasionally .....
- Quite often .....
- Very often .....

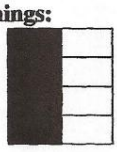


I have lost interest in my appearance:
- Definitely .....
- I don't take so much care as I should
- I may not take quite as much care
- I take just as much care as ever ...



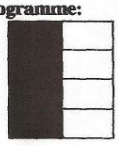
I feel restless as if I have to be on the move:
- Very much indeed .....
- Quite a lot .....
- Not very much .....
- Not at all .....

I look forward with enjoyment to things:
- As much as ever I did .....
- Rather less than I used to .....
- Definitely less than I used to .....
- Hardly at all .....



I get sudden feelings of panic:
- Very often indeed .....
- Quite often .....
- Not very often .....
- Not at all .....

I can enjoy a good book or radio or TV programme:
- Often .....
- Sometimes .....
- Not often .....
- Very seldom .....



APPENDIX Q: ADAPTED SESSION RATING SCALE

Adapted Session Rating Scale

Please rate the appointment(s) by circling the number that best fits your experience.

Relationship

0	10	20	30	40	50	60	70	80	90	100
I did not feel heard, understood, and respected.										I felt heard, understood, and respected.

Goals and Topics

0	10	20	30	40	50	60	70	80	90	100
We did not talk about what I wanted to talk about.										We talked about what I wanted to talk about.

Approach or Method

0	10	20	30	40	50	60	70	80	90	100
The therapist's approach is not a good fit for me.										The therapist's approach is a good fit for me.

Overall

0	10	20	30	40	50	60	70	80	90	100
I do not feel at all hopeful following these appointment(s).										I feel hopeful following these appointment(s).

APPENDIX R: SUITABILITY RATING SHEET FOR VIDEO RECORDINGS

Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS)

Suitability Rating Sheet for Video Recordings

Having watched the video recordings of the assessment appointment(s), please complete the rating scale below:

In your opinion, how suitable would cognitive-behavioural therapy (or CBT) be for this client?

1	2	3	4	5
Not at all suitable				Very suitable

APPENDIX S: AGNEW RELATIONSHIP MEASURE SHORT FORM 12 – THERAPIST VERSION (ARM-12)

ARM - Therapist's scale

Client No: LDP1/01/ / Session: Date: / /

Thinking about today's meeting, please indicate how strongly you agreed or disagreed with each statement by circling the appropriate number.

		strongly disagree	moderately disagree	slightly disagree	neutral	slightly agree	moderately agree	strongly agree
1	My client is friendly towards me	1	2	3	4	5	6	7
2	I feel supportive	1	2	3	4	5	6	7
3	I feel bored or impatient with my client	1	2	3	4	5	6	7
4	I follow my own plans, ignoring my client's view of how to proceed	1	2	3	4	5	6	7
5	My client and I agree about how to work together	1	2	3	4	5	6	7
6	My client and I have difficulty working jointly as a partnership	1	2	3	4	5	6	7
7	My client has confidence in me and my techniques	1	2	3	4	5	6	7
8	My professional skills are impressive to my client	1	2	3	4	5	6	7
9	I feel confident in myself and my techniques	1	2	3	4	5	6	7
10	My client is worried about embarrassing her/ himself with me	1	2	3	4	5	6	7
11	My client keeps some important things to her/ himself, not sharing them with me	1	2	3	4	5	6	7
12	My client feels she/he can openly express her/ his thoughts and feelings to me	1	2	3	4	5	6	7

APPENDIX T: OUTCOMES AND DEMOGRAPHICS SHEET

Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS)

Outcomes and Demographics Sheet

Please complete this information sheet for each client completing the COG-OPSS.

Client Details

Client Age:	
Client Gender:	
Client Ethnicity:	
Reason for Referral:	

If you completed a HoNOS 65+ for the client, please enter the scores below:

1. Behavioural disturbance	☐	7. Problems associated with depressive symptoms	☐
2. Non-accidental self injury	☐	8. Other mental and behavioural problems	☐
3. Problem drinking or drug use	☐	9. Problems with social or supportive relationships	☐
4. Cognitive problems	☐	10. Problems with activities of daily living	☐
5. Problems related to physical illness or disability	☐	11. Overall problems with living conditions	☐
6. Problems associated with hallucinations and/or delusions or false beliefs	☐	12. Problems with work and leisure activities – quality of day time environment	☐

Helpfulness of Using the COG-OPSS with this Client

Overall, how helpful was the COG-OPSS to you when deciding whether or not cognitive-behavioural therapy (CBT) was suitable for this client?

0	10	20	30	40	50	60	70	80	90	100
Not at all helpful										Very helpful

Outcome

What happened after the assessment?

❑ **I offered the client further psychological assessment**	❑ **Yes**	❑ **No**
If **Yes**, did the client accept this offer?	❑ Yes	❑ No
❑ **I referred the client on for further psychological assessment**	❑ **Yes**	❑ **No**
If **Yes**, did the client accept the referral being made?	❑ Yes	❑ No
❑ **I offered the client a psychological intervention**	❑ **Yes**	❑ **No**
If **Yes**, was this:	❑ Individual	❑ Group Therapy
	❑ CBT	❑ Other
If **Yes**, did the client accept the intervention offered?	❑ Yes	❑ No
❑ **I referred the client on for a psychological intervention**	❑ **Yes**	❑ **No**
If **Yes**, was this:	❑ Individual	❑ Group Therapy
	❑ CBT	❑ Other
If **Yes**, did the client accept the referral being made?	❑ Yes	❑ No

How helpful was the COG-OPSS to you in deciding what to do after the assessment?

0	10	20	30	40	50	60	70	80	90	100
Not at all helpful										Very helpful

APPENDIX U: ETHICS APPROVAL LETTER FOR AMENDED PROTOCOL

National Research Ethics Service
Coventry & Warwickshire Research Ethics Committee
Prospect House
Fishing Line Road
Enfield
Redditch
B97 6EW

Tel: 01527 582532
Fax: 01527 582540

18 March 2011

Dr. Jon Williamson
Trainee Clinical Psychologist
School of Psychology
University of Birmingham
Edgbaston
Birmingham
B15 2TT

Dear Dr. Williamson

Study title:	**The Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS): Development, Validation and Evaluation of a New Method for Assessing the Suitability of Cognitive-Behavioural Therapy for Older People with Anxiety and/or Depression**
REC reference:	**10/H1211/22**
Protocol number:	**RG_10-124**
Amendment number:	**AM01**
Amendment date:	**07 March 2011**

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Client Information and Outcome Sheet	2	07 March 2011
Participant Consent Form	2	07 March 2011
Participant Information Sheet: Professional Participant Information Sheet	3	07 March 2011
Protocol	2	07 March 2011
Notice of Substantial Amendment (non-CTIMPs)		07 March 2011

Covering Letter		07 March 2011

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

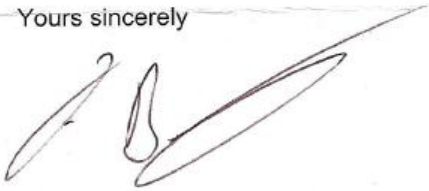
All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H1211/22:	**Please quote this number on all correspondence**

Yours sincerely



Mrs Rosa Downing
Acting Committee Co-ordinator

Email: rosa.downing@westmidlands.nhs.uk

Enclosures: List of names and professions of members who took part in the review

Coventry & Warwickshire Research Ethics Committee

Sub-Committee:

Name	*Profession*	*Capacity*
Dr Helen Brittain	Clinical Psychologist (Retired)	Lay
Mr Roger Cross	Senior Clinical Pharmacist	Expert

APPENDIX V: AMENDED MEMBER OF STAFF INFORMATION SHEET

Professional Participant Information Sheet Version 3: 7th March 2011

Study Title: The Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS): Development, Validation and Evaluation of a New Method for Assessing the Suitability of Cognitive-Behavioural Therapy for Older People with Anxiety and/or Depression

Researcher: Jon Williamson, Project Chief Investigator and Trainee Clinical Psychologist

You are being invited to take part in a research study. This research is being conducted as part of my Doctorate in Clinical Psychology at the University of Birmingham. The study has been reviewed and given ethical approval by Coventry and Warwickshire Research Ethics Committee. Before you decide whether or not you wish to take part, please read this information sheet and if appropriate discuss it colleagues (e.g. manager or supervisor). You can also ask us if there is anything that is not clear or if you would like more information on the project.

The purpose of the study

The aim of the study is to develop an assessment tool and evaluate its use by mental health professionals who deliver psychological therapies to older people. Specifically, this tool aims to help professionals in deciding to what extent a particular form of psychological treatment, cognitive-behavioural therapy (CBT), is suitable for older people with anxiety and/or depression.

Why have I been chosen?

We are asking mental health professionals working within the Mental Health Services for Older People (part of XXXX) to take part in the study. Overall, the study is looking for these professionals to complete the Cognitive-Behavioural Therapy for Older People Suitability Scale (or, COG-OPSS) assessment tool with 50 clients with anxiety and/or depression. Of course, participation in the project is entirely voluntary and participating individuals can withdraw at any time without giving a reason.

What will be asked of me if I take part?

If you agree to participate in the study, you will be asked to complete a new assessment, the COG-OPSS, after you have assessed clients referred to the Mental Health Services for Older People with primary complaints of anxiety and/or depression. The COG-OPSS is assessment measure, developed through focus groups with mental health professionals working with older people, which has been designed to be pertinent to assessing the suitability of CBT for an older person, including awareness of thoughts/cognitions,

awareness/differentiation of emotions, cognitive functioning and physical health, disability and mobility issues.

You will also be asked to complete your own evaluation measures for the COG-OPSS, looking at whether using it has been helpful or not in your practice. In terms of using the COG-OPSS after you have seen a client, this should take you approximately 20 – 30 minutes.

The data from the assessments performed will be put into a database and analysed together with data from the other participants in the study. All data will be anonymised. The results of the study will be written up for a doctoral thesis as well as for publication. The findings may also be presented at conferences.

What are the possible side effects or risks of taking part?

In terms of working with clients, the COG-OPSS is not thought to ask any questions that differ substantially from those that would be asked in standard assessment appointments. However, scoring the COG-OPSS and completing the evaluation measures will require some additional time on the part of participating professionals. However, if you participate in the project you will be asked to complete the COG-OPSS instead of your standard assessment method – you will not be expected to do both with a client participating in the research.

What are the possible benefits of taking part?

At the moment, there are no formal assessment tools for mental health professionals to help them decide how suitable cognitive-behavioural therapy is for an older person. It is hoped that this study will lead to the development of such a tool which therefore may benefit future older persons accessing services. In terms of more immediate benefits, completing the interview may help you and the client you are working with in thinking about their difficulties and possible ways of addressing these. For those videotaping assessment sessions, professionals may wish to additionally use these in supervision for professional development.

To thank professionals for participating, the names of those taking part will be entered into a draw for two £25 shopping vouchers. You can opt out of this draw should you wish to.

How long does the research study last?

This research study lasts for 1 year, from September 2010 to September 2011.

Will my taking part in the study be kept confidential?

Yes, all information collected as part of this research, including questionnaires and notes from interviews will be kept in a locked filing cabinet in the School

of Psychology at the University of Birmingham. Any information from or about you will have your name and any other identifying features removed so that you cannot be recognised from it. This means that your anonymity will be preserved at all times during and after the study time period.

Who should I contact if I have further questions or concerns?

If you have any questions about the study, please feel free to contact either:

Jon Williamson – Chief Project Investigator and Trainee Clinical Psychologist
Telephone: XXXX
Post: XXXX
E-Mail: XXXX

Jan Oyebode – Academic Supervisor and Consultant Clinical Psychologist
Telephone: XXXX
Post: XXXX
E-Mail: XXXX

Susan Adams – Principal Investigator and Clinical Psychologist
Telephone: XXXX
Post: XXXX
E-Mail: XXXX

Alternatively, if you have any complaints about the conduct of the research you can contact:

XXXX – Consultant Clinical Psychologist
Telephone: XXXX
Post: XXXX
E-Mail: XXXX

Thank you for taking the time to read this information sheet. This copy is for you to keep.

APPENDIX W: AMENDED MEMBER OF STAFF CONSENT FORM

Professional Participant Consent Form **Version 2: 7th March 2011**

Study Title: The Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS): Development, Validation and Evaluation of a New Method for Assessing the Suitability of Cognitive-Behavioural Therapy for Older People with Anxiety and/or Depression

Researcher: Jon Williamson

	Please initial box
1. I confirm that I have understood the information sheet dated 13th August 2010 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research, without giving any reason.	☐
3. I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data.	☐
4. I understand that all information about me will be kept in a confidential way and destroyed in line with the University's policies.	☐
5. I understand that the findings of this project will be written up for publication in scientific journals and may be presented at conferences in the UK and abroad. However, my anonymity will be protected at all times.	☐
6. I agree to take part in the above study.	☐

.....	.....	.....
Name of member of staff	Date	Signature
.....	.....	.....
Name of witness	Date	Signature
.....	.....	.....
Name of researcher	Date	Signature

Would you like to receive a written summary of the findings of this research study?

❑ Yes ❑ No

If Yes, please give the address to which you would like this summary sending:

Address: _____

_____

_____

Postcode: _____

Would you like to be entered into the draw held for participating professionals at the end of the study (two prizes of £25 shopping vouchers)?

❑ Yes ❑ No

Vouchers will be sent to the postal address stated above.

APPENDIX X: COMPACTED COG-OPSS STUDY BOOKLET

Cognitive-Behavioural Therapy for Older People Suitability Scale (COG-OPSS)

Please complete this after your assessment with the client. This may be a generic assessment (e.g. the Health and Social Care assessment) or a profession-specific assessment.

To help structure your assessment (e.g. the questions asked and the information gathered), you may find it help to familiarise yourself with the COG-OPSS suitability scales and the kinds of information that will help you complete ratings on them before you see the client.

Your Details

Your Name:	
Your Professional Role:	

Client Details

Client Age:	
Client Gender:	
Client Ethnicity:	
Reason for Referral:	

If you completed a HoNOS 65+ for the client, please enter the scores below:

1. Behavioural disturbance	☐	7. Problems associated with depressive symptoms	☐
2. Non-accidental self injury	☐	8. Other mental and behavioural problems	☐
3. Problem drinking or drug use	☐	9. Problems with social or supportive relationships	☐
4. Cognitive problems	☐	10. Problems with activities of daily living	☐
5. Problems related to physical illness or disability	☐	11. Overall problems with living conditions	☐
6. Problems associated with hallucinations and/or delusions or false beliefs	☐	12. Problems with work and leisure activities – quality of day time environment	☐

COG-OPSS Suitability Scales

Based on the information you collected during your assessment with the client, please provide a rating on each of the 10 scales below. If you do not feel you have enough information to make a rating on a scale, please give a score of 3.

1. Ability to Identify Beliefs/Thoughts

What This Scale Measures: The extent to which the client is able to identify (and report) what they are thinking (their beliefs, thoughts, attitudes, mental images and pictures, what they 'say to themselves', what 'goes through their head' and so on), especially in relation to their anxiety and/or depression symptoms but also more generally. Clients may show this awareness in several different ways e.g. through speech, writing, drawing.

When Scoring on This Scale Consider:

- To what extent the client can say what they're thinking about when they become anxious or depressed (can they report any beliefs, thoughts, attitudes, mental images and pictures? Can they what they 'say to themselves' or what 'goes through their head'?) Thinking that may be linked to the client's anxiety and/or depression symptoms could include beliefs concerning: how they client sees themselves, how they think others see them, what they think is going to happen in a situation (e.g. that they might not cope), what they think the future holds for them, the client's physical and/or mental health, how they view mental health difficulties, changes in roles (e.g. employment) of value to client, issues with family, friends and so on and views on what it means to become older.
- To what extent the client seems able to identify or 'tune in' to their thinking in relation to other matters e.g. what they were thinking before the assessment appointments.

5 (CBT more likely to be suitable)	The client shows a good ability to identify (and report) what they are thinking (being able to report more than two beliefs and thoughts), especially in relation to their anxiety and/or depression symptoms and perhaps also more generally. This may occur spontaneously or though occasional prompting by the interviewer/assessor.
4	
3	The client shows some ability to identify (and report) what they are thinking, being able to report one or two beliefs or thoughts in relation to their anxiety and/or depression. They may also be able to report some of their thinking more generally (e.g. in relation to matters other than their anxiety and/or depression difficulties). More than occasional prompting is required by the interviewer/assessor for this to occur.
2	
1 (CBT less likely to be suitable)	The client shows no ability to identify (and report) what they are thinking, being unable to report any beliefs or thoughts in relation to their anxiety and/or depression symptoms. The client may deny that they think anything when the anxiety and/or depression symptoms happen, saying that it is the situation(s) they are in that causes the difficulties. This is despite the interviewer/assessor providing the client with several opportunities to help them identify their thoughts and beliefs (e.g. giving examples of common thoughts associated with anxiety and/or depression symptoms). The client also finds it difficult to report their thinking in relation to other matters (those not relating to anxiety and/or depression symptoms).

2. Ability to Identify Emotions/Feelings

What This Scale Measures: The extent to which the client is able to identify (and report) how they are feeling (what emotions they are experiencing e.g. happiness, sadness, anger, fear, worry and so on), both in situations associated with their difficulties with anxiety and/or depression as well as more generally. This includes their ability to differentiate between different emotional experiences (in terms of the type of feelings and their strength/intensity).

When Scoring on This Scale Consider:

- The extent to which the client can describe their emotions and feelings, both more generally and in association with their anxiety and/or depression symptoms; how these feelings are different to those experienced at other times; the extent to which the client can identify changes in the intensity (or strength) of their emotions and feelings, both generally and in relation to the difficulties; the client's emotional awareness both within the session (can the client identify how they feel when certain issues or topics are discussed in the session) and outside of it (the client's reports of feelings towards previous or current events).

5 (CBT more likely to be suitable)	The client shows a good level of emotional awareness, being able to identify how they feel (including the type of feeling and the strength of the feeling) especially in relation to their anxiety and/or depression symptoms e.g. how they feel when they are in certain situations or when they think about certain things. The client also shows a good general ability to identify how they feel in relation to other matters in their life. This ability may be evident both in the assessment appointments and outside of them. This emotional awareness occurs either spontaneously or through occasional prompting by the interviewer/assessor.
4	
3	The client shows some emotional awareness, and can report one or two examples of how they feel (including the type of feeling and its strength), especially in relation to their anxiety and/or depression symptoms e.g. how they feel when in certain situations or when they think about certain things. The client requires more than occasional prompting from the interviewer for this to occur.
2	
1 (CBT less likely to be suitable)	The client shows no emotional awareness, being unable to say how they feel (including type and strength of feeling) both generally and in relation to their anxiety and/or depression difficulties. This is despite several attempts by the interviewer/assessor to elicit the client's feelings. This lack of emotional awareness is evidence both within and outside of the assessment session(s).

3. Mindedness to CBT Explanation of Difficulties

What This Scale Measures: The extent to which the client identifies with and accepts a cognitive-behavioural explanation of psychological difficulties (i.e. that how they feel in a given situation is linked to what they are thinking about).

When Scoring on This Scale Consider:

- The extent to which the client can make links between their thoughts regarding a given event and their subsequent feelings and behaviours; how the client responds when given an explanation of a CBT way of working e.g. using the definition of a cognitive-behavioural therapist and using the cat-burglar worksheet; the extent to which the client sees value in therapeutic work that would work from the assumption their thinking determines their feelings and behaviours; the client's own views and beliefs concerning their current mental health difficulties and how they see these improving or resolving; the extent to which the client subscribes to other explanations for their mental health difficulties e.g. a medical account.

5 (CBT more likely to be suitable)	The client appears to clearly relate to a cognitive-behavioural explanation (seeing it as an important part, along perhaps with other factors e.g. medical) of their difficulties, seeing a link between how they think and how they feel and behave. The client may also report seeing the logic in therapeutic tasks working from a CBT perspective e.g. testing out beliefs by discussion, behavioural tasks etc.
4	
3	The client appears to relate to some degree to a cognitive-behavioural explanation and can sometimes see the link between how they think and how they feel and behave. The client appears at times to favour alternative explanations of their difficulties but they are prepared to consider a CBT account alongside these. The client sees some logic or sense in therapeutic tasks working from a CBT perspective.
2	
1 (CBT less likely to be suitable)	The client does not accept a cognitive-behavioural explanation of psychological distress and cannot see any relevance of this to their current difficulties. This is despite attempts by the interviewer to socialise the client to the cognitive-behavioural way of working e.g. explaining the way a cognitive-behavioural therapist works or using the cat-burglar worksheet. The client may strongly adhere to another explanation e.g. a medical account and cannot see any sense or logic in undertaking any tasks or discussions that would examine the links between their thoughts, feelings and behaviours.

4. Willingness to Explore Relationship Between Thinking and Feelings/Behaviours

What This Scale Measures: The extent to which the client is willing to explore the relationship between their thinking and feelings and behaviours, including given that doing so may result in distress or discomfort.

When Scoring on This Scale Consider:

- To what extent the client sees their thinking as something 'to be tested out' and examined; to what extent the client acknowledges that there might be different ways of looking at how they think about things; what the client feels could be the potential benefits/costs of exploring the relationship between thinking and feeling and behaviour.
- To what extent the client is willing to explore how their thinking impacts on their feelings and behaviour, even if this might result in them becoming distressed or upset; more generally, how the client responds when distressing or discomforting topics are raised in the assessment (e.g. how long can the client stay with the topic, are certain topics avoided); to what extent does the client currently place and keep themselves in situations that provoke distress and discomfort; how has the client dealt with other adversities or hardships in their lives; what beliefs or thoughts does the client have about themselves in terms of coping (i.e. do they see themselves as someone who can cope with difficult situations).

5 (CBT more likely to be suitable)	The client appears willing to and sees value in exploring the relationship between their thinking and feeling and behaviour, even if this might result in distress or discomfort. The client is able to discuss distressing or discomforting topics (or shows little avoidance of these if raised by others) and shows resiliency when faced with psychological distress or discomfort (e.g. they may report placing and keeping themselves in situations they currently find distressing or discomforting).
4	
3	The client shows some willingness and sees some value in exploring the relationship between their thinking and feeling and behaviour. The client appears able to tolerate some distress and discomfort though avoids certain topics, tasks and activities. The client shows some resiliency when faced with psychological distress or discomfort, such as being able to keep themselves in distressing situations for a brief period.
2	
1 (CBT less likely to be suitable)	The client appears unwilling to and sees no value in exploring the relationship between their thinking and feeling and behaviour. The client is unable to talk about distressing issues for even a brief period of time and avoids these if raised by others. In their day-to-day life the client avoids any situation provoking distress or discomfort.

5. Therapeutic Relationship

What This Scale Measures: The extent to which the client appears able to form open, trusting and durable relationships with others, feels comfortable and safe in these relationships, and can use relationships to discuss/explore difficulties and problems.

When Scoring on This Scale Consider:

- The client's current and past (especially those in childhood) relationships (e.g. partner, spouse, family, friends, carers, other professionals and so on) and whether the client feels these relationships are/were: loving, caring, supportive, trusting, reliable and durable (i.e. the relationship endured arguments, disagreements and so on), a place where the client felt 'heard' and understood and a place to discuss difficulties they were having (not necessarily those concerning mental health); the client's presentation during the assessment e.g. their 'warmth', eye contact, body posture, the extent to which they are open or guarded when asked questions, especially those of a more personal nature.

5 (CBT more likely to be suitable)	There is evidence that the client has experienced and /or continues to experience trusting, supportive and enduring relationships with others. The client has had positive experiences of discussing difficulties with others and sees relationships as a way of exploring difficulties or problems they are experiencing. In the interview, the client appears to talk openly, and there is a good sense of rapport between the client and the therapist e.g. eye contact is made, 'warmth', the client appears to feel heard and understood by the therapist.
4	
3	There is evidence that to some degree the client's relationships with others (past and/or current) have been trusting, supportive and enduring. The client may have had both positive and negative experiences of confiding in others and at times appears reluctant to use relationships to explore difficulties (this may be due to feelings of mistrust, concerns that they won't be 'heard' and so on). In the interview, the client appears guarded at times though there is some evidence of rapport between the client and therapist e.g. some eye contact, some sense of 'warmth' and so on.
2	
1 (CBT less likely to be suitable)	There is no evidence that the client has experienced or experiences trusting, supportive and enduring relationships with others. The client may have little to no experience of confiding in others or if they have describe these in negative terms. The client does not see relationships as an appropriate forum to discuss difficulties and appears generally guarded and mistrustful of the therapist during the interview. There is little sense of rapport between the client and the therapist, as shown by poor eye contact, a lack of 'warmth' and so on.

6. Interpersonal Context

What This Scale Measures: The extent to which the interpersonal context of a client (that is, the relationships they are a part of, both personal e.g. family, friends, and professional e.g. other services or organisations working with the client) plays a part in causing and/or maintaining the client's difficulties, and how compatible the client's interpersonal context would be were a CBT intervention offered to the client.

When Scoring on This Scale Consider:

- The current relationships, both personal and professional, the client is involved in; the extent to which the client's difficulties may be caused and/or maintained by these relationships (this could be because others feel they are actually helping the client or because the client's difficulties benefit the relationship in some way e.g. focusing on the difficulties draws attention away from other difficulties); how supportive these relationships have been if previous therapeutic work has been carried out with the client and/or would be if CBT work was carried out with the client.

5 (CBT more likely to be suitable)	The interpersonal context of the client (e.g. the relationships , both personal and professional, the client is involved in) appears to play little to no role in causing and/or maintaining the client's difficulties; if a CBT intervention was offered to the client, it is not felt that the interpersonal context of the client would be disruptive to this.
4	
3	There is some evidence that the interpersonal context of the client (e.g. the relationships, both personal and professional, the client is involved in) is playing a role in causing and/or maintaining the client's difficulties; if a CBT intervention was offered to the client, it is felt that the interpersonal context of the client could at times be disruptive but not significantly.
2	
1 (CBT less likely to be suitable)	There is evidence that the interpersonal context of the client (e.g. relationships, both personal and professional, the client is in) would be very disruptive and detrimental to any CBT working. These relationships appear to play a very significant role in causing and/or maintaining the difficulties and it is felt that any attempts to bring about change through working with the client would be counteracted and met with significant resistance by others.

7. Duration and Course of Difficulties

What This Scale Measures: The length of time the client has been experiencing the difficulties with anxiety and/or depression and the extent to which they have been shown to be improvable (this could be spontaneously or through some form of intervention e.g. medical, psychological, family support).

When Scoring on This Scale Consider:

- How long the difficulties have been apparent as a proportion of the client's life; to what extent there have been periods of symptom improvement or remission (either spontaneously or due to intervention); if the difficulties are longstanding, are they constant in severity or is this changing with time (e.g. do the difficulties seem to be decreasing over time, increasing over time, or staying constant); to what extent the difficulties have impacted on the client's life, and how long has this impact been apparent.

5 (CBT more likely to be suitable)	The client's difficulties have a relatively recent onset (e.g. the last few years) and have not been apparent previously. Alternatively, if the difficulties have been apparent previously they have been short-lived (either spontaneously improving or responding well to intervention) and have only had a minimal impact on the client's life overall.
4	
3	The client's difficulties have been apparent beyond their recent past (e.g. more than the last few years) and have had a moderate impact at times during the client's life. The difficulties have shown some improvement, either spontaneously or through intervention.
2	
1 (CBT less likely to be suitable)	The client's difficulties have been apparent for most of their life and have had a significant and longstanding impact on the client's life. The difficulties have shown little to no improvement during this time, either spontaneously or in response to interventions.

8. Physical Health, Disability and Mobility

What This Scale Measures: The extent to which the client has issues with their physical health, disability and mobility that would negatively impact on CBT working and could not be adapted for by the therapist.

When Scoring on This Scale Consider:

- Whether the client has any issues with physical health (including difficulties with pain), disability (including sight and hearing issues) or mobility that would impact on CBT working; whether these issues could be accommodated for by modifications to working (e.g. for individuals with sight difficulties, printing materials in larger fonts) or by other means (e.g. the use of glasses or a hearing aid).

5 (CBT more likely to be suitable)	It is felt that the client's issues (if any) with physical health, disability and mobility would impact minimally on CBT working. Any impacts on working can be readily accommodated either by adaptations by the therapist e.g. printing materials in larger fonts for those with sight difficulties or by other interventions e.g. the client's use of glasses or a hearing aid. It is also felt that any physical health, disability or mobility issues would not distract the client significantly during any sessions (e.g. if the client has issues with pain, these do not significantly distract them from discussions with others).
4	
3	It is felt that the client's issues with physical health, disability and mobility would impact to some degree on CBT working. Whilst adaptations would not fully accommodate for these issues (e.g. materials are still difficult to read even in larger fonts, glasses and hearing aids only partially correct sensory difficulties) it is still felt that with these modifications CBT work could still take place. The client's physical health, disability or mobility issues may prove distracting at times during sessions but are not very disruptive.
2	
1 (CBT less likely to be suitable)	It is felt that the client's issues with physical health, disability and mobility would be very disruptive to any CBT working and could not be accommodated for by modifications. For example, the client may have: severe pain issues that makes it very difficult for them to focus on therapeutic work or severe sensory impairments that would make it very difficult to communicate information.

9. Cognitive Abilities

What This Scale Measures: The extent to which the client has issues with cognitive abilities (such as memory, attention and comprehension) t hat cannot be adapted for by a therapist and would consequently negatively impact on any CBT intervention offered to the client.

When Scoring on This Scale Consider:

- The presentation of the client during the assessment, including: the extent to which the client was able to maintain their concentration (and if it did wander how readily it could be brought back to the issue of focus); the extent to which the client could learn and recall information provided to them during the assessment (and if difficulties arose, whether repetition of information or prompting was beneficial); the extent to which the client was able to grasp the meaning of what was being said (and if there were difficulties, whether repeating or rephrasing information helped); the extent to which the client responded to questions in a timely manner (or if the client appeared to have difficulties processing information promptly, whether allowing more time improved responding).

5 (CBT more likely to be suitable)	No issues are apparent concerning the client's cognitive abilities or if issues are apparent these are only minimal and/or can readily be accommodated for by the individual working with the client e.g. using more frequent recaps, allowing more time for information to be processed.
4	
3	Some issues with cognitive abilities are apparent and these have some impact on working with the client e.g. concentration wanders and a little difficult to bring back. Whilst modifications to CBT working (e.g. using more frequent recaps) may not fully address these issues it is felt that they are sufficient to allow some work with the client to occur e.g. with the modifications, the client is able to remember some of the information discussed and focus on some of the conversation.
2	
1 (CBT less likely to be suitable)	The client's cognitive abilities appear to be significantly impaired (e.g. learning of new information very difficult, concentration lost very easily and difficult to bring back, comprehension/understanding poor even when repeated, rephrased etc.). It is felt that any therapist would find it very difficult to adapt a CBT intervention to reduce the impact these cognitive issues would have on it.

10. Readiness to Change

What This Scale Measures: The extent to which the client sees the difficulties with anxiety and/or depression as a problem and how motivated they are to make changes in relation to these difficulties.

When Scoring on This Scale Consider:

- The extent to which the client sees the difficulties with anxiety and/or depression as a problem; to what extent the client wants things to be different regarding the anxiety and/or depression (i.e. to what extent they'd like to feel less anxious or depressed); how important is it for the client for things to be different regarding their anxiety and/or depression; to what extent does the client feel that changes regarding their difficulties with anxiety and/or depression are possible and achievable; to what extent does the client feel they would benefit were the difficulties with anxiety and/or depression to be lessened; do the difficulties provide the client with any gains or benefits and how prepared are they to have these reduced.

5 (CBT more likely to be suitable)	The client views the difficulties they are experiencing as a problem and something that they wish to be different. The client is willing to engage in tasks and activities to bring about change and may already have started to take actions to bring about change themselves or with the support of others e.g. trying to build up their tolerance of situations they find anxiety provoking.
4	
3	The client views the difficulties they are experiencing as a problem and identifies that change would result in more benefits than costs. However, the costs are still apparent in the client's thinking at times and as a result they are only somewhat willing to engage in tasks and activities to bring about change.
2	
1 (CBT less likely to be suitable)	The client does not view the difficulties they are experiencing as a problem and consequently feels there is no need for anything to change. Alternatively, the client acknowledges that the difficulties are a problem but strongly feels that change is not possible and/or that the costs of making changing far outweigh the benefits. The client does not see any value in undertaking any tasks/actions to bring about change regarding their anxiety and/or depression.

Helpfulness of Using the COG-OPSS with this Client

Overall, how helpful was the COG-OPSS to you when deciding whether or not cognitive-behavioural therapy (CBT) was suitable for this client?

0	10	20	30	40	50	60	70	80	90	100
Not at all helpful										Very helpful

Outcome

What happened after the assessment?

❑ **I offered the client further psychological assessment**	❑ **Yes**	❑ **No**
If **Yes**, did the client accept this offer?	❑ Yes	❑ No
❑ **I referred the client on for further psychological assessment**	❑ **Yes**	❑ **No**
If **Yes**, did the client accept the referral being made?	❑ Yes	❑ No
❑ **I offered the client a psychological intervention**	❑ **Yes**	❑ **No**
If **Yes**, was this:	❑ Individual	❑ Group Therapy
	❑ CBT	❑ Other
If **Yes**, did the client accept the intervention offered?	❑ Yes	❑ No
❑ **I referred the client on for a psychological intervention**	❑ **Yes**	❑ **No**
If **Yes**, was this:	❑ Individual	❑ Group Therapy
	❑ CBT	❑ Other
If **Yes**, did the client accept the referral being made?	❑ Yes	❑ No

How helpful was the COG-OPSS to you in deciding what to do after the assessment?

0	10	20	30	40	50	60	70	80	90	100
Not at all helpful										Very helpful

ARM-12 Questionnaire

Thinking about your appointment today with this client, please indicate how strongly you agreed or disagreed with each statement by circling the appropriate number.

		strongly disagree	moderately disagree	slightly disagree	neutral	slightly agree	moderately agree	strongly agree
1	My client is friendly towards me	1	2	3	4	5	6	7
2	I feel supportive	1	2	3	4	5	6	7
3	I feel bored or impatient with my client	1	2	3	4	5	6	7
4	I follow my own plans, ignoring my client's view of how to proceed	1	2	3	4	5	6	7
5	My client and I agree about how to work together	1	2	3	4	5	6	7
6	My client and I have difficulty working jointly as a partnership	1	2	3	4	5	6	7
7	My client has confidence in me and my techniques	1	2	3	4	5	6	7
8	My professional skills are impressive to my client	1	2	3	4	5	6	7
9	I feel confident in myself and my techniques	1	2	3	4	5	6	7
10	My client is worried about embarrassing her/ himself with me	1	2	3	4	5	6	7
11	My client keeps some important things to her/ himself, not sharing them with me	1	2	3	4	5	6	7
12	My client feels she/he can openly express her/ his thoughts and feelings to me	1	2	3	4	5	6	7