COGNITIVE THERAPY SCALE FOR PSYCHOSIS (CTS-PSY)
Haddock et al (2001)

MODIFIED FROM COGNITIVE THERAPY SCALE
YOUNG AND BECK, (1980)
MODIFIED BY HADDOCK AND KINDERMAN (1994)
MODIFIED BY HADDOCK ET AL (2001)

Reference:

Haddock, G., Devane, S., Bradshaw, T., McGovern, J., Tarrier, N., Kinderman, P., Baguley, I., Lancashire, S. and Harris, N. (2001) An investigation into the psychometric properties of the Cognitive Therapy Scale for Psychosis (CTS-Psy). Behaviour and Cognitive Psychotherapy 29, 2, pp 221-233.

Abstract:

Inter-rater reliability of trained raters using the CTS-Psy was investigated using taped therapy of trainees engaged in a CBT oriented psychosis, training course. Validity was investigated in relation to examining the degree to which the scale could be used to assess a range of therapist ability and patient severity and by assessing the degree to which the CTS-Psy could pick up changes in skill acquisition during the course over a 9-month period. The CTS-Psy demonstrated excellent inter-rater reliability and good validity in relation to it being able to rate all standards of therapy and all types of patient sessions in the sample studied. In addition, the scale was sensitive to changes in clinical skills during a training course.

CTS-PSY CHECKLIST

Coding key: 0 = inappropriately omitted
1 = appropriately included
9 = not applicable (carries a score of 1)

I GENERAL

a) AGENDA

1 The therapist noted patient's current emotional status regarding agenda setting.

2 Therapist and patient established agenda for session.

3 Priorities for agenda items were established.

4 Agenda was appropriate for time allotment (neither too ambitious not too limited).

5 The agenda provided an opportunity for the patient to discuss salient events or problems occurring during the time since the last session.

6 The agenda was adhered to during the session where appropriate.

b) FEEDBACK

1 Therapist asked for feedback regarding previous session.

2 Therapist asked for feedback and reactions to present session.

3 Therapist asked client specifically for any negative reactions to therapist, content, problem formulation etc.

4 Therapist attempted to respond to patient's feedback.

5 Therapist checked that the client clearly understood the therapist's role and / or the purpose and limitation of sessions.

6 Therapist checked that s/he had fully understood the patient's perspective by summarising and asking client to fine-tune as appropriate.

c) **UNDERSTANDING**

1 Therapist conveys understanding by rephrasing or summarising what the patient had said.

2 Therapist shows sensitivity e.g. by reflecting back feelings as well as ideas.

3 Therapist's tone of voice was empathic.

4 Therapist acknowledged patient's viewpoint as valid and important.

5 Therapist did not negate patient's point of view.

6 Where differences occurred, they were acknowledged and respected.

d) INTERPERSONAL EFFECTIVENESS

1 Therapist seemed open rather than defensive shown by not holding back impressions or information, nor evading patient's questions.

2 Content of what therapist said communicated warmth, concern and caring rather that cold indifference.

3 The therapist did not criticise, disapprove or ridicule the patient's behaviour or point of view.

4 The therapist responded to, or displayed, humour when appropriate.

5 Therapist made clear statements without frequent hesitations or rephrasing.

6 Therapist was in control of the session, s/he was able to shift appropriately between listening and leading.

e) **COLLABORATION**

1 Therapist asked patient for suggestions on how to proceed and offered choices when feasible.

2 Therapist ensured that patient's suggestions and choice were acknowledged.

3 Therapist explained rationale for intervention(s).

4 Flow of verbal interchange was smooth with a balance of listening and talking.

5 Therapist worked with patient even when using a primarily educative role.

6 Discussion was pitched at a level and in a language that was understandable by the patient.

SPECIFIC _____

f) **GUIDED DISCOVERY**

1 Therapist used question to determine the meaning a client attached to an event or circumstance.

2 Used questions to show incongruities or inconsistencies in patient's conclusions without demeaning the person.

3 Used questions to help patient explore various facets of a problem.

4 Used questions to examine patient's arbitrary conclusions or assumptions.

5 Used questions to elicit alternative ways of showing a problem.

6 Used questions to consider alternative explanations.

g) **FOCUS ON KEY COGNITIONS**

1 Therapist elicited (or referred to) specific thoughts, assumptions, images, memories, beliefs or perceptions in relation to problems.

2 Such cognitions elicited (or referred to) above are ones the patient reports as involved in key problems.

Such cognitions are usually explained or discussed in terms of:

3 Phenomenological characteristics (content, form, frequency, duration etc).

4 The relationship with patient's key problems.

5 The link between cognition and affect.

6 Such discussions take place in an atmosphere of collaboration between therapist and patient.

h) **CHOICE OF INTERVENTION**

1 Therapist selected cognitive–behavioural techniques of intervention.

2 The overall strategy was specifically related to the patient's problems.

3 Each individual cognitive-behavioural technique was relevant to tone of the key problems of the patient.

4 Strategies used were directly related to a formulation or rationale.

5 The techniques chosen had demonstrable (via research evidence etc) potential for change with respect to the problems at which they were targeted.

6 Therapist sought adequate feedback from the patient regarding the strategy for change.

i) **HOMEWORK**

1 Therapist explicitly reviewed previous week's homework.

2 Therapist summarised conclusions derived, or progress made, from previous homework.

3 Appropriate homework was assigned.

4 Therapist explained rationale for homework assignment.

5 Homework was specific and details were clearly explained.

6 Therapist asked patient if s/he anticipated problems in carrying out homework.

j) **QUALITY OF INTERVENTION : COGNITIVE–BEHAVIOURAL TECHNIQUES**

1 The therapist applied no cognitive–behavioural techniques.

Technique applied with:

1 barely adequate level of skill
2 mediocre
3 satisfactory
4 good
5 very good
6 excellent
7 ***Note:*** score for this question is 0 if no cognitive-behavioural techniques are applied.

THORN COURSE: SUMMARY SCORE SHEET

Centre **Course** **Student**

Client **Date** **I/F**

Title and Assessment No:

ITEM		MAX SCORE	ACTUAL SCORE	COMMENTS
A	Agenda	6		
B	Feedback	6		
C	Understanding	6		
D	Interpersonal effectiveness	6		
E	Collaboration	6		
F	Guided discovery	6		
G	Focus on key cognitions	6		
H	Choice of intervention	6		
I	Homework	6		
J	Quality of Intervention	6		
	Total	**60**		
	Percentage Score			
	Final Score			

Overall Comments:

Signature of first marker:

Date:

Signature of second marker:

Date:

Signature of external marker:

Date: