



Unresolved Issues Regarding Homework Assignments in Cognitive and Behavioural Therapies: An Expert Panel Discussion at AACBT

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This article presents a panel discussion on the integration of homework assignments into cognitive behaviour therapy sessions. The panel comprised experts in research and practice who had been invited as keynote presenters for the 32nd National Conference for the Australian Association of Cognitive and Behaviour Therapy. Experts responded to questions about the definition of homework, the mechanism by which homework produces its effects, and the relative importance of homework adherence for effective therapy. Interwoven through the discussion was an emphasis on a collaborative approach to homework, as well as specific recommendations for the integration of homework into sessions. Selected case illustrations were also discussed.

■ **Keywords:** homework assignments, cognitive behaviour therapy, cognitive therapy, definition, process research

The Australian Association of Cognitive and Behaviour Therapy (AACBT) held its 32nd national conference in 2009. When A.T. Beck, Rush, Shaw, and Emery's 'Cognitive therapy for depression' was published in 1979, it reiterated an emphasis on the importance of homework in earlier psychotherapy works (A.T. Beck, 1976; Ellis, 1962; Shelton & Ackerman, 1974). Homework is certainly not a new topic of discussion. However, homework has the potential to critically influence therapy, and there are many unresolved issues regarding its use in practice. In surveys of practitioners in the community, one of the most commonly cited reasons for unsuccessful therapy, or therapy that does not meet the needs of clients, is homework 'noncompliance' also known as 'nonadherence' (Helbig & Fehm, 2004). Other data support the expe-

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rience of homework nonadherence as frequent in clinical practice; for example, a survey by Kazantzis, Lampropoulos, and Deane (2005) found that psychologists estimated that 20% of their patients had low adherence with homework. The fact that clinical trials observe enough variability in homework adherence in order to evaluate correlations with symptom change suggests nonadherence is also commonplace in research settings (Kazantzis, Deane, & Ronan, 2000).

Some patients may regard homework as a test of their abilities, as an indicator of likely success in therapy, or as something to be done to a desired standard to please the therapist (A.T. Beck et al., 1979). Therefore, both the manner with which homework is discussed by the therapist, and the specific task for homework, has the potential to activate negative schemas about self, others, world, the future (J. Beck, 1995; Kazantzis, MacEwan, & Dattilio, 2005).

In alphabetical order, invited keynote speakers to the AACBT national conference — Drs Arnoud Arntz, Tom Borkovec, Emily Holmes and Tracey Wade — kindly agreed to join in a panel discussion to respond to questions regarding the definition of homework, the mechanism by which homework produces its effects, the relative importance of homework adherence for effective therapy, and commented on useful strategies for the practical use of homework (Dr Nik Kazantzis was Chair). The session was well attended and the panel enjoyed the opportunity to discuss questions and comments from those in attendance. This article presents those questions and their responses so that the broader AACBT membership may benefit from the ideas and comments generated.

Definition of Homework

The word ‘homework’ itself will often have associations for patients, some of which will be positive, many of which will be negative. Patients probably have a range of memories, expectations, and emotions associated with the term. In the professional literature, homework assignments have often been defined as specific, structured, therapeutic activities that are routinely discussed in session, to be completed between sessions. The process involves collaborating to specify the therapeutic goals for the homework, arriving at some activity or data collection as part of the homework, planning how the homework will be practically carried out, and then reviewing the homework in the following session.

Homework was once described as ‘the most generic of behavioural interventions — and one that greatly and immediately distinguishes behaviour therapy from psychoanalysis’ (Goisman 1985, p. 676). Despite its association with, and popularisation by Beck’s cognitive therapy, homework is no longer limited to the narrow province of this theoretical tradition (Nelson, Castonguay, & Barwick, 2007). Case studies from a broad range of theoretical orientations have been published explaining how homework can be utilised to facilitate therapeutic change, in client-centred, interpersonal, psychoanalytic, systemic, and emotion-focused experiential approaches (Kazantzis & L’Abate, 2007; Kazantzis & Ronan, 2006). Thus, one unresolved issue concerns the definition of homework, and where the line can be drawn between ‘homework’ and a patient’s own assimilation of homework (or its basic essence) as one of many adaptive coping strategies to be used in their lives. The following two questions were asked of the panel regarding the definition:

1. What do we mean by psychotherapeutic homework?

2. Does homework consist only of those activities recommended or assigned by the therapist for the client to do between sessions?

Tom Borkovec

I'm the oldest person here, and I started my training in behaviour therapy mid-1960s when there was no cognitive therapy. The model that our professors provided to us was an educational model, in contrast to psychodynamic and Rogerian therapies that were prominent at the time. It was from the educational model that I think we early on got the term 'homework assignment'.

It was in the context of the prevailing best-known principles upon which to develop therapy techniques that behaviour therapy grounded itself. It [behaviour therapy] had to do with the view that psychological difficulties are habits and that change is going to require a strengthening of opposites — the strengthening of behaviours that are opposite to the problematic behaviour. And so, as an educational form of therapy it was quite natural that we would start thinking in terms of having our clients practice and try to develop increased habit strength for new adaptive responses that were being identified and tried out in therapy.

Homework to me always meant this to the client:

'Ok, let's go out and practise these things in the real world. But wouldn't it be better if we could make this 60 minutes no different from any other hour, or any other day of your week? So that we can grease the skids in terms of what we mean in terms of learning, and then practise. We can practise in the session, and then have homework assignments to practise outside the session, and we can begin to view this hour just like any other hour — so let's practise the new techniques here, just like we would in any other hour of the week.'

Emily Holmes

Well, from the oldest member of the panel, to the youngest member of the panel. I think that homework could be almost anything, but something that you decided to do in the session before the next session. And I guess just to be provocative, I wouldn't really like the word 'assigned' because that sounds very 'top-down', so from my perspective, doing something like trauma treatment, you're asking someone to do something that they really don't probably want to do — for example listening to a reliving exposure tape. So it is really important that is a collaborative decision to make those 50 minutes spread into the rest of the week for very good reason, and I think if I 'assigned' that, it wouldn't work.

Tracey Wade

While I don't look as old as Tom (I don't think) I was brought up in a behaviourist training, because cognitive behaviour therapy had not been discovered when I did my training. So I think might be still going through a little bit of a reaction to that trauma where I am very keen to include both thinking types of homework, and doing types of homework. I think it encompasses anything that you and the client agree on, for the client to continue out of session — that somehow tackles the vicious circle, and somehow is relevant to the case conceptualisation.

One of my favourite bits of homework is where I just ask the client to notice things that they usually don't notice, like when they are being competent. For example, if their core beliefs are around their incompetency and low self-esteem — then the homework might be to look for something I did competently today, and of course, rate the degree of competency, because you are not looking either complete competence or no competence. I have a broad definition of what can go in that homework basket and I certainly agree that unless it is set collaboratively, it won't be done. A lot of work that I do with people with anorexia is working with them to put on weight, which they don't want to do. They have worked with people previously and that hasn't worked. So, that collaborative relationship is the key, I think.

Arnoud Arntz

I was trained a little bit later, both in behaviour therapy and in cognitive therapy, but at that day, at least in my training, homework was really an assignment that the therapist gave to the patient, and said 'Fill out the diary, challenge thoughts, listen to the tape', and the idea is that it was essential to the change process.

It's a little bit provocative, but perhaps it's easier for the discussion if we restrict homework to a real explicit assignment (e.g., an exposure tape — an essential ingredient of treatment). Working with more difficult, less motivated patients, I learnt that you get really dependent if you view homework that way. Many patients don't do it — and you get into a sort of power struggle. I am not so sure whether it's true that this sort of homework is essential to change. I am aware that in research that has tried to relate homework to outcome has produced findings that are very mixed. There is no clear evidence between the levels that patients do their homework exercises and outcome. A lot of that makes sense, because you can do what somebody tells you and that is not seen as a true engaging a change process.

In my work with people with personality disorders, which generally don't do homework, even if they agree, or ask for it — they don't do it. I tend to rely more on things that the patient wants to change themselves, but if they would not do it, I would not make a big issue of it.

The other thing I wanted to say concerned the experimental findings. If you look at trials that compare CBT versus non-CBT, especially in the treatment of depression, IPT versus Cognitive Therapy for depression, then generally both are equally effective. However, IPT does not involve any homework at all. It is involved in change processes, but it is up to the autonomous decision of the patient.

Tom Borkovec

I am resonating with what Tracey and Emily are saying about client agreement on homework assignments. It reminds me of a notion that we talk about, of organic change, that actually applies to several different things including how we do cognitive therapy, and how we can start with some of the strengths of the client's belief systems, to help them to expand those beliefs, that we would otherwise (through Socratic questioning and through evidence) lead them to. Why this is becoming more important to me is because of the work that Emily and others have been doing with cognitive modification methodologies where active generation is critical to emotional change (c.f. Holmes, Mathews, Dalgleish, & Mackintosh, 2006; Holmes, Lang, & Shah, 2009). You can change emotional bias, but if you are going to get changes in mood state, those changes are going to have to have been involved in the active generation of new cognitive material (e.g., imagery).

Reflecting back on my clinical experience, when the client is generating the ideas, and when it comes to homework assignments, then I might say to the client:

'Ok, given what we have talked about today, and some of the things we have discovered that might be useful for you, what would you like to try them out in the upcoming week? And how would you like to try them out? What kinds of perspectives would you like to adopt? Do you think we need to set up any external or internal cues to remind you to do that?'

'Ok, close your eyes for a moment, using any of the techniques you have learned, and imaging being in one of those cue situations, and imaging a worry beginning to develop, go ahead and try those techniques out here.'

This is one small example of what I mean about trying to blur the distinction between imagery in the office and reality — out in the real world. So at every point, we are trying to have the client develop the actual experience of it, using our knowledge of the process of change for creating a context in which the client can do that.

Mechanism of Effect

A patient's decision to engage in a between-session therapeutic activity has many elements in common with the decision to engage in other health behaviours, such as an exercise routine, maintenance of a healthy diet, a healthy proportion of work and play, regular sleep, and so forth. In attempting to understand what would encourage an individual to engage in health behaviours, classical conditioning models would emphasise specific features of a situation, or stimuli that serve as antecedents (triggers) to the homework. Operant conditioning models emphasise attention towards the link between the homework task and its consequences, where adverse outcomes (punishments) and desirable outcomes (intrinsic rewards, such as reduced symptoms, sense of progress towards treatment goals) would be important in understanding shaping (small steps towards desired behaviour). Social cognition theories suggest that intention (or motivation) to engage in a particular homework assignment is determined by a balance between the costs and benefits of the activity. In sum, traditional theories suggest that patients form attitudes or beliefs about a task that determine whether it is attempted (review of theoretical foundation available in Kazantzis & L'Abate, 2005).

The first time we ask patients to complete a homework assignment (ideally the first session), they may have a memory or schema activated. Often patients will have a belief about authority figures asking (or telling) them to do things, or some other general belief about others or the world. Of course, patient's core beliefs about themselves, their future, affect (presenting problems), behaviour (methods of coping) can also be activated during this process, such as: 'If I try to do something, I'll fail', 'If I focus on my problems, I'll feel worse', 'If I start to feel bad, I'll fall apart'.

Although there is good theory upon which to hypothesise the mechanisms by which homework facilitates cognitive and behavioural changes, these mechanisms are still not well understood. Thus, a second unresolved issue concerns why and how homework assists patients towards their therapeutic goals. The following two questions were asked of the panel regarding the mechanism of homework effects:

1. What do you consider the central theoretically meaningful determinants of engagement with homework?
2. How do homework assignments facilitate processes of behavioural and cognitive change?

Tracey Wade

Well, I am not sure I understand the first question, so if I get in quickly, I can answer the second one, and you guys can address that.

As you have been talking I have been thinking about a health anxiety client, and we were talking about the general principle of seeing fewer health practitioners — that would be something that would be helpful for reducing her health anxiety. In session we talked about how we could make that happen. She said, 'Well, this week I don't think I could see less people, but I could add a person, I could go and see a physiotherapist'. She had back pain, which she perceived as cancer.

That was actually a powerful experiment for her; she actually gained relief from her pain. She decided therefore that it was inconsistent with it being because of her cancer — the fact the physiotherapy had helped. In fact that was a turning point.

I think up to that point, with that particular client, I had been trying to prescribe certain things, rather than take her wisdom on board. I think we probably have that experience again and again with clients — they bring a lot of wisdom to therapy, and that's where we

really work with them to put these experiments together because they will actually have some really good ideas. I think what worked for her in that case was that she experienced something that was inconsistent with her belief, she was saying, ‘Well, if you have cancer, you don’t run off and have physio’. She was testing out whether physiotherapy helped and what that would tell about her type of pain. That is certain an important ways, its acting in a way that is inconsistent with your catastrophic belief and seeing how much benefit that has.

Tom Borkovec

I’ll take a shot at the first one. I guess I would see that in terms of client motivation. For us, motivating clients to continue to engage in new choices, new behaviours, or new cognitions is based on whether they think they are going to have any effect. They need to experience the effect in the session, which comes back to my earlier comments about making the session identical to their daily life.

My therapists are trained to engage in action and demonstration all the time in the session. If they are talking longer than 90 seconds, they are talking too much. My hyperbolic statement!

We want to be generating ideas together about whatever techniques, alternative choices, ways of perceiving, and ways of acting to immediately act on those, to demonstrate to myself, that ‘when I think this way ... or imagine this way ... it has this immediate measured effect’. We use a 0- to 100-point scale, moment to moment throughout our therapy session, so that client and therapist are able to see the immediate impact, cause and effect, cause and effect. ‘When I try out one my usual habits, or when I try one of these alternatives that we have come to (e.g., relaxation training), this is what immediately happens.’ To the extent that they discover that they can make shifts, rapidly and immediately, tiny ones, and just for a tiny moment, the fact that there is a causal ingredient, this is one of the prime motivators to getting them to do it then outside of the therapy session — Yippee!

Emily Holmes

I will go back to the bottom one again. It very much echoes parts of what Tom has just said, and I want to move us down to the level of very basic psychological studies on these sorts of issues (Holmes, Mathews, Mackintosh, & Dalgeish, 2008). This transition from the lab to the clinic, to the real world, the real world back to the clinic, I suppose it is about having an understanding of basic process, like having an understanding about context dependent learning. Learning to do something in a learning situation and being able to do that in a novel situation.

One of the reasons I think imagery is so fun in that is that you can use that as your ‘teleporter’, because you can really imagine in session (Hackman & Holmes, 2004; Holmes, Arntz, & Sucker, 2007). In fact, you can really imagine obstacles to behavioural experiments in the real world as your homework task, and actually brainstorm and work those out in that situation, and see that as part of your way of being collaborative and working together. And then you can take that image — and images are very nice, they have this way of being very ‘sticky’ — so if that person is able to being that image to mind, in whatever we call the ‘real world’, the ‘scary world’, the “difficult world” where you have to perform that homework assignment, it can help guide action.

To end on a positive note about facilitating change, just to go to something neutral, an experiment we discussed in my workshop yesterday, was a really simple study published in 2007 in *Psychological Science* where all the authors (Libby et al.) did was send an email out asking people to imagine voting in a polling booth. This was in the American election — where it was very important that people came out and exercise their right to access demographic voting, and they contrasted groups where people imagined going to poll, vote, filling out a voting paper, and not. Those who imagined their actions, and in this case from an observer perspective, of being an agent in the situation, were 15% more likely to vote in a real election. Now if you can do that for something so simple, like voting, then what can we do one to one with a therapist, collaboratively, when we can really work on someone’s concerns. So a great sign for optimism in this process of behavioural and cognitive change.

Arnoud Arntz

Trying to address the first issue, as I understand it, I think understanding why people make decisions to change — how that process actually takes place, is not very well understood. I am not talking about first steps towards an exposure exercise or something, I am thinking about the bigger changes people sometimes make, or have to make in their life. Personality disorder patients that I work with, it is often the case, they have to make major decisions:

‘Will I stay with this partner or not?’

‘Will I leave my family or not?’

‘What will I do with my brother that abused me?’

‘Will I confront him?’

So, it’s a puzzle for me. I don’t really understand it, how this process takes place — but it’s very important. I agree with Tom and Emily that imagery can be very helpful in that process; not to force people to do something, but to find that out, to more experience how a certain decision feels, to empower themselves, to make the decision.

One fascinating example from the workshop yesterday was a borderline client who was fairly mistreated by her mother, an unsafe family, there were a lot of weapons in the house, and through the re-experiencing of that childhood experience, we put the mother in jail. Her mouth was shut with tape, so that the patient could tell her mother what she felt about maltreating her. In that week — she was married with a very abusive husband, and was very passive in that, despite my efforts to motivate her to set limits with this partner or leave the relationship (she was extremely passive) — after the re-scripting, she set a limit with her partner, without any homework or connection to that. She said ‘If you beat me, I will call the police’. Somehow there is some different feeling created in imagery that generalized and helped her make a very important decision in her life.

You can theorize why that happens, and it is very nice to see it. It creates a little bit of a puzzle. What does it happen sometimes, and why doesn’t it happen in other circumstances?

Tracey Wade

Part of the theoretical perspective that picks up is from motivational interviewing, when we talk about not just readiness, and importance to change, but confidence to change, which all adds to self-efficacy. I think it can help people to see themselves doing things, and then build up on that component. In CBT sometimes, we have these wonderful things written in books about behavioural experiments we can do, and the temptation is to say: ‘Try this one!’ But we really need to put that in the context of a motivational approach, where people have to develop some confidence before they try things.

Tom Bokovec

That’s a good point. It reminds me of a conversation I had with Marv Goldfried in a jacuzzi ... and this was right around the time I was beginning to think that we needed to target interpersonal and emotional functioning in our GAD clients more broadly than we did before. The point is this: We learned back in the 60s how to do good assertion training — distinguishing aggressive versus submissive versus assertive responding. Sure the two of you could collaborate to try to think through possible scenarios of behaviours, try to be more effective, and try to maximise the likelihood of changing the other person’s behaviour. But Marv said, ‘You know, Tom, if that person could deeply experience what they are really feeling about that person, in that situation, the adaptive natural words flow out. And they flow out with the primary emotion linked with those ideas, and that will be the maximally impactful response’. It was a very eye-opening experience for me, and then we got involved with experiential emotional deepening with our clients and discovered indeed that was the case. This is another example of ‘organic’ active generation of behavioural response in a therapy session, versus client therapist collaboration to try and work out mechanistically a behaviour that might maximise outcomes.

Emily Holmes

That generation part is so interesting and critical. And that takes me back to your question Nik, perhaps homework is a simple scaffolding, at an explicit level to decide what to do, and then within-session change is the real stuff of therapy, and may what emerge in wonderful spontaneous ways, and maybe we don't have that control over it. Maybe what homework does is it gives us some kind of spotlight to help cast on that transfer. The real meat is when the client then runs with it.

Tom Borkovec

It could be a catalyser. We discovered in our earliest trials with people who received only relaxation training that many of them started asserting themselves appropriately. When there is disinhibition of previously learned adaptive behaviour, it emerges. So, when our clients were less anxious, because of the various CBT techniques they were learning, they suddenly discovered all the adaptive behaviours being cued by the adequate stimulus that made a request for it. So we then shifted to the homework assignment to 'watch what new types of things come out of you during the week'. That emphasizes the active generation and creation on behalf of the client and the organic emergence of new responses. When they are more relaxed they come up with better alternatives and responses.

The Relative Importance of Homework Adherence

According to some authors, homework has been researched more than any other transdiagnostic process in cognitive and behaviour therapies (Persons, Davidson, & Tompkins, 2000). Studies attempting to demonstrate the effectiveness of the process have compared two groups of clients receiving the same therapy, that is, one condition including homework (i.e., experimental group) in relation to a second condition without homework (i.e., control group). Meta-analysis of those studies revealed that homework does produce a homogeneous medium sized effect ($d = .77$ in Kazantzis et al., 2000, and $d = .48$ in Kazantzis, Whittington, & Dattilio, 2010). These effect sizes suggest that approximately 62% of patients involved in a therapy with homework would improve, compared to 38% in a therapy without homework (based on Rosenthal and Rubin's 1982 effect size display with $d = .48$). However, non-experimental studies correlating patient homework adherence with posttreatment symptom changes have found that only small correlations (i.e., $r = .22$) exist. Thus, a third unresolved issue concerns the utility of studying homework 'adherence' as opposed to theoretically meaningful determinants of adherence and clinical changes in behaviour and cognitive therapies. The following two questions were asked of the panel regarding the data on homework effects:

1. How can we reconcile the findings that (a) homework seems to make an additive effect to therapy, with (b) homework compliance shows a small correlation with symptom change?
2. How could research be directed to address more pertinent issues for practice?

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Arnoud Arntz

I need a little more information about the meta-analysis. Were these comparisons of the same therapy, say cognitive therapy with, and without homework assignments?

Nik Kazantzis

Yes.

Arnoud Arntz

So, then you run the risk of first design a treatment which is dependent on homework assignment, and take out one of the active ingredients, and you get a small effect, which is not the same as designing a treatment which does not rely on homework.

Nik Kazantzis

Yes, that's right. It raises the question, what do the 'control' conditions represent? Would such conditions be true to tenets of the therapy?

Arnoud Arntz

A different kind of question, but perhaps more important is how do therapies compare that have active homework assignments, with those that do not, but are still a complete treatment. So to answer your question, perhaps we could pay more attention to helping the clients to make their own decisions, to facilitate more, what Tom has called, that organic process.

Emily Holmes

Maybe this is a more radical discussion to the question, coming from our previous discussion, is it actually doing the homework, or is setting the homework? One of the things we have been talking about is the importance of collaboratively doing something, and also the importance of being in the world as a result of transfer of what one has learnt. Maybe what would be interesting is not the exact homework, a relaxation or a noticing, or whatever, but deciding that that might be something that would be good to do, and what spontaneously emerges from that. I guess a pertinent issue might be not compliance with homework, but how was that homework collaboratively decided upon. Did the client learn something about that process for themselves, for their own sense of progression in the future? And I don't think those research trials could capture, unless there was some outcomes in there that I have not understood.

Nik Kazantzis

You are quite right, only a small proportion of studies have evaluated therapist facilitative behaviours in using homework.

Tracey Wade

I really like the idea that Emily was making about the therapeutic collaboration. It just brings to mind those old NIMH findings where they were comparing IPT, which does not have formal homework, with CBT, and medication, trial for depression. Because one of the best predictors of outcome wasn't the type of treatment, but it was the degree of therapeutic alliance. I think part of therapeutic alliance is how you set homework up with people. The fact that you are seeking, as I call it, their wisdom, and for the first time you are treating them like the expert in their life, and to be true to that. They might have been discounting what they have to offer. So just the actual process of asking a person, how it helps, how it would look, and even the problem-solving component, what obstacles could get in the way. All of these things are modelling, ideas of self-efficacy, problem solving, and self-respect. I like the idea of just even discussing homework that can be therapeutic, if you discuss it collaboratively.

Tom Borkovec

One of the ways I think about this problem relates to potential measurement challenges we have here. Are we measuring behaviours — including the notion of a cognitive shift in perspective as a behaviour? Are we targeting those things in terms of the mechanisms that need to be targeted — in our homework assignments, so that we can assess them? And how are we going to assess them?

In GAD, it is kind of constant flow, moment to moment of shifts through anxiety, tension, creating a variety of reactions to the environment throughout the day. I am not talking about problems like a specific phobia where both therapist and client highly operationally define homework assignments. Talking about the flow of process reminds me of the discussion in a NIMH workgroup a couple of years ago aimed at promoting meditational analysis in research in order to facilitate our identification of mechanisms within psychotherapy. One of the points I made at that conference was that we need to establish the ideal, so that we know how close we can come to that and in that way judge the validity and reliability of our attempt to assessing. The ideal is that you need to be measuring the client's cognitive, affective, and behavioural states every second of every hour of every day, in session and between each session. That obviously we cannot do in 2009. Maybe 3009 they will have figured out how to do that.

But let's keep this ideal in mind in terms of homework assignments. What does that mean? For my clients it means for every moment learning to pay attention, monitor, and objectively observe what's going on in here, what's going on out there, how are they affecting each other in walking through choices and the discriminative stimuli that tell me, 'Oh, I experienced some imagery with my therapist, and I can deploy that coping response, and I will have some good consequences from using that in order to reduce my anxiety'. That is really what the ideal is in homework assignments. From that perspective, doing things that are adaptive for me between sessions does relate to my getting better, and not doing things differently that I learned in therapy sessions, that I haven't been doing, is not going to make lasting change. This is the ideal, and then we can more greatly approximate this ideal with the various pathologies in how to do that and how to target the specific critical instances while continuously measuring those.

Future technology is going to help us out here with frequent sampling of a client to generate data about what they are actually doing, moment to moment, at least in critical situations.

Concluding Comments

It has been a wonderful learning experience to participate in the panel discussion (and this article) on the issue of therapeutic homework. When we first considered the idea of the panel we mainly had questions. In reaching the conclusion, the expert panel has offered some interesting ideas in response, some prompts for reflection regarding our clinical practice, as well as some suggestions for future work. Arnoud, Emily, Tom, and Tracey are thanked for generously contributing their time and expertise. Needless to say, the article would not exist without their ideas and participation, and it has been valuable to have their ideas on using homework assignments presented here.

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