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The Development of the Beth Israel Adherence Scale

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A Dissertation
Presented to the Faculty
of
The Gordon F. Derner
Institute of Advanced Psychological Studies
Adelphi University
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In Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

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ABSTRACT

Ensuring that a therapeutic treatment is being administered as designed is an important issue in psychotherapy outcome studies. Adherence measures which assess the degree and frequency with which the therapist intervenes in specific ways represent one way of operationalizing fidelity to a psychotherapy protocol. Although the literature reflects that common factors in therapy play a significant role in positive outcome, the value of refining the measurement of discrete approaches is important given the differential utility of specific theoretically-driven techniques for particular populations. The development of the Beth Israel Adherence Scale, a 52-item, observer-rated, Likert-type scale, is part of an NIMH-funded study at Beth Israel Hospital in New York City which aims to assess the efficacy of three treatments: cognitive-behavioral, brief-dynamic and interpersonal-experiential, for patients prone to ruptures in the therapeutic alliance. The scale is comprised of three subscales which reflect these three treatment modalities. A rating manual was also developed. Ninety, five minute segments, thirty from each modality, were randomly selected from the beginning, middle and end of sessions. In this paper, psychometric properties of the scale, specifically interrater reliability, internal consistency and discriminant validity, were tested. A moderate degree of reliability was established for the scale overall. Internal consistency for each
subscale was quite strong. The treatments were found to discriminate with all probabilities \( \leq .001 \). Future efforts might focus on methodological improvements and the development of a competence measure.
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CHAPTER 1
Introduction

As psychotherapy outcome research continues, isolating the role of the therapist's in-session behavior has emerged as a critical focus of study (Vallis, Shaw, and Dobson 1986). The goal of psychotherapy research is to understand alternative forms of treatment, the mechanisms by which these treatments operate and the impact of treatment on functioning (Bergin & Garfield, 1994). A pivotal issue in designing treatment outcome studies is ensuring that the treatment is administered as designed. Treatment manuals, competence monitoring and adherence scales have become instrumental in this assessment of explicit, specific therapist conduct. Evaluating therapist conduct with rigorous attention to defining discrete interventions is similar to operationalizing criteria for diagnosing mental disorders, a development which has facilitated sound research in psychiatric epidemiology (Rounsaville, O'Malley, Foley, and Weissman 1988). The breakdown in treatment integrity is considered one of the greatest dangers in outcome research (Bergin & Garfield, 1994). The subject of this dissertation, the development of the Beth Israel Adherence Scale, is part of an effort to articulate and more closely measure the comparative efficacy of three treatments, Brief-Dynamic, Cognitive-Behavioral and Interpersonal-Experiential, in an outcome study conducted at Beth Israel Hospital in New York City.
Definition of Terms

Treatment fidelity is an umbrella term which encompasses competence, adherence and the development and use of therapy-specific manuals. Fidelity, in general, is the confirmation that the independent variable, the therapist's behavior, was manipulated as planned. Two subcategories of fidelity are competence and adherence. Competence refers to the adequacy or skill with which the therapist applies the procedures relative to some critical external standard (Shaw & Dobson, 1988). Adherence refers to the degree and frequency with which the therapist intervenes in specific ways, as prescribed by the protocol. Adherence measures may also distinguish one type of therapy from another by assessing discriminant validity, the degree to which the scale distinctly reflects a single therapeutic approach. The meaning of adherence as separate from competence was put forth by Shaw and Dobson (1988):

purity, integrity and adherence measures are related but are not the same as competency measures. The former group evaluates the quantity of the intended therapy (i.e. "Does the therapist do the things he or she is supposed to do?") but not the quality with which they are performed" (p.666).

Adherence measures, in addition to clarifying the independent variable, may also predict positive outcome. Dobson and Shaw (1988) cite a study (Luborsky, Woody, McLellan, O'Brien & Rosenzweig, 1982) of methadone-maintained opioid addicts in which therapists
performed either cognitive therapy or supportive-expressive therapy. The study concluded that the degree of adherence to manuals was related to better patient outcome. Although the findings were significant in this study, we cannot ignore the possibility that more rigorous adherence to manual guidelines is simply one of the features that reflect inherently better therapists.

Treatment-specific manuals are another component of fidelity and have thus become a central part of most outcome studies. The main function of manuals is to facilitate greater conformity to the essential techniques of the intended treatment (Luborsky et al., 1982). Manuals specify the strategic and technical guidelines for the therapist intervention in the conduct of therapy and have been developed for many types of treatment in the past twenty years (Dobson and Shaw, 1988). According to Svartberg (1989), among the approaches that have created manuals to help achieve fidelity are various behavior therapies (McLean, 1978; Rehm & Kornbluth, 1978; Willis et al., 1987; Wolpe, 1969), cognitive therapy for depression (Beck and Rush, 1979), interpersonal psychotherapy for depression (Klerman and Neu, 1976; Klerman, Rounsaville, Chevron, Neu & Weissman, 1979), supportive-expressive psychoanalytically-oriented treatment (Luborsky, 1976, 1984) and two of the major short-term dynamic approaches: time-limited dynamic psychotherapy (Butler 1987, Strupp & Binder, 1982) and the Davanloo approach (Winston,
Flegenheimer, Pollack, Laikin, Kestenbaum, & McCullough, 1987). Lambert and Ogles (1988) identified ten different manuals describing various behavioral, cognitive and psychodynamic approaches to treating outpatients. Recently, the number of manuals has grown to include humanistic approaches as well (e.g. Gestalt experimental therapy, Greenberg & Goldman, 1988; focused expressive therapy, Daldrup, Beutler, Engle & Greenberg, 1988). In theory, manuals have made the execution of specific therapies purer; techniques that constitute a given therapy are delivered with more consistency and techniques that are specific to other treatments are avoided (Waltz, Addis, Koerner & Jacobson, 1993). Manuals may also be valuable in the reevaluation of outcome results. An example which illustrates the use of the manual in evaluating outcome results is the analysis of a study by Snyder and his colleagues (1991; Snyder & Wills, 1989) that compared behavioral marital therapy and insight-oriented therapy for the treatment of marital discord. No differences were found at post-treatment and at six-month follow-up on several marital adjustment scales. At a four-year follow-up, a significantly greater percentage of couples in the behavior condition had been divorced. Examination of the treatment manuals for each intervention raised questions about the extent to which the treatments being administered were representative of each treatment. Specifically, Jacobson (1991) noted that the insight-oriented treatment resembled behavioral
marital training used in contemporary research and practice more than the behavioral treatment in the study.

**History of Fidelity**

Interest in treatment fidelity emerged briefly in the early 1950's with challenges regarding psychotherapy effectiveness. But it was not until the early 1970's, in an attempt to bolster the validity of outcome studies, that the collection of in-session data was introduced. Despite a heightened awareness of fidelity issues in the 1970's, most studies continued to ignore empirical assessments of fidelity. In a review by Billingsley, White and Munson (1980) of 108 studies in the Journal of Applied Behavioral Analysis (JABA) (1977-78) only 5.6% of the studies assessed treatment implementation while 83% of the same studies reported reliability of outcome measures (Rounsaville et al., 1988). In another review of treatment fidelity, it was found that consideration of treatment integrity in outcome studies had not improved from 1968-1979 (Rounsaville et al., 1988). Finally, in a more recent review of 359 treatment studies from eight major professional journals publishing outcome research in the 1980's, 55% ignored the issue of treatment fidelity (Rounsaville et al., 1988).

**Relevance of Fidelity and Applications in Research**

Treatment fidelity is relevant in all outcome research (Bergin & Garfield, 1994). In studies in which no statistically significant
differences are found between treatments it is postulated that there is an "unintended diffusion of treatments, that is, an overlap in conditions that were intended to be delivered to the separate groups" (Bergin & Garfield, p.38). In these studies, treatment fidelity serves the purpose of clarifying, standardizing and discriminating therapeutic modalities. Even when statistically significant differences are found between treatments, it is important to carefully assess integrity because the possibility exists that, for example, if one treatment is complex or new to the therapists, it is more vulnerable to being administered with variability and departure from the manual. Thus, the differences found between treatments may not in fact be attributable to distinct features of one therapy but may instead be a function of the degree of comfort with which the therapist delivered the treatment.

Treatment can depart from the intended procedures in many ways. A dramatic example of integrity being sacrificed is illustrated in a study in which none of the intended treatment sessions was actually held with the clients (Sechrest, White & Brown, 1979). A number of outcome studies have shown no difference between treatment conditions when individual interventions were not administered as intended, e.g. patients in one condition received interventions from another condition or patients in a control condition received interventions they were not supposed to receive
(Feldman, Caplinger & Wodaski, 1983; Liberman & Eckman, 1981). One reason cited for the inability to find differences between treatments is the curative role of common factors (e.g. empathy, positive regard, therapeutic alliance) which treatments may share (Stiles et al, 1986). Large variation in how individual treatments are carried out across patients within a given condition and failure to implement critical portions of treatments may also lead to no differences between two or more treatment conditions. Identifying the role of lapses in treatment integrity in accounting for results in many studies is difficult because the assessment of treatment integrity in psychotherapy research is the exception rather than the rule (Kazdin in Bergin & Garfield, 1994).

While research which aims to discriminate therapies and assess differential outcome continues, other studies, given the purported curative effects of common factors, have looked at the transtheoretical therapist behaviors that significantly contribute to outcome. The research base is substantial for the conclusion that what therapies share constitutes what is therapeutic in many cases. Murphy, Cramer and Lillie (1984) asked patients to generate a list of factors they thought were therapeutic in a cognitive-behavioral therapy protocol. Those factors suggested by a significant portion of patients were advice (79%), talking to someone interested in [their] problems (75%) encouragement and reassurance (67%), talking to someone who understands [them] (58%),
and "installation" of hope (58%). Other studies suggest that personal qualities of the therapist, which are similar across certain treatments, such as sensitivity, gentleness and honesty, were also factors patients attributed to positive treatment outcome (Lazarus, 1971). Bergin and Garfield (1994) cite "unlearning" old response patterns, a caring relationship and cathartic release of affect as factors in therapy efficacy which are representative of different traditional schools of therapy but not necessarily unique to these orientations. According to a review of the literature by Bergin and Garfield (1994) one way to read the sum of outcome studies is to conclude that common ingredients are a combination of affective experiencing, cognitive mastery and behavioral regulation.

Although there is much evidence to support the role of common factors in therapeutic effectiveness, the issue of differential contributions to outcome has not yet been decisively dismissed. Specific techniques may contribute to positive outcome and the nature of the patient population may play an important role in understanding the efficacy of these unique approaches (Fairburn, Kirk, O’Connor & Cooper, 1986). The rationale for the development of an adherence scale as part of a study comparing three different treatments given the evidence for the therapeutic value of common factors will be elaborated in the description of the Beth Israel Hospital projects.
Summary of Literature Review

Emphasis on more rigorous methodology in comparative treatment efficacy studies now requires empirical demonstration of the integrity and discriminability of treatments being compared (Carroll, Nich & Rounsaville 1994). Isolating, defining and measuring the independent variable, therapist behavior, has thus become a central part of psychotherapy outcome research. Adherence measures, one type of fidelity gage, specifically reflect the degree and frequency with which the therapist is delivering a particular treatment. Although the practice of assessing fidelity emerged in the 1950’s many comparative outcome studies continue to fail to assess integrity. This failure contributes to an inability to draw meaningful conclusions from comparative outcome studies. Although the literature reflects that common factors in therapy play a significant role in positive outcome, the value of refining the measurement of discrete approaches is important given the differential utility of specific theoretically-driven techniques for specific patient populations.

Context for Study: The NIMH Beth Israel Project

To date, psychotherapy research has shown that while cognitive and psychodynamic therapies are equally effective treatments, approximately 30% of the patients fail to benefit from either treatment (Bergin & Garfield, 1994). The research literature has also demonstrated that the nature and quality of the therapeutic
relationship is the best predictor of outcome, regardless of treatment orientation (Hartley, 1985; Horvath & Symonds, 1991) and that treatment failures are characterized by a pattern of negative interactions between patient and therapist (Henry, Schacht & Strupp, 1986, 1990). The Beth Israel Brief Psychotherapy Research Program, conducted at Beth Israel Medical Center in New York City, is currently undertaking an NIMH-funded pilot project designed to target potential treatment failures by evaluating the quality and nature of the therapeutic relationship in short-term cognitive and psychodynamic treatments for personality disorders and to investigate the efficacy of a new treatment specifically designed to work with ruptures in the therapeutic alliance. The experimental treatment is interpersonal-experiential therapy which is reflected in the IET subscale of the Beth Israel Adherence scale. The development of the Beth Israel Adherence Scale, and the establishment of its psychometric properties, are a component of this grant and the subject of this dissertation.

Patients for the Beth Israel study are selected from those undergoing short-term, brief-dynamic therapy (BAP) or cognitive-behavioral treatment (CBT) for personality disorders in the Beth Israel Brief Psychotherapy Research Project. Those determined to be potential treatment failures early in treatment will be offered the option of being randomly reassigned to one of two alternative treatments: (a) interpersonal-experiential therapy
(IET) or (b) the treatment that they currently are not in (i.e., CBT or BAP). The rationale is based on the assumption that targeting potential treatment failures as such will increase the precision in matching patient to treatment and thus the power of the design. The hypothesis is that patients selected on the basis of this in-session performance variable (failure to establish a good therapeutic alliance) will benefit more from a treatment designed specifically to work with problems of this nature.

Treatment failures, as measured after the 10th session determined from patient and therapist versions of Post Session Questionnaires (PSQ), are cases evidencing problems in the therapeutic relationship or poor therapeutic alliance. The PSQ includes a 16-item version of the Interpersonal Adjective Scale IAS: Wiggins et al., 1988; IAS-16: Muran et al., 1991), a 12-item version of the Working Alliance Inventory (WAI: Horvath & Greenberg, 1989; WAI-12: Tracey & Kokotovic, 1989), and Session Evaluation Questionnaire (SEQ: Stiles 1980). It also includes two items scaled in a Likert-type format relating to session helpfulness and general problem resolution. Variations of these two items have been used in previous studies and have proved to be quite sensitive as measures of suboutcome (e.g. Muran & Safran, 1990; Safran et al., 1987; Wexler & Elliott, 1988). Finally, the Post-Session Questionnaire includes five questions regarding the presence of any problem in the therapeutic relationship, the
location of the problem in the session, the severity of the problem, the degree to which the problem was resolved by session's end, and a brief open-ended description of the problem.

The theoretical and methodological premises of the study are based on the growing evidence which reflects the importance of the nature of interpersonal transactions and the quality of the alliance in outcome. The primary goal of the study is to evaluate the hypothesis that patients reassigned to interpersonal-experiential therapy will show greater improvement than those reassigned to the other treatments. Other goals include developing a treatment manual and adherence scale for interpersonal-experiential therapy as well as extending preliminary findings regarding the validity of a model representing the processes involved in resolving problems in the therapeutic relationship.

A description of the features which distinguish interpersonal-experiential therapy from other forms of treatment, specifically short-term dynamic and cognitive behavioral, will explain the rationale for the Beth Israel project and contribute to an understanding of the development of the scale. Interpersonal-experiential therapy integrates interpersonal, experiential and cognitive traditions. This orientation involves using the therapeutic relationship to explore and challenge dysfunctional interpersonal schemas. Dysfunctional interpersonal schemas are the redundant interpersonal patterns that often characterize an
individual’s experience. Sullivan refers to them as "me-you patterns". Interpersonal theory postulates that maladaptive behavior persists over lengthy periods because it is based on perceptions, expectations or constructions of the characteristics of other people that tend to be confirmed by the interpersonal consequences of the behavior emitted (Safran and Segal, 1990). An example of a dysfunctional interpersonal schema is anticipation of hostility, interpretation of neutral behavior as hostile and consequent eliciting of hostility from others (Safran & Segal, 1990 p.73). Such schemas result in the enactment of vicious cognitive-interpersonal cycles which invariably lead to problems in the therapeutic alliance. Through metacommunication, the process of the therapist conveying his/her own feelings to help the patient become aware of his/her impact on others and to begin the process of affective exploration, these ruptures can be resolved. (See Gill, 1982; Greenberg & Safran, 1987; Kiesler, 1988; Safran & Segal 1990, for theoretical and empirical justification of the above IET features in the treatment of alliance problems.)

Interpersonal-experiential therapy differs most critically from the control conditions in a number of respects. First, the primary intervention involves phenomological exploration, rather than interpretation or disputation. Second, a sharp focus is maintained on a systematic exploration of the particularities of the therapeutic interaction in the here and now (in the room
between therapist and client) rather than on the elucidation of more generalizable themes. Any attempt to link the therapeutic interaction to other interpersonal situations occurs only after the interaction has been thoroughly explored in depth, which involves therapist acknowledgement of his/her own contribution and patient tangible recognition of his/her own internal experience during the interaction. Links to other interpersonal situations are often made spontaneously by the patient. Third, the process in IET tends to be more affectively immediate than the process in the two other treatments as the focus of most of the interventions is uncovering the interpersonal experience as it unfolds in the room between client and therapist. Of course, there is an implicit focus and may even be explicit interventions in the other treatments which have the aim of uncovering the in-the-moment experience between therapist and client. For example, a BAP therapist may explore transference. The important difference, particularly for the purpose of comparative outcome studies using manuals and adherence measures with a limited number of interventions, is that in IET the experiential process between therapist and client forms the building block of the treatment and thus there are, relative to the other treatments, fewer interventions which do not have this as a central focus.

Theory Informing the Subscales

A brief description of the theory which informs items in each
subscale will provide a basis for understanding the construction, specifically item selection, of the scale and the differences between each subscale.

The interpersonal-experiential therapy (IET) subscale is comprised of 21 items which were derived from a number of sources (Safran & Segal, 1990; Greenberg & Goldman, 1988). Items were also developed by this author and the raters for the project. Cognitive-behavioral, interpersonal, gestalt and experiential traditions have contributed to the formulation of interpersonal-experiential theory (Safran & Segal, 1990). Carl Rogers' client-centered focus on unconditional positive regard and the notion of indwelling in the patient's world have also informed the development of this tradition. Phenomenological, “here and now” interventions, which attempt to modify cognitive processes in an emotionally immediate way, constitute a central working focus. Interpersonal-experiential therapy “emphasizes maintaining a therapeutic focus by paying careful attention to what is alive for patients” (Safran & Segal, 1990, p.240).

Further, IET is informed by interpersonal and emotion theories. Change is conceptualized as the expansion of self. General principles of technique include mindfulness and metacommunication. Tracking the process between client and therapist is a central activity of the therapist. The therapeutic relationship is considered a laboratory where the client is the
arbiter of meaning. (See Appendix A for scale).

The short-term dynamic psychotherapy (BAP) subscale is comprised of 14 items which were derived from a number of short-term dynamic approaches (e.g., Luborsky, 1984; Strupp & Binder, 1984). A treatment manual and adherence scale (Pollack, Flegeneheimer, Kaufman & Sadow, 1990) have been developed for this approach. The short-term dynamic orientation involves the early identification of a maladaptive pattern and the use of the transference relationship to link the pattern to its genetic origins. The treatment process involves uncovering the general maladaptive pattern, working through, resolution and termination. The therapeutic relationship is understood in terms of transference. The therapist is, implicitly, the arbiter of meaning through his use of interpretation.

The principles of psychodynamically-oriented psychotherapy, which inform this short-term method, reflect a focus on warded-off impulses, transference, resistance and interpretation. As an exhaustive review is not useful in this context, Greenson’s (1967) conceptualizations of the fundamentals of this tradition will provide a brief sketch of the general practices of the therapist in the brief-dynamic treatment modality.

Although the psychodynamically-oriented tradition has evolved considerably in the past fifty years by integrating various philosophies from object relations to self-psychology, specific
characteristics continue to distinguish psychodynamically oriented therapy. According to Greenson (1967), a major component of the psychoanalytic tradition, from which psychodynamic therapy has emerged, is the giving of insight by means of interpretation. Moreover, the rule of abstinence, as originally articulated by Freud, continues to be a guiding principle in the psychodynamic tradition. Although different therapists in this tradition practice varying degrees of abstinence, and their use of neutrality has been tempered by different traditions such as ego, self and interpersonal theory, abstinence rather than self-disclosure continues to be a central working notion.

The cognitive behavioral therapy (CBT) subscale is comprised of 17 items, all of which were derived from both Beck and his colleagues' work (Beck & Emery, 1985; Beck et al., 1979; Beck & Freeman, 1990; Young, 1990) and from the 96-item Collaborative Study Psychotherapy Rating Scale. This scale was developed for the Treatment of Depression Collaborative Research Program (Hollon, Waskow, Evans & Lowery 1984). A treatment manual and adherence scale (Turner & Muran, 1991) have been developed for this approach. [Note: the CBT subscale does not contain all the items that comprise the Collaborative Study Psychotherapy Rating Scale.] The CBT subscale reflects central theoretical and treatment ideas of the cognitive behavioral tradition. The theory of personality is based on schema theory. Treatment involves assessing automatic
thoughts and disputing dysfunctional attitudes. These thoughts and attitudes reflect maladaptive self-schemas which underlie distorted cognitive processing. The treatment process includes establishing a problem list, conducting a functional analysis, cognitive and behavioral strategies for change and termination, which, if successfully accomplished, implies generalization. The therapeutic relationship is understood as a collaborative, empirical endeavor. The metaphor of therapist as scientist captures his/her role as a partner in the objective examination of the client’s thoughts, feelings and behaviors.

The cognitive-behavioral tradition, as articulated by Beck, hypothesizes that the patient’s change in his/her automatic thoughts is crucial to his/her behavioral and emotional change (Safran & Segal, 1990). In this treatment, the therapist’s energies are focused on cognitive phenomena. As described by Beck, Rush, et al., 1979), "a good working relationship is conceptualized as necessary but not sufficient for effective cognitive therapy". Emotion is regarded as a postcognitive phenomenon (Safran & Segal, 1990). Dobson & Shaw (1988, p. 674) summarize some specific therapist activities in this method:

The application of cognitive therapy typically moves from focus on behavioral activation to a focus on the relatively specific automatic thoughts that are involved in negative affect and behavior to a final focus on the more general dispositional attitudes, beliefs, and self-conceptualizations that underly the individual’s propensity toward disturbance (Beck et al., 1979).
Each subscale does not have the same number of items. As the IET is the most experimental treatment, the scale has the largest number of items to increase the likelihood of including relevant items which reflect the construct. Subsequent to statistical analyses which will provide data concerning internal consistency of each subscale, scales will be modified.

Statement of the Problem

To date, there is not an adherence scale which measures the interpersonal-experiential treatment as put forth by Safran and Segal. Goldman and Greenberg, (1981) made initial strides towards establishing reliability and validity for a scale reflecting Experiential Therapy. This scale shares some items with the IET subscale of the Beth Israel scale, however, the IET subscale has many items which are not captured in the Experiential Therapy scale. The Beth Israel Adherence scale, containing three subscales, will thus provide a necessary instrument in comparative psychotherapy research, currently the NIMH study at Beth Israel Hospital, which aims to assess the relative efficacy of IET.

Hypotheses

1) Inter-rater reliability will begin to be established, as measured by Intraclass Correlation Coefficients, for each subscale: Interpersonal-Experiential, Short-term Dynamic and Cognitive Behavioral. 2) Internal consistency will be established for the scale as measured by Cronbach’s Alpha. 3) Discriminant Validity
will begin to be established such that the three subscales reflect distinctly different modalities. This will be assessed by conducting a One-Way Analysis of Variance (ANOVA).

The Beth Israel Adherence Scale is a 52-item, observer-rated, 6-point, Likert-type scale. Items, comprising three subscales, reflect therapist interventions drawn from interpersonal-experiential, short-term dynamic and cognitive behavioral treatment modalities. An accompanying manual (Appendix B) is used by raters to explicate and provide examples of items (therapist interventions).
CHAPTER 2
METHODS

Transcripts

Ninety five-minute segments, 30 from each modality, were randomly selected from the beginning (sessions 1-5), middle (sessions 6-10) and end (sessions 11-15) of therapy. A total of 18 sessions were rated, 6 from each modality. The sample was comprised of nine patients, three from each modality (two sessions of each patient) and three therapists.

Transcripts reflecting IET were taken from a study conducted by Safran at the Clarke Institute, Toronto. Short-term dynamic therapy (BAP) transcripts were derived from ongoing psychotherapy research studies at Beth Israel Hospital in New York City. These transcripts were used to develop a manual of Brief Adaptive Therapy (Pollack et al., 1990). CBT transcripts were taken from a transcript library of the Minnesota Cognitive Therapy Study by Steve Hollon. These transcripts were also used to formulate a manual for Cognitive Behavioral treatment (Turner & Muran, 1991). Researchers involved in comparative outcome studies looking at these orientations chose segments they deemed representative of each modality. The fact that the CBT and BAP tapes were derived from protocols which were manualized provides a reasonable level of
substantiation that the sessions are representative; the existence of a manual contributes to the respective construct validity of each modality. A formal manual had not yet been developed for the IET treatment at the time of transcript selection. However, the participation of an author of IET, Jeremy Safran, in the selection of the transcripts provides a reasonable level of certainty that they are representative of this modality. Greenberg and Goldman (1988) also use the method of transcript selection described here, in which researcher/clinicians in a particular modality choose representative segments of transcript.

Raters

Three raters were trained in all three therapy modalities and rated the same 90 segments. Two of the three raters were advanced graduate students in clinical psychology and the third had achieved a masters level in developmental psychology. Raters were not informed of the purpose of the study, the nature of the hypotheses or the numbers and types of therapies represented.

Training

The raters were initially trained over a three-month period during which time they met weekly for five hours. A manual explicating each item and providing examples of items, was a central tool of the training. The manual is also an important part of the reliability effort as it contributes to standardization of
the conditions under which raters are training with and using the scale. Raters used the manual to learn the scale items initially and to rate each transcript segment. Homework, in the form of practice transcripts to be rated, was given each week and reviewed the next. In-training exercises included raters role-playing therapist/client dyads to experientially grasp the subtle distinctions between items. Didactic instruction, including the use of video tapes, also provided raters with operationalized definitions of items.

Rater drift was assessed midway through (45 segments) the rating period. Four re-calibration sessions were held over the rating period to prevent rater drift by reviewing specific anchors for items and to clarifying nuances of meaning.

**Scale Development**

**Rating Criteria**

Raters were instructed to consider therapist intervention, any comment, question or remark made by the therapist, in each five-minute segment on two dimensions: frequency and intensity. Both dimensions, frequency and intensity, were considered because adherence requires that the treatment be carried out "as intended" (Bergin & Garfield, 1994), and refers to "quantity" (Shaw & Dobson, 1988). Intensity and frequency were deemed two important dimensions of quantity. An intervention which was considered high
on intensity was a behavior that was an extremely good example of that item. An intervention which was considered high on frequency was one that occurred often in that five-minute segment. One rating on the 6-point scale was then chosen which reflected the rater's individual assessment of how these two dimensions were to be collapsed into one score. Through calibration efforts which included raters' sharing their formula for combining frequency and intensity to arrive at one number, raters generated anchors for each item on the scale. Raters rated each five-minute segment on all three scales using a combination of trained, subjective intuition and this formula to rate each segment.

The rating process consisted of a series of decisions. First, the rater read the five-minute segment noting, in the margin of the transcript, the number of each item on each subscale which occurred in that segment. To calculate frequency for that segment, the rater counted the number of times each intervention appeared in the margin. Anchors were established for frequency through establishing consensus among raters about what constituted "frequent" for a particular item. This number, frequency, was the first half of the calculation.

The rater then read the segment again and assessed the intensity of each intervention that had already been noted. Anchors were established throughout training for intensity. Raters
assessed each therapist intervention by evaluating the extent to which it was a good example of that item. Specifically: 1=not at all, meaning the item never explicitly occurred, 2=a little, meaning the item occurred at least once (and may have occurred a few times) and was not an in-depth or particularly good example of the item, 3=somewhat, meaning the item occurred several times and was a moderately in-depth or fairly good example of the item, 4=moderately, meaning the item occurred with relative high frequency and was a moderately in-depth or good example of the item, 5=considerably, meaning the item occurred with high frequency and was very in-depth or a very good example of the item, 6=extensively, meaning the item occurred with great frequency and was extremely in-depth or a prime example of this item.

Rationale for Criteria

A checklist which requires that the rater assess whether or not the intervention occurred or did not occur is the most time-efficient, simple means of gauging adherence (Jacobsen, 1994). For example, a checklist of techniques which reflects each of the three therapy modalities may have been generated. The raters' task would then be to note the occurrence/non-occurrence of these interventions in each segment of transcript.

Rating the frequency and intensity on a continuous scale, the method chosen for this project, is a more detailed adherence check.
One can gather from this method not only whether the intervention was made but the differential frequency/intensity of items in each orientation thereby increasing the likelihood of identifying items which most reflect a specific orientation. This method, in addition to establishing occurrence/non-occurrence of intervention, provides information which allows for a greater degree of refinement of the scale. With a continuous scale, items that are identified with the greatest frequency/intensity will be identified in the higher range, 5 and 6, on the scale and those that are identified with moderate frequency/intensity will be rated 3 or 4 on the scale. In refining the scale after only gaging occurrence/non-occurrence, one might eliminate items which are identified in the mid-range on the continuous scale thus overlooking relevant items.

It was important to include frequency and intensity as components of the definition of adherence as certain items were more suitably rated by one or the other, and others were rated according to both. For example, the CBT item "Assigns Homework", might be rated only on frequency as the construct does not vary dramatically in intensity. Another example of an item which would, most of the time, be rated for frequency is the IET item "Deepens awareness through assigning out-of-session awareness exercise." However, the IET item "Emphasizes the subjectivity of his own perceptions" is an example of an item that would be rated on both
frequency and intensity because the extensiveness with which it is rendered varies. An example of this item which would receive a low rating on intensity is T: "I’m thinking that you’ve brought things out in the open like you’ve never done before." An example of this item which would receive a high rating on intensity or extensiveness is T: "If I am understanding you, I guess in my own mind, you’ve brought things out in the open like you’ve never done before."

Assessing intensity does not require that the rater make inferences about the therapist’s level of skill or competence. Competence refers to delivery of treatment as intended but with special skill. This implies the quality of delivery (Hill, O’Grady, & Elkin, 1992). The construct of competence has been collapsed with that of adherence (e.g. CSPRS: Hollon, Evans, Elkin & Lowery). Adherence scales have also been developed without considering adherence as a separate construct from competence (Luborsky et al., 1982). The goal of this study is the development of an adherence scale. The development of competence ratings will be included in future efforts to refine the instrument.

Item Development

In addition to the pre-existing scales from which items were drawn, psychotherapy transcripts and videotapes were viewed by this author to generate and more clearly operationalize items. Items
refined throughout training by the raters. During training, in order to facilitate item clarification, raters only rated transcripts of one modality at a time. They would then share impressions of the "fit" between the scale item and the phenomena as read in the transcript. Items that were difficult to operationalize, such as the IET item "therapist intervenes with a present and immediate quality", would be substantiated in video or transcript segments to ascertain that the item as described was observable and not simply theoretically driven. Early ratings were matched against expert ratings to anchor items. Anchoring continued throughout the training process as part of the reliability effort.
CHAPTER 3
RESULTS

Hypothesis 1

Hypothesis 1 states that inter-rater reliability will begin to be established as measured by Intraclass Correlation Coefficients, for all 52 items of the scale. Interrater reliabilities were determined through intraclass correlation coefficients for random effects (Shrout & Fleiss, 1979). These correlations reflect the extent to which three raters agree on items across 90 segments. Assessing ICCs by item is one approach to calculating rater agreement (Caroll, Nich & Rounsaville, 1995).

By-item ICCs ranged from .07 to .89. Most values were between .56 and .88. ICCs were also calculated by subscale. The coefficient for the scale overall was .63. The by-item ICCs for each subscale, the mean of all item ICCs in a particular subscale, were .55, .64 and .79 for the IET, BAP and CBT subscales respectively (see Table 1). After items with ICCs of < .65 were eliminated, the coefficient for the scale overall was .80. The by-item ICCs for each subscale were .78, .79 and .83 for IET, BAP and CBT subscales respectively. See Table 2 for by-item ICCs.

The items which remained after items with ICCs < .65 were eliminated were:
Table 1

By-item ICCs for Scale Overall and for Subscales

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>IET</th>
<th>BAP</th>
<th>CBT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>.63</td>
<td>.55</td>
<td>.64</td>
<td>.79</td>
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Table 2

By-item ICCs

<table>
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<th>Item</th>
<th>Intraclass Correlation Coefficient</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>.70</td>
</tr>
<tr>
<td>2</td>
<td>.66</td>
</tr>
<tr>
<td>3</td>
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<td>.63</td>
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<td>37</td>
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<td>38</td>
<td>.88</td>
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Table 2 continued

<table>
<thead>
<tr>
<th>Item</th>
<th>ICC</th>
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<tr>
<td>39</td>
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<td>43</td>
<td>.90</td>
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<td>.88</td>
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<td>.78</td>
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<td>.78</td>
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<td>47</td>
<td>.55</td>
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<td>51</td>
<td>.87</td>
</tr>
<tr>
<td>52</td>
<td>.58</td>
</tr>
</tbody>
</table>
Interpersonal-Experiential Subscale

1. Tracks client's experience in a moment-to-moment fashion.
2. Explicitly gauges client's willingness to proceed further with task.
3. Intervenes with a present and immediate quality.
10. Metacommunicates by conveying own feelings to help the client become aware of his/her impact on others and role in the interaction.
15. Deepens awareness through awareness experiment in session.

Brief-Adaptive Psychotherapy Subscale

23. Interprets client's defenses.
28. Interprets by linking components of a conflict.
29. Interprets by linking parental figures to significant others.
30. Interprets by linking significant others to therapist.
31. Interprets by linking parental figures to the therapist.
35. Confronts client, suggesting he/she is saying, feeling or thinking something different than what the client claims.

Cognitive-Behavioral Therapy Subscale

37. Probes for client's beliefs, personal meaning, behind client's thoughts.
38. Helps client identify cognitive distortions, errors that were present in his/her thinking.
39. Explores with the client the general belief, or underlying
assumptions, which underly negative thoughts/beliefs.
40. Engages in didactic persuasion.
42. Asks client to report specific thoughts.
43. Encourages client to distance him/herself from his/her thoughts, viewing them as beliefs rather than facts.
44. Helps client examine currently available evidence or information to test validity of client’s beliefs.
45. Encourages client to test beliefs prospectively.
46. Facilitates client’s consideration of alternative explanations for events.
50. Assigns and reviews homework.
51. Engages in socratic questioning aimed at guiding client’s reasoning process.

Hypothesis 2

Hypothesis 2 states that internal consistency will be established for the scale as measured by Cronbach’s Alpha. Internal consistency, as reflected in coefficient alphas were determined. The alphas were .94, .94 and .97 for IET, BAP and CBT respectively. These figures are reported in Table 3. These levels of internal consistency are quite strong and provide preliminary support for the internal consistency of each subscale.

Hypothesis 3

Hypothesis 3 states that discriminant validity will begin to be established such that the three subscales reflect distinctly
Table 3
Cronbach’s Alpha by Sub-Scale

<table>
<thead>
<tr>
<th>Sub-Scale</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal-Experiential</td>
<td>.9428</td>
</tr>
<tr>
<td>Brief-Adaptive</td>
<td>.9391</td>
</tr>
<tr>
<td>Cognitive-Behavioral</td>
<td>.9649</td>
</tr>
</tbody>
</table>
different modalities. A One-Way Analysis of Variance (ANOVA) was conducted for each subscale. ANOVAs for each subscale are reported in Tables 4, 5 and 6. All probabilities were ≤ .001 ANOVAs indicate that each subscale is being identified properly; the three subscales reflect distinctly different modalities. For segments which reflected IET, the mean was 2.06, means for BAP and CBT were 1.33 and 1.24 respectively. For segments which reflected BAP, the mean was 2.23, means for IET and CBT were 1.29 and 1.16 respectively. For segments which reflected CBT, the mean was 2.69, means for the IET and BAP were 1.11 and 1.76 respectively. One-Way ANOVAs with an orthogonal contrast were also conducted and significant p values of < .001 were found. Student Newman-Keuls tests were conducted and significance levels of < .05 were found. Results indicate that therapists exhibited more behaviors appropriate to their own respective treatment than to other treatments. Treatments were deemed distinct. Figure 1, a bar graph, illustrates discriminant validity by comparing mean ratings within each treatment type rated. As validation is a matter of degree, it is an unending process; thus we may posit that a measure of validity has been established for each subscale. As BAP and CBT contain items which are common to scales that have a greater measure of validity established (Luborsky, 1984; Strupp & Binder, 1984; Turner & Muran, 1991), establishing initial validity for the IET subscale was a particular focus of the study.
Table 4

One-Way ANOVA for Interpersonal-Experiential Subscale

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>DF</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>2</td>
<td>6.25</td>
<td>55.40*</td>
</tr>
<tr>
<td>Within Groups</td>
<td>87</td>
<td>.113</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>89</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p<.001
Table 5

One-Way ANOVA for Brief-Adaptive Subscale

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>DF</th>
<th>Mean Squares</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>2</td>
<td>10.03</td>
<td>69.23*</td>
</tr>
<tr>
<td>Within Groups</td>
<td>87</td>
<td>.14</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>89</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p<.001
Table 6

One-Way ANOVA for Cognitive-Behavioral Subscale

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>DF</th>
<th>Mean Square</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>2</td>
<td>23.51</td>
<td>163.22*</td>
</tr>
<tr>
<td>Within Groups</td>
<td>87</td>
<td>.1440</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>89</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p<.001
Figure 1

 Discriminant Validity

[Graph showing mean scale ratings for different treatments: Interpersonal-Experiential, Brief-Adaptive, Cognitive-Behavioral. The graph includes bars representing the mean ratings for each treatment category.]
CHAPTER 4
DISCUSSION

The aim of this project is to begin to establish psychometric properties for the Beth Israel Adherence Scale. Specifically, the goals are to begin to establish interrater reliability, consistency and discriminant validity. The following is a discussion of what the data indicate.

Intraclass correlation coefficients were assessed by item. The wide range of item coefficients (.07 to .89) suggests that there are many items pulling down the mean that require further scrutiny to determine utility. Most item values were between .62 and .88. Interrater reliabilities for the Collaborative Study Psychotherapy Rating Scale (CSPRS, ICC (2,8)), a frequently cited and well-studied measure, ranged from .47 to .88 (Hill, O'Grady and Elkin, 1992). The fact that this is the first attempt at establishing agreement for this scale may contribute to the modest agreement level. As in the CSPRS (Hill et al., 1992), moderate interrater reliability estimates for individual items, overall, highlight the difficulty of the rating task (Carroll et al., 1995). After items with ICCs <.65 were eliminated, the overall by-item scale coefficient was .80, which is modest-strong. Subscale reliabilities of .78, .79 and .83 for IET, BAP and CBT respectively were also...
modest-strong.

Before items are eliminated from the scale their contribution to the alpha should also be assessed. As the goal is to attain the highest alpha possible, if their presence increases or does not affect the alpha, items should be kept, if their presence decreases the alpha, they should be eliminated. A content analysis of items should accompany this effort.

The by-segment IET subscale coefficient of .78 (attained after items with ICCs < .65 were eliminated) shows moderate level of agreement. This level may be modest because of raters' relative unfamiliarity with this treatment. Also, IET items had not been subject to previous tests of reliability like certain BAP and CBT items (Luborsky, 1984; Strupp & Binder, 1984; Hollon, Waskow, Evans and Lowery, 1984). IET items are also more phenomenological than, for example, CBT items, which may contribute to raters' difficulty reliably identifying them.

The agreement coefficient of .79 (attained after items with ICCs < .65 were eliminated) for the BAP subscale may be understood in a number of ways. First, this subscale had the fewest items which may affect agreement adversely. In addition, because raters' training was largely in psychodynamic therapy, in response to raters' questions and gaps in knowledge, a relative emphasis may have been placed on explicating IET and CBT items. Although equal time was initially spent explaining all three modalities and items, BAP may not, ultimately, have received as much training focus. This
was an error as BAP, although grounded in dynamic principles, is a specific type of dynamic treatment with interventions that require attention to these details. A feature of BAP which is more significant in explaining its relatively low agreement, however, is the abstract nature of the modality. Items that comprise both IET and CBT subscales are more phenomenological than those comprising the BAP subscale. For example, interpreting the unconscious aspects of a person's behavior is difficult to specify and operationalize as the unconscious is not a manifest construct. Although the item reflects the therapist's behavior, interpreting the unconscious aspects of a patient's behavior, the extent to which any construct in an item is open to idiosyncratic interpretation reflects the extent to which it will not be reliably identified. In contrast, the CBT item "explores advantages and disadvantages of dysfunctional attitudes", like many items in this modality, refers to relatively defined aspects of manifest behaviors.

The CBT scale has the highest coefficient (.83 after items with ICCs < .65 were eliminated) perhaps, because cognitive behavioral interventions are circumscribed and relatively straightforward to operationalize. These items, therefore, are the least susceptible to idiosyncratic interpretation. Also, most of the items that comprise this subscale were extracted from the Collaborative Study Psychotherapy Rating Scale which has already established a measure of reliability and
validity (Hollon et al., 1984).

The alphas for the three subscales were quite strong. Alphas reported for the CSPRS subscales ranged from .70 to .94 (Hollon et al., 1984). Internal consistency as reflected in coefficient alphas for IET, BAP and CBT suggest the extent to which items "hang together" to reflect a particular construct, in this case a therapy modality.

Discriminant validity, as assessed by One-Way ANOVAs showed that the subscales were distinct from each other. The differences are significant. Larger differences may have been found if the length of segments were extended from 5 minutes to 15 minutes. This would extend the range increasing the likelihood of a modality-specific intervention occurring.

Confounding Factors

An important consideration which impacts all analyses in this study is segment non-independence. Independence in this context refers to the extent to which each segment contains a therapist/patient/session content unit that is distinct from every other therapist/patient/session content unit. Ideally, each segment would be, in this way, independent from each other segment. One way in which the data are non-independent is that there are three therapists and three modalities. Thus, therapist and modality cannot be considered separate variables. This means that we don’t know if raters are identifying three separate therapists or three
separate treatments. To the extent that therapist style which includes speech idiosyncrasies, average number of interventions, tone, is identifiable across segments, it may influence rater agreement. However, the training process, comments documented by raters while rating, and post-rating interviews which suggest that the focus was largely on interventions may counter the potential inflationary effects of therapist/modality non-independence. In addition to the intervention-focused training, in which each item was defined and operationalized, and an intervention-focused rating process, in which raters were asked to rate each segment on the basis of the number of times an intervention occurred, raters made notes on rating sheets which reflected their focus. For example, upon reviewing rating sheets and session segments, it was clear that raters were tallying and analyzing interventions. A rater comment which reflects the spirit of many other rater notes was "unclear whether this intervention reflects BAP or IET". The fact that the focus of all rater tasks was intervention does not eliminate modality/therapist non-independence. It does, however, increase the likelihood that therapist style played a relatively minimal role in the rating process.

Another way in which the segments were non-independent was that segments may share patients. Thus, to some extent, inter-segment consistency as reflected in multiple representations of therapists and patients may exert an inflationary influence on
reliability and validity outcomes. However, the direction of this influence is not known. Because time also affects the level of independence of a segment, meaning, when in the course of the rating a rater comes across a particular segment, segments are never the same events even though they may have consistent elements. So, for example, therapist x and patient y, time 1, meaning the first time the rater rates a segment which shares these two variables, and therapist x and patient y time 2, meaning the second time the rater rates a segment which may share therapist and patient, are not the same event given the influence of time 1 on time 2. Therapist/patient consistency may influence ratings because raters may hypothesize, for example, at therapist x patient y, time 1 that therapist x represents the BAP treatment. When the rater comes across therapist x, patient y in a different segment at time 2, the rating may be influenced by this hypothesis. This hypothesis may be correct, in which case therapist/patient consistency will exert an inflationary effect on outcome. This hypothesis may also be incorrect so that therapist/patient consistency may actually deflate agreement. One cannot apriori specify the direction of the influence that inter-data consistency will have on agreement.

In this study, as reflected in the literature, independence is understood to exist on a continuum. Some segments in this data set are more independent than others. Luborsky et al. (1984) considered
sessions that were randomly chosen but had some contaminating features such as multiple representation of therapists as "largely independent" (p.59). Future efforts to refine the scale should use segments which are more independent on all dimensions, therapist, patient and session.

Segment non-independence is a limitation of this study. This limitation does not diminish the promise which the study demonstrates since the influence of consistency on outcome is unclear. Replication studies, especially given this limitation, are important to generate data that have less serious constraints on generalizability.

Several other factors related to segment non-independence may have contributed to contamination of the data. First, although identifying information such as names and places were deleted from the transcripts, themes discussed in a particular therapy may have remained consistent across segments. Future efforts to refine the scale might minimize the likelihood of rater recognition of similar themes across segments by increasing the sample size, including the number of therapists and patients, to increase the number of independent segments.

The ICC coefficients may also have been influenced by what may be considered extensive rater training. The length of training, 60 hours, was necessary for the initial development of the scale as the task was two-fold: to generate items for, in particular, the
IET subscale and to assess reliability and validity of all subscales. But it is not clear that 60 hours is significantly more training than other raters received in other outcome studies. In an investigation by Hill, O'Grady and Elkin (1992), comparing three treatment modalities which applied the Collaborative Study Psychotherapy Rating scale to rate therapist adherence to cognitive behavior therapy, interpersonal therapy and clinical management raters were trained for 50 hours. In fact, in a study by Hill, O'Grady and Price (1988) investigating sources of rater bias, lengthy rater training was cited as a factor contributing to the lack of rater bias found in certain scales. The number of hours raters were trained in this study was also 50. In this study, hours of rating seemed to vary according to the number of items in the scale and number of treatments being compared. In the scale used, there were 96 items and five treatment conditions. The greater item number and treatment variety in this study argues for more training hours. But, the use of a scale, the CSPRS, which had already achieved a measure of reliability and validity, lends some justification for the greater number of rater hours used in the pilot version of the Beth Israel Adherence Scale. However, training hours should be reduced in future studies given that the rater's task will be simplified by a reduced number of items, a less complex task and a more efficient scale rating form.

The use of items from an established scale, the CSPRS may
have implications for the psychometric properties of the Beth Israel Adherance Scale. The more firmly established reliability and validity for some of the BAP and CBT items, given their use in the CSPRS, may explain why the ICCs for these subscales in this study, .79 and .83 respectively, were relatively higher than the ICC for IET which was .78.

**Directions of Future Research**

This project constitutes an initial attempt to establish psychometric properties of the Beth Israel Adherance Scale. It is important that future investigators take further steps in its development to contribute to the utility and generalizability of the measure. Specific areas on which efforts might focus include revising items of the scale, assessing rater bias, standardizing and improving methodology and adding a competence dimension.

**Specific Scale Items**

First, additional item analysis might consider the influence of awkward wording or poorly operationalized descriptions on reliability. Items which are not clearly worded, describing relatively simple, operationalized behaviors should be reassessed and modified. This assessment should be made in the context of ICC and alpha values. Waltz, Addis, Koerner and Jacobson (1993) outline a number of limitations of many adherence and competence measures and propose specific guidelines to improve them.

Four recommendations emerge in their study which would
substantially improve the methodology of the Beth Israel Adherence Scale. First, they suggest that transtheoretical, non-specific factors found to be therapeutic, such as warmth, empathy, and supportive encouragement be included in adherence scales and evaluated relative to the treatment manual. The addition of non-specific factors would allow for more comprehensive measurement of what is the same about treatments. Some of these factors, such as warmth and empathy, may be difficult to operationalize. However, this addition is important as it will make it possible to begin to rule out or rule in the often proposed hypothesis that what therapies share is actually what is most therapeutic. These revisions would improve discriminant validity by increasing the chances that interventions are particular to specific modalities and not shared by all treatments. Waltz et al. (1993) specifically propose the inclusion of four types of items in an adherence scale: 1) therapist behaviors that are unique to that treatment modality and essential to it. For the IET subscale, for example, this would be metacommunication items. 2) Behaviors that are essential to the treatment but not unique to it. For example, empathy, or any of the non-specific therapeutic interventions shared by many treatments. 3) Behaviors that are compatible with the specific modality and therefore not prohibited but neither necessary nor unique. For the BAP subscale, for example, an item that is essential but not unique would be paraphrasing or self-disclosure. 4) Behaviors that are
proscribed. For example, for the CBT subscale a proscribed therapist intervention would be focusing on the unconscious determinants of behavior. As an alternative to the continuous Likert-type scale used in this study, Waltz et al., propose that for adherence only, a present-or-absent checklist is sufficient. This would considerably ease the rater’s task minimizing cost and rating time.

Specific scale modifications which have already been made include the reduction of scale items so that there are an equal number of items for each modality (12 each). This reduction of items will substantially diminish rating time. Time efficiency in rating is an important variable to consider as rater drift may occur if too much time elapses between training and rating. A brief description of each item and examples were also added to the scale to facilitate rating by reducing time spent referring to the manual. See Appendix C for a preliminary draft of this version of the scale (Patton, 1995).

Methodological Improvements

Waltz et al. (1993) and Shaw and Dobson (1988) argue for standardizing the process of developing integrity measures, including rater training, unit of analysis rating procedure and competence. One important dimension which should be standardized is the rating procedure. Future projects devoted to improving the
methodology of the scale might address the high expense and time associated with rater training and session transcription. Carroll, Nich and Rounsaville (1995) investigate the former by introducing therapist self-report session checklists as a strategy for monitoring treatment process without independent raters. The study piloted a method which used therapist's self-report after a session to gauge adherence. The investigation correlated independent observer ratings of adherence with therapist self-report ratings. Moderate but acceptable levels of agreement were found. The study suggests that therapists' report of their own in-session behavior offers a more comprehensive, rapid and inexpensive technique of monitoring treatment delivery. This method is more comprehensive because, rather than using representative segments of sessions, therapists could rate entire sessions. It is more rapid because of the elimination of transcription of sessions and subsequent rater viewing and rating. They suggest that this method is less expensive because one eliminates the compensation for training and rating for independent raters. Waltz et al. (1993) and Carroll et al. (1995) note limitations of the therapist self-report method of adherence proposed by Carroll et al. (1995). Waltz et al. (1993) note the potential bias involved in therapists rating their own sessions. In fact, Caroll et al. (1993) found that therapists in the study tended to overestimate their use of specific techniques relative to raters. This means that there were more cases of therapists indicating that they had delivered an intervention when the raters
indicated they had not done so. Another limitation of the study was that only one type of treatment was evaluated for therapist-observer concordance. Thus, it may be that agreement varies across treatment types. Finally, the study by Caroll et al. employed an occurrence-non-occurrence checklist which reflects only that treatments are distinct, so that degree of adherence and skillfulness were not assessed.

Another practical methodological issue that should be addressed in future studies is the cost and time of transcribing therapy sessions. Future efforts might use audio tapes. Of course the use of audio tapes introduces other potentially confounding variables such as the possibility of raters recognizing therapist and patient tone of voice.

An important focus of future studies is increasing the power and generalizability of the Beth Israel Adherence Scale. The main way to achieve this is to increase the sample size. Ideally, to increase the likelihood of finding differences between treatments when in fact the treatments are truly different, it will be important to extend the sampling across different research sites and continue the investigation over a protracted period to accumulate cases. As mentioned, using independent segments will also be important. Also, the potential for rater bias, as elaborated by Hill, O'Grady & Price (1988) should also be kept in mind. Specific features of the rating process which they identify as important to consider are characteristics of the rater, client
and therapist, the similarity of characteristics between rater and therapist or client, and the perceived similarity between rater and therapist or client.

**Competence**

Given the importance of assessing competence (Waltz et al. 1993) as part of a complete integrity check, future developments of this scale should include a competence measure. Competence refers to the level of skill shown by the therapist and should be assessed in the context of each modality and not as a general therapeutic concept. Citing Schaeffer (1982) and Strupp (1986), Waltz et al. (1993) assert that because therapist competence is often not assessed, adherence measures largely fail to determine if a treatment was actually given a fair test.

Competence is distinct from adherence as it refers to the level of skill shown by the therapist. Waltz et al. (1993) assert that often adherence and competence are mistakenly treated as one. They propose that competence should be assessed in the context of each modality, and not as a general therapeutic concept. The guidelines for competence can be derived from the treatment manual but it is important that adherence to the treatment manual not become tantamount to competence. Scales which assess the quality of treatment delivered taking into consideration contextual variables are necessary. For example, a cognitive behavioral intervention such as exploring underlying assumptions will be skillful or not
skillful depending on, for example, this intervention’s relationship to the exploration of client’s automatic thoughts and depressive symptoms (Waltz et al., 1993).

Another approach to competence is based on case formulations (Silberschatz, Fretter & Curtis, 1986). Rather than modality-specific guidelines to treatment, Silberschatz et al. (1986) formulate competence guidelines relative to specific cases. Shaw and Dobson (1988) argue that competence is best considered a state-like variable, with therapists demonstrating higher competence when they skillfully treat patients across a range of difficulty levels. They propose competency measures for various systems of psychotherapy and for various modalities (individual, group, family). Developing a competence measure for the Beth Israel Adherence Scale is an important next step in contributing to its use as a treatment integrity measure.
CHAPTER 5
SUMMARY

Treatment fidelity has become an increasingly important part of psychotherapy outcome research in the past twenty years. Clarifying and operationalizing therapist in-session behavior for different treatments is a central part of identifying the therapeutic mechanisms of change in therapy; it is also critical in conducting meaningful studies which compare treatments. Treatment manuals, adherence scales and competence measures constitute the core means of assessing fidelity.

A recognition of the importance of gauging fidelity emerged in the 1950's with a surge of interest in psychotherapy effectiveness. But it was not until the 1970's that rigorous methodologies began to be developed. Even with these developments, however, more than half of outcome studies conducted in the 1980's ignored the issue of treatment compliance (Rounsaville et al., 1988). The relevance of fidelity extends from clarifying the non-specific common factors which have been found to be therapeutic to articulating the therapist interventions which make therapies unique.

To date, psychotherapy research has shown that while cognitive and psychodynamic therapies are equally effective treatments, approximately 30% of the patients fail to benefit from either treatment (Bergin & Garfield, 1994). Evidence of the value of the
therapeutic relationship regardless of treatment modality has emerged as well (Hartley, 1985; Horvath & Symonds, 1991). These findings form the rationale for the context of this study, an NIMH-funded project being conducted as part of the Beth Israel Brief Psychotherapy Research Program. Patients in the Beth Israel study are selected from those undergoing short-term, brief dynamic (BAP) or cognitive-behavioral (CBT) treatments for personality disorders. Those determined to be potential treatment failures early in treatment, as indicated by a number of outcome measures, which gauge, among other variables, the formation of therapeutic alliance, are targeted for interpersonal-experiential treatment. The hypothesis is that patients selected on the basis of this in-session performance variable (failure to establish a good therapeutic alliance) will benefit more from a treatment designed specifically to work with problems of this nature. The Beth Israel Adherence Scale is the instrument that is being developed to measure the extent to which therapists are delivering the three treatments which are being compared.

Attempts to evaluate the differential impact of specific treatments require that those treatments be reliably discriminable and that clinicians actually conform to the principles of those treatments. Three therapeutic modalities are the focus of this
project: Brief Adaptive Psychotherapy (BAP), a dynamically oriented psychotherapy which links early relational patterns to current functioning; Cognitive Behavioral Therapy (CBT), a therapy focused on pointing out maladaptive thought patterns; and Interpersonal-Experiential Therapy (IET), a treatment which emphasizes the relationship between the therapist and patient in the here-and-now. The three subscales reflect these traditions.

The three modalities have different theoretical origins and distinct interventions. Cognitive-behavioral therapy is rooted in the theory of Beck and his colleagues (Beck & Emery, 1985; Beck et al., 1979; Beck & Freeman, 1990; Young, 1990). The identification of cognitive distortions and the disputation of dysfunctional attitudes form the central interventions. According to cognitive-behavioral theory these thoughts and attitudes reflect maladaptive self-schemas which underlie distorted cognitive processing. The metaphor of therapist as scientist captures his/her role as a partner in the objective examination of the client's thoughts, feelings and behaviors. The CBT subscale is comprised of 17 items.

Brief-adaptive psychotherapy is based on the principles of psychodynamically-oriented psychotherapy the focus of which is warded-off impulses, transference, resistance and interpretation. The items of this subscale were derived from a number of short-term dynamic approaches (Luborsky, 1984; Strupp & Binder, 1984). The
treatment process involves uncovering the general maladaptive pattern, working through, resolution and termination. Through his use of interpretation, the therapist is implicitly, to some degree, the arbiter of meaning. The BAP subscale is comprised of 14 items.

Interpersonal-experiential theory is drawn from a number of traditions including cognitive-behavioral, interpersonal, gestalt and experiential. The 21 items were derived from a number of sources (Safran & Segal, 1990; Greenberg & Goldman, 1988). Phenomenological, here-and-now interventions which aim to modify cognitive processes in an emotionally immediate way constitute a central working focus of this treatment. IET differs from the other treatments in a few important respects. In addition to the emphasis on phenomenological exploration, there is a sharp focus on the particularities of the therapeutic interaction rather than on the elucidation of more generalizable themes. A thorough, in-depth exploration of the process between therapist and client includes the therapist's acknowledgement of his/her contribution to the interaction and the patient's tangible recognition of his/her own internal experience during the interaction (Safran & Segal, 1990). Although some features are not entirely unique to IET, for example, a BAP therapist may explore the transference in a here-and-now manner, the difference lies both in the attention to experiential process and in the relative frequency with which the therapist
employs a phenomenological approach. In IET, the experiential process between therapist and patient forms the building block of the treatment.

There is not currently an adherence scale that measures interpersonal-experiential therapy as put forth by Safran & Segal. Goldman and Greenberg (1981) made initial strides towards establishing reliability and validity for a scale reflecting experiential therapy.

The Beth Israel Adherence Scale is a 52-item, observer-rated, 6-point Likert-type scale comprised of three subscales: interpersonal-experiential (IET), short-term dynamic (BAP) and cognitive-behavioral treatment (CBT).

Ninety five-minute segments, 30 from each modality, were randomly selected from the beginning (sessions 1-5), middle (sessions 6-10) and end (sessions 11-15) of therapy. A total of 18 sessions were rated, 6 from each modality. The sample was comprised of nine patients, three from each modality (two sessions of each patient) and three therapists. Raters, with the use of a manual developed for this project were trained in all three modalities and rated the same 90 segments. They trained over a 3-month period during which time they met weekly for five hours. Raters assessed each therapist intervention on dimensions of frequency and intensity by evaluating the extent to which a therapist
intervention was a good example of a particular item. The scale is continuous, which, unlike a simple occurrence-non-occurrence checklist, is a more detailed adherence check facilitating future refinements of the scale. Assessing intensity does not require that the rater make inferences about the therapist's level of skill or competence.

Interrater reliabilities were determined through intraclass correlation coefficients for random effects (Shrout & Fleiss, 1979). By-item ICCs ranged from .07 to .89 with a mean of .63. By-item subscale means were .55, .64 and .79 for the IET, BAP and CBT subscales respectively. A moderate degree of reliability has begun to be established for the scale overall. When items with agreement values of <.65 were eliminated, the reliability coefficient for the scale overall was .80. The coefficients for each subscale were then .78, .79 and .83 for IET, BAP and CBT subscales respectively. The coefficient alphas, measuring internal consistency, were quite strong. The alphas for IET, BAP and CBT were .94, .94 and .97 respectively. These levels provide preliminary support for the internal consistency of each subscale. ANOVAs were conducted to determine discriminant validity. The treatments were deemed distinct with significant p values of <.001. Results indicate that therapists exhibited more behaviors appropriate to their own respective treatment than to other
treatments.

Several factors should be considered when assessing the data. First, segments were not independent; certain segments shared therapists and/or patients contributing to some potential sources of contamination. Increasing the number of independent segments will further address this issue and contribute to the generalizability of the scale. Training of raters may also have been too extensive. Future investigations might shorten the rater training given the reduction of items and improved rating form. Other specific areas on which future investigators might focus include standardizing and improving methodology and adding a competence dimension. Waltz, Addis, Koerner and Jacobson (1993) outline a number of limitations of many adherence and competence measures and propose specific guidelines to improve them which future refinements of this scale might follow. Future projects devoted to improving the methodology of the scale might address the high expense and many hours required to transcribe sessions and train raters. Caroll, Nich and Rounsaville (1995) investigate a new method of adherence, a therapist self-report measure which was developed to reduce cost and rating time. Although modest levels of agreement were found for this measures, limitations, most importantly potential rater bias, may compromise the use of such a method. On the other hand, given the advantages of this approach,
it may be worthwhile to simply address rater bias. Hill, O'Grady and Price (1988) discuss areas of rater bias, which, in general, may confound measure development. Other methodological issues to consider in future investigations are the differential advantages of a continuous vs. a non-continuous scale, the use of audio tapes in the place of transcripts to reduce the cost of transcription and increasing the sample size to improve generalizability. As part of an effort to increase the scale's function as an integrity check a competence dimension of the scale should also be developed (Waltz et al., 1993).

Role in Beth Israel Project

The scale as elaborated in this dissertation is the first step in the development of this measure. In addition to beginning to establish internal consistency, discriminant validity has begun to be established. Discriminant validity, in this case, reflects the extent to which raters were able to distinguish between three therapeutic modalities as represented by "gold standard" transcripts. These transcripts are selected by experts in each orientation and are deemed particularly good examples of each modality. After internal consistency and discriminant validity have been further established through replication studies, the scale may be used to discriminate between treatments in comparative psychotherapy research like the project at Beth Israel Hospital of which this scale is a part.
Implications for Therapist Training

Training raters to use this scale involved education in theory and review and practice of interventions particular to each of three treatments. The practical part of the process involved videotape viewing of therapist/patient dyads and rater roleplays to facilitate an experiential grasp of each intervention. The sequence of training was organized by modality beginning with interpersonal-experiential followed by brief-adaptive and then cognitive-behavioral therapy with theory first and practice second. Because interpersonal-experiential therapy was the least familiar to raters it was introduced first to prevent time limitations at the end of training from interfering with the process of fully learning this orientation.

Educating therapists, like training raters, is a process which involves training in theory and technique. How might a therapist best be trained to be proficient in more than one theoretical modality? This is a complex question which depends on many factors including the purpose of training (research or clinical), the therapist's level of experience and theoretical predisposition and the resources available for training. Deriving a formula which would maximize a therapist's ability to grasp multiple modalities is a difficult task. Based on this author's training as a psychotherapist which was largely based on training in one theoretical orientation and the experience of training raters one modality at a time, it seems that solid exposure to one treatment
before the introduction of others may facilitate therapists' ability to negotiate the complexity and ambiguity of the psychotherapeutic process. As the role of the beginning psychotherapist is far more emotionally and interpersonally challenging than that of the rater, the early introduction of multiple theoretical and practical principles may result in a number of less than optimal outcomes. Given the emotional intensity of sitting with clients in the early stages of training and this author's view that beginners tend to rely too heavily on intellectual concepts to ease this pressure, learning multiple theories may intensify therapists' interest in finding "the intervention" which will magically dissolve the client's dilemma. Even if a therapist's defense of choice in the therapeutic situation is not intellectualization, premature introduction of many schools of thought may communicate the message that quantity of knowledge and not quality or depth is of central importance in therapy. Another distressing experience which may result from premature introduction of more than one theoretical orientation is one of plain confusion; sitting with clients, particularly early in training, most therapists are fortunate if they can mentally engage in and appropriately introduce one set of principles. It seems that therapists' attempt to balance emotional, intellectual and interpersonal activity may best be cultivated if they are only managing the theory, technique and interpersonal principles of one modality at a time. This approach may also contribute to the
consolidation of a therapist identity which can, if not rigidly maintained, provide continuity for both the therapist’s sense of self and for the treatment. The Chinese proverb which urges parents to give children "roots and wings" seems appropriate in this context as therapists might do well to learn one modality, thereby grounding themselves, before attempting to broaden their repertoire with knowledge of other therapeutic schools of thought.

Of course, a compelling argument may also be made for the early introduction of multiple modalities in the training of therapists. Reasons to do so include the environment of eclecticism as driven by the empirically demonstrated utility of various techniques and the economic pressure by clinical agency-monitoring bodies to use them. The early introduction of more than one orientation may also help beginning students of psychotherapy to find their niche or preferred way of working. And the knowledge of multiple treatments in itself may be an identity-consolidating experience for some. As is the case with many endeavors in which process is at least as important as content, it seems that the preferred style and past experience of the educators involved in training therapists might be determinative of this issue.
References


Appendix A

The Beth Israel Adherence Scale

The following items represent therapist interventions.

Rate each item on the following 6-point scale:

1  2  3  4  5  6
not at all somewhat moderately extensively

Interpersonal-Experiential Subscale

1. Tracks client’s experience in a moment-to-moment fashion.

2. Explicitly gages client’s willingness to proceed further with task.

3. Intervenes with a present and immediate quality.

4. Intervenes with skillful tentativeness.

5. Asks exploratory questions which probe for the feeling/experience underlying client’s utterance.

6. Directs or redirects the focus to the "here and now" of the relationship between therapist and client.

7. Explores client’s expectations and fears in an affectively immediate fashion between therapist and client.

8. Emphasizes the subjectivity of his own perceptions.

9. Acknowledges his contribution to the interaction.

10. Metacommunicates by conveying own feelings to help the client become aware of his/her impact on others and role in the interaction.

11. Metacommunicates by conveying own feelings to the client to probe for his/her internal experience.

12. Metacommunicates about the nature of the relationship between himself and client. (-general-Not captured by other items)

13. Respects client as arbiter of experience.
14. Deepens client's experience through evocative empathy.
15. Deepens awareness through awareness experiment in session.
17. Identifies and points out specific client behaviors or subtle non-verbal communications to help the client become aware of his/her underlying experience.
18. Identifies and points out specific client behaviors or subtle non-verbal communications to help client become aware of an avoidance.
19. Engages in empathic conjecture: hypothesizing, exploring the nature of the client's experience and then "checking in" after making the conjecture. (This is often, but not always, interrogative.)
20. Traces the development of the emotional experience in the here and now.
21. Explores the how, or mechanism of a client's defense not the why.
22. Facilitates individuation/self-assertion.

Short-term Dynamic Subscale
23. Interprets client's defenses.
25. Explores and elucidates the unconscious aspects of major maladaptive patterns.
26. Explores and elucidates the unconscious aspects of client's thoughts and behaviors (other).
27. Inquires for specific information about an issue.
28. Interprets by linking components of a conflict.
29. Interprets by linking parental figures to significant others.
30. Interprets by linking significant others to therapist.
31. Interprets by linking parental figures to the therapist.

32. Interprets other aspects of client's behavior or experience (Not captured in other items).

33. Reflects the content of client's statement.

34. Frames symptoms as coping attempts.

35. Confronts client, suggesting he/she is saying, feeling or thinking something different than what the client claims.

36. Identifies and specifies the concrete details of the major maladaptive pattern.

Cognitive-Behavioral Subscale

37. Probes for client's beliefs, personal meaning, behind client's thoughts.

38. Helps client identify cognitive distortions, errors that were present in his/her thinking.

39. Explores with the client the general belief, or underlying assumptions, which underly negative thoughts/beliefs.

40. Engages in didactic persuasion.

41. Explores advantages and disadvantages of dysfunctional attitudes.

42. Asks client to report specific thoughts.

43. Encourages client to distance him/herself from his/her thoughts, viewing them as beliefs rather than facts.

44. Helps client examine currently available evidence or information to test validity of client's beliefs.

45. Encourages client to test beliefs prospectively.

46. Facilitates client's consideration of alternative explanations for events.

47. Therapist and client practice rational responses to client's negative thoughts or beliefs.

48. Works with client to plan or practice alternative overt behaviors for the client to use both inside and outside of therapy.
49. Provides rationale for teaching about the role of cognition in dysfunction.

50. Assigns and reviews homework.

51. Engages in socratic questioning aimed at guiding client's reasoning process.

52. Reviews realistic consequences of client's beliefs.
Appendix B

Rater's Manual

RATER'S MANUAL FOR

THE BETH ISRAEL ADHERENCE SCALE

Adapted from:


GENERAL GUIDELINES

1. Rating

Items refer to therapist's behaviors, not the patient's behavior or the patient's responses. In rating therapist behaviors, the rater should consider how frequently or with what intensity the therapist made a particular intervention. Competency - the success or skill with which the therapist carries out the intervention is not being assessed.

2. Confidentiality

All transcripts and rating scores are confidential material. Please treat all materials with sensitivity to confidentiality. Do not discuss the content of sessions with anyone but project staff.


In order to prevent rater drift, use the manual each time a segment is rated. The descriptions of each item and examples are to be used to understand subtle distinctions between items. It is important that the rater understand these distinctions.
Interpersonal-Experiential (IET) Items

1. Tracks client's experience in a moment-to-moment fashion.

Definition of terms: "Tracking" - refers to the act of following client’s perceptions, thoughts, feelings and actions as they emerge. The therapist follows the client’s process at every moment. "Moment-to-moment"- refers to the notion of the organism as an experiential process; the organism becomes aware of something new at every moment. The therapist follows client and attempts to increase his/her awareness of both current experience and the continuity in experience from one statement to another.

Example of therapist not engaging in skill:

The therapist makes reference to client processing that is not currently experienced. Lectures or discussions of material unrelated to client’s experience or the pursuit of a topic that seems generated by the therapist are examples of not tracking moment-by-moment experience. [Note, there are other ways that the client may fail to be engaging in this skill.]

2. Explicitly gages client’s willingness to proceed further with task.

This is a tentative, collaborative intervention which reflects the therapist's attempt to be "with" the client moment-to-moment while probing for internal experience. The idea is that the therapist is not commanding or challenging the client but rather guiding and exploring with him/her. For example: Therapist (T): "Are you willing to take this further?" or T: "Should we explore this feeling more?"

3. Intervenes with a present and immediate quality.

The therapist shares with the client his/her present and immediate experience in the moment with an attempt to be congruent with the client. In this intervention, the therapist authentically expresses him/herself in the moment revealing anything that s/he expects to be of value to the therapy. This intervention is based on the belief that it is important for one person to contact the emotional core of the other and thereby confirm the existence of the other. It is characterized by qualities of congruence, directness and being fully present and mutual. "Congruence" - refers to the therapist's attempt to think and speak the client's experience. "Mutuality" - refers to reciprocal openness of the client and
therapist. "Present" - reflects the fullness of the therapist’s attention, interest and openness to the client. For example: T: "When I hear you say that, I feel sad and I wonder how you feel."

4. Intervenes with a skillful tentativeness.

This item refers to a quality of therapist’s behavior which is reflected in an attitude of exploration and subjectivity. An intervention is tentative if the therapist uses words like perhaps, it seems, possibly. For example: T: "It seems as if you feel fearful of what to do next" or T: "I’m not sure of this, but perhaps you’re feeling cut off" or T: "I experience you as cautious right now."

5. Asks exploratory questions which probe for the feeling or experience underlying client’s utterances.

The therapist makes inquiries into what the client is currently experiencing. The therapist encourages the exploration of client experiences by asking questions that will encourage the client to attend to and explore her/his experience. Important to note: Probing for the feeling refers to encouraging the client to focus on what he/she currently feels. In order to refer to experience the client must "check inside", often using a bodily sensation or a bodily felt-sense. The therapist is asking the client to actually re-experience what s/he felt, rather than just refer to past experience. For example by asking "Did you miss him when he went away?", the therapist is asking the client to "report" on what was felt. This is not an example of this item. On the other hand, if the therapist asks, "What was it like for you when he went away?" she/he would encourage the client to turn attention inward to re-experience what was experienced. The rater must be careful to assess the referent of the therapist’s question. For example, if the therapist asks "What was the conversation like?", the rater must assess whether the therapist is referring to the conversation, in which case s/he would be asking for a description of the conversation, or whether the therapist is asking what the conversation was "like for you" (the client). There may be an implied or explicit "for you". Further, if the therapist asks the client to "imagine", "envision" or "picture" the experience, the rater has to assess the degree to which the therapist is encouraging the client to re-enter a past experience or enter into a future projected experience or is asking for a description or thought about a situation in order to experience it. Thus, "picture (or imagine) how you would feel if you were to get angry at your husband" is an experiential question whereas "picture (or imagine) what will happen if you get angry at your husband" is not. For example (experiential item) - Client (C): "I feel disgusted with myself. I am lazy. I stay home all the time. I’m not very
exciting." T: "What happens for you when you say that?" or C: "But I said I would wait until he invited me and then I'd be happy to go. So one thing I feel uneasy about is that change of mind, between the two phone calls. I mean the first time, when I said I'd drop him a note and invite myself up, I don't know whether that was um HER thinkin' or mine. And then afterwards when I don't wanna go up without the note, I know that's me. But um (pause)" T: "The first one, you don't know whether it's her thinking or yours? How do you mean?" "How" is key here. "What do you mean" could be an attempt to encourage the client to merely explain or clarify meaning. "How" encourages the client to delve into or expand on her emotional experience as opposed to "what" which might elicit a more intellectual response. Another example: C: "I want him to say he never meant it. I don't care if he doesn't love me ... but I want him to know." T: "What does that feel like inside?"

6. Directs or redirects the focus to the here and now.

The therapist actively focuses the client on his/her internal experience in the present. For example: T: "What are you feeling right now?"

7. Explores client's expectations and fears in an affectively immediate fashion between therapist and client.

The therapist explores the client's expectations and fears while using the "here and now" situation. For example: T: "So, you are feeling dissatisfied right now. You are wanting something other than what I am giving?" or T: "What about with me? What - what would satisfy you with me right now, around this issue? Do you have any sense of what you want, and whether you are getting what you want or not?"

8. Emphasizes the subjectivity of his own perceptions.

Therapist suggests that the client is the arbiter of his reality. He makes a statement that is qualified; he explicitly makes references that suggest that his intervention is merely his own tentative appraisal. For example: T: "So you really feel you don't-as you say sounds like you really opened things up with her...brought things out into the open in a way that if, I am understanding, that you haven't really quite done before." or T: "I can't help, I guess in my own mind..."

9. Acknowledges his contribution to the interaction.

The therapist discloses his feelings/thoughts, acknowledging his role in the interaction. For example: T: "I think I've been acting in a hostile way towards you." or T: "I think I have been short with you."
10. Metacommunicates by conveying own feelings to help the client become aware of his/her impact on others and role in the interaction.

In this form of metacommunication, or talking about the relationship between therapist and client, the objective is to help the client become more aware of the impact he/she has on others and to help him/her clarify what he/she is contributing to the interaction. For example: T: "I feel shut out right now." or T: "I feel like protecting you right now." or T: "I'm feeling put down right now."

11. Metacommunicate by conveying own feelings to the client to probe for his/her internal experience.

This form of metacommunication takes self-disclosure one step further. In this case, the therapist goes on to probe for the client's internal experience. For example: T: "I'm feeling very cautious with you right now...as if it would be easy for me to say or do the wrong thing. Does that connect with anything you experience?" or T: "I feel like I'm playing a game of chess. Does that make any sense to you?" or T: "I feel like I've been attacking you in little ways. Does this fit with your experience at all?"

12. Metacommunicates about the nature of the relationship between himself and the client.

This item is similar to #11, however the emphasis is speaking about the relationship between the therapist and the client, rather than on probing for client's internal experience. For example: T: "This is feeling like a game of chess" or T: "It seems we're doing a dance around this topic."

13. Respects client as arbiter of experience.

This is an attitude or stance which is reflected in many specific interventions. By respecting the client as the arbiter of experience, the therapist maintains a humble, subjective, exploratory, often interrogative stance. There is a sense that the therapist is not the "expert" on the client's feelings; rather he is facilitating their unfolding.

14. Deepens client's experience through evocative empathy.

The therapist takes the client's either implicitly or explicitly expressed feelings and empathizes with these feelings to amplify or elaborate the client's felt experience of them. In this intervention, the therapist often takes the client's expressed
feelings one step further, without actually interpreting or assigning meaning to the feeling. For example: T: So you’re feeling a bit shut down and angry." or For example: T: "So, you’re feeling like no one really understands how hard it is for you."

15. Deepens awareness through awareness experiment in session.

The therapist attempts to deepen or increase the felt experience of the client’s experience/awareness of his feelings. Often, when a client has just expressed an emotion, the therapist will say, for example: T: "Try saying this to me directly." or T: "Try saying, 'I'm angry at you.'"


This item is similar to item #15 except that the awareness exercise is assigned as an out-of-session task. For example: T: "Over the week, be aware of when you get sad or close off and withdraw."

17. Identifies and points out specific client behaviors or subtle non-verbal communications to help the client become aware of his/her underlying experience.

The therapist comments on a particular aspect of client's functioning. This can be an observation of facial expression, bodily movement or posture or a particular inflection in the client's voice. Comments of this kind aim to bring an aspect of the client's functioning into focus. This is done in a supportive and non-judgmental way. It is important that the client not feel pounced on scolded or "caught." There is, to the extent possible, no sense of a confrontation. Example: T: "I'm aware of a particular tone in your voice." or T: "When you say this, you have a very angry expression on your face."

18. Identifies and points out specific client behaviors or subtle non-verbal communications to help the client become aware of an avoidance.

This is similar to item #17 except that the focus is to help the client become aware of the way in which he/she is avoiding an interpersonal or emotional experience.

19. Engages in empathic conjecture: hypothesizing, exploring the nature of the client’s experience and then "checking in" after making a conjecture. (This is often, but not always, interrogative.)

The therapist empathically hypothesizes about what the client may be experiencing. Conjecture refers to a "guessing" stance which
includes asking the client to "check in" with his/her experience. This refers to experiences that lie beyond the client's current conceptualization of his/her experience. The conjecture is about inner experience not about psychogenetic causes or patterns in behavior or experience. For example: If the client says that every time she/he criticizes her/himself she/he feels depressed and worthless, the therapist might say "and so this is when I guess the hopelessness sets in...is that true for you?" or For example: C: "When that happens I feel like saying what right do you have to say that?" T: "Yeah, but I guess you feel really hurt."

20. Traces development of the emotional in the here and now.

This item involves the therapist "unpacking" the client's moment-to-moment emotional experiences/behaviors. For example: T: "Wait a second, let's go back and explore how you were feeling at that moment. From when you felt criticized, what was the feeling?"

21. Explores the how of the client's defense not the why.

This item refers to the therapist's focus on the feelings underlying the patient's defense and not the reasons for them. Unlike dynamic interventions, the goal is not to establish causal links, or to discern patterns; the focus is on the feelings which elicit certain defenses. For example: T: "Are you aware of interfering with your feelings in any way?" or T: "Are you aware of controlling your feelings right now?"

22. Facilitates individuation/self-assertion.

The therapist encourages the client to either ask for what he/she wants or to express his/her feelings directly to the therapist. For example: T: "Do you have a sense of what you want from me now?"

Short-Term Treatment (BAP) Items

23. Interprets client's defenses.

An interpretation goes beyond what the client has overtly recognized. The interpretation might provide a new understanding or offer a label of an inner state. It might take one of several forms. It might establish connections between seemingly isolated statements or events or it might indicate themes, patterns or causal relationships in the client's behavior or personality. An interpretation presumes knowledge by the therapist of the other's experience and places it in the speaker's frame of reference. For example: C: "I'm feeling really confused right now. I wasn't sure before this about seeing you because I didn't know what to expect from this counseling, that's why I didn't show up last session. " T: "Yeah. It sounds like you have trouble figuring out who you are
and what you want out of your life separate from what your parents want. When this happens, you avoid situations which will make you feel more confused."


The therapist recognizes and shows the client that particular symptoms are associated with particular events in the client’s relationships. This intervention is based on the belief that symptoms are a result of previously dysfunctional, significant relationships. These symptoms are then associated with and re-evoked in current relationships. Definition of terms: Symptom: in a broad sense, the dysfunction of a usually intact function or capacity. For example, a momentary forgetting is a dysfunction of memory in the sense that we usually can remember the thoughts that we have just intended to say. Anxiety and depression are also examples of symptoms. Examples of intervention: The therapist notices that every time a client’s attractiveness is noticed, a strong expression of sadness is displayed. The therapist might be reminded of the previously discussed fact that the client did not get recognition from her father whom she both loves and resents. To the client, being in a close relationship means hiding her strength and knowledge to please the other. The therapist might say, T: "Each time I notice and comment that you are looking attractive or that you’re doing well in your work you get tearful and cry." C: "I feel I’m not attractive. I feel I will be rejected. Father could never stand it. I won a ribbon in a race and he only could say the competition was not too great." T: "I see, so you feel you have some well established, old reasons for feeling that way with me."

25. Explores and elucidates the unconscious aspects of major maladaptive patterns.

The therapist explores the unconscious parts of the client’s central, dysfunctional cycles. These patterns, or themes, may be elucidated in a variety of ways. One way may be in terms of identifying the feeling/action/feeling cycle. For example: a) you feel scared b) so you act hostile c) and then you feel regretful. Another way may be to identify any of the components, e.g. T: "There’s a need you have to feel frustrated."

26. Explores and elucidates the unconscious aspects of client’s thoughts and behaviors.

This item is similar to item #25 in its attempt to capture the unconscious elements of the client’s experience. The difference is that this item focuses on thoughts and behaviors. For example: C: I was yelling at my boyfriend the other night and he got really mad and we went to sleep all upset. It was really awful." T: "You were
yelling at your boyfriend because you have the wish to be both victim and victimizer."

27. Inquires for specific information about an issue.

The therapist asks for more information about a specific aspect of the person's life or experience, a particular client issue or an event that occurred in the client's life either recently or in the past. The rater might sense a specific "agenda" behind the therapist’s questions; the inquiry may seem direct or pointed. For example: T: "So, how was your relationship with your father?" or T: "Can you tell me what your mother was like?" or T: "What do you do when your wife tells you she wants to be alone?"

28. Interprets by linking components of a conflict.

(Relevant for items 28-32). An interpretation goes beyond what the client has overtly recognized. The interpretation might provide a new understanding or offer a label of an inner state. It might take one of several forms. It might establish connections between seemingly isolated statements or events or it might indicate themes, patterns or causal relationships in the client’s behavior or personality. An interpretation presumes knowledge by the therapist of the other’s experience and places it in the speaker’s frame of reference.

(Item 28) The therapist provides a construction that links or associates different components of an internal conflict. There are generally four components a) drives, motives, and wishes b) anxiety c) defensive processes (avoiding, resisting, minimizing) or d) affects, cognitions and behaviors. What is important in this item is the associating of different aspects of the client’s functioning. For example: T: "You felt anxious and that made you pick a fight with your brother. or T: "Possibly, you are afraid to look at what these feelings are." or T: "You want to leave but you are afraid so you stay."

29. Interprets by linking parental figures to significant others.

The therapist provides a construction that links significant others in the client's life to historically-important figures (parents and/or parent-like figures). The therapist attempts to show the client how similar patterns exist(ed) in the client's relationships with parental figures as compared to those with significant other(s). Definition of terms - significant others - meaningful relationships other than with therapist, historically-important figures - parent and/or caretaker figures. For example: T: "One of the things that we have learned about you from your relationship with your family is that you will do a great deal in order to keep in people's favour, particularly in your relationship with your
mother, so that you will do the "right" thing, the accommodating thing, so that you can continue to be mommy's little girl and it seems that you do a similar thing with Bob, never crossing him, always trying to say the right thing so that he won't be angry at you, he won't be cross with you."

30. Interprets by linking significant others to therapist.

The therapist provides a construction that links current significant others in the client's life to the therapist. The therapist attempts to show the client that patterns exist in his/her relationships with significant others that are similar to the relationship between therapist and client. For example: T: "So you used to rely on John on a daily basis, as someone you could talk to, someone you could sit down with and chat about what happened in your day, and now you can't do that anymore because he's gone, so you feel like you are starting to rely on me for those things, for support."

31. Interprets by linking parental figures to the therapist.

The therapist provides a construction that links historically-important caretakers to the therapist. The therapist attempts to show the client that his/her relationship with the caretaker is similar to the one that exist(s)(ed) in the client's relationship with the therapist. For example: T: "One of the things that we know about you from your relationship with your parents is that you have always been right in there saving everybody, doing everything you can to calm things down, appease people, be the strong one, and it is interesting how when there is a silence between you and me I feel like you had better do something, like as if something has gone wrong between us and you had better do something to patch things up. Does that fit for you?" or T: "Your disappointment with your father resembles your current disappointment with me."

32. Interprets other aspects of client's behavior or experience (not captured in other items).

If raters decide a statement is a General interpretation the rater must ensure that it does not fall under any of the specific interpretations (items #28-#31.) For example: T: "You are identifying with your mother's hostility." C: "You've made me think about some things. I'm feeling really confused right now. I wasn't sure before this about seeing you because I didn't know what to expect from this counseling but you seem to understand me. Maybe you can help me figure out some of this mess with my parents and school." T: "Yeah. It sounds like you have trouble figuring out who you are and what you want out of your life, separate from what your parents want."
33. Reflects the content of client’s statement.

The therapist attempts to understand the meaning of the content or gist of the client’s expression from the client’s perspective and reflects it back to client. It is often a summary of what the client has said rather than a reflection of feeling. It seems as if the therapist’s primary intention is to show the client that her/his meaning is understood rather than to focus the client on current experience or attempt to encourage a re-experiencing. For example: C: "Exactly. There’s a lot more of being patient between us you know just like, instead of just calling and talking, in generalizations and just like feeling out each others moods now like we’re just sayin I’m in a good mood or I’m in a bad mood, and you know that’ that---" T: "Being more clear." or C: "Yeah and I’m just thinking that you know over break I’m just gonna have to remember to constantly remember everything that I’ve learned and really put it into practice. Cause like this is a good reminder to come here every week." T: "It makes you think about it."

34. Frames symptoms as coping attempts.

The therapist recognizes and frames symptoms as problem solutions or coping attempts. The therapist recognizes and points out that particular symptoms can be understood as faulty and costly attempts at a problem-solution. For example, the therapist might recognize the client’s need for caring and points out the patient’s faulty solution. T: "You really want care and attention, but you think you won’t be given it, so you just don’t even try. Or, the therapist might recognize the patient’s overeating as solution for a lack of comfort and care. T: "You really want someone to soothe you but nobody is there so you eat as a way of feeling better."

Cognitive-Behavioral Treatment (CBT) Items

35. Probes for client’s beliefs, personal meaning, behind client’s thoughts.

This measures whether the therapist explores the personal meaning system surrounding the automatic thought(s) reported by the client. A "personal meaning system" refers to an idiosyncratic associative network of beliefs, most or all of which are likely to occur once they are "triggered" by certain negative thoughts. The therapist is likely to explore this personal meaning system by asking the client (sometimes repeatedly) to report beliefs that to her/him are implied by the initial automatic thought. The following example illustrates the therapist helping the client explore his personal meaning associated with the thought: "I really screwed that up." T: "What were your thoughts at the time?" C: "Well, I thought, 'I really screwed that up. I should have known better.'" T: "So, you
had the thought, 'I really screwed that up.' What did that thought mean for you?" C: "Well, I did it again! I blew it! Even when I try hard, I screw up!" T: "And if you tried hard and screwed up, what does that mean?" C: "It means that I really am a loser, I can't make things go right no matter how hard I try." T: "That sounds pretty discouraging. When you think that, how does it make you feel?" C: "I feel very down." T: "I wonder if most people wouldn't feel down if they believed that they were doomed to failure even when they tried their hardest? It seems natural that you feel that way given that those beliefs are triggered when you screw something up." or T: "Can you say more about your underlying belief?"

38. Helps client identify cognitive distortions, errors that were present in his/her thinking.

The therapist helps the client to identify specific types of cognitive distortions or errors (e.g. all-or-none thinking, overgeneralization) that were present in the client’s thinking. This item measures whether the therapist recognizes and identifies cognitive errors present in the client’s thinking. Cognitive errors are defined as characteristic errors in information processing or aberrant or unreasonable ways of thinking about the world. The therapist need not have assigned a specific label to a cognitive error. But, the therapist must have helped the client to recognize or identify it as such. Types of Cognitive Errors:
1. Magnification or minimization: over or underestimating the significance or magnitude of an event.
2. Disqualifying the positive: dismissing the positive aspects of a situation.
3. Overgeneralizing: applying a rule or belief based on only observation to another situation whether or not they are similar.
4. Personalizing: assuming personal responsibility for negative events.
5. Catastrophizing: assuming the worst.
6. Dichotomous thinking: considering only extremes and not gradations in between.
7. Predicting without sufficient evidence: assuming something will happen simply because the possibility exists or because it has occurred in the past.
8. Arbitrary inference: drawing conclusions that are not supported by the fact.
9. Selective abstractions: basing conclusions on only one aspect of the available information and ignoring contradictory evidence.

An example of dichotomous thinking – T: "So how did your presentation go?" C: "Very poorly. I was awful." T: "How do you know it went poorly?" C: "I stumbled over my words a couple of times and once the slide projector jammed. It certainly wasn’t the smoothest presentation I’ve ever given." T: "I believe that you have given presentations in which the slide projector didn’t break
down and your delivery was smoother but you said you were awful. What else went wrong with the presentation?" C: "Nothing really...I got through all the material I wanted to present, a miracle when you consider how badly I presented it." T: "You said this wasn’t the best presentation you’ve given, was it the worst?" C: "No, I’ve certainly given worse. Sometimes I haven’t even covered all the material." T: "Yet you say this presentation went very poorly. It sounds like unless your presentation would have gone very well, you were likely to end up thinking it went poorly. Do you see how that kind of ‘black and white’ thinking doesn’t leave room for the possibility that it was neither great nor awful, but somewhere in between?"

39. Explores with the client the general belief, or underlying assumptions, which underly negative thoughts/beliefs.

This item reflects whether the therapist helps the client identify and explore her/his underlying assumptions. Underlying assumptions are general beliefs that form the basis for the client’s automatic thoughts. The assumptions are unarticulated rules which determine how the client perceives and interprets: 1) events around her/him, and 2) her/his own behavior. The automatic thoughts have a common theme which is expressed by the underlying assumption. As such, underlying assumptions provide a key to understanding how the client views the world. The following are some examples of underlying assumptions a client might hold:

1. "I have to be successful in order to be happy."
2. "If I make a mistake, it means I am inept."
3. "My value as a person depends on what others think of me."
4. "It is not possible to disagree with someone and still like that person."
5. "Everything in the world should be fair."

Example of a dialogue: T: "So despite the fact that you’re upset with her you don’t plan to tell her because you don’t want to start any trouble?" C: "Yeah, it’s just not worth it to me." T: "You’ve said that before about other situations in which you’ve not wanted to talk to someone who you are upset with or who owes you something. Have you noticed that?" C: "It’s true that I hate to ask people who owe me money to repay me...usually I’d rather just not push it, you know?" T: "Not wanting to push it seems like a common reaction you have to issues like this, even if it means that you don’t let people know when they make you mad or when they’ve forgotten to repay you what you are owed. What makes it the case that you don’t want to push it?" C: "I don’t want to get people mad at me and end up having them dislike me." T: "Does it seem to you that unless you’re agreeable all the time and don’t push it people won’t like you?"
40. Engages in didactic persuasion.
This is an item which can describe many different specific interventions. The stance is one of teaching/guiding/persuading. The therapist in this intervention is goal-directed and, through examining evidence, attempts to convince the client that his/her way of thinking is maladaptive or erroneous. For example: T: "Do you think, given those examples, that you may be viewing the situation irrationally?"

41. Explores advantages and disadvantages of dysfunctional attitudes.
This item reflects the degree to which the therapist explores the pros and cons, the positives and negatives, the logical outcome of the client's belief or attitude. For example: T: "What are the advantages of that belief or looking at it that way?" or T: "Do you see the disadvantage of that dysfunctional belief?"

42. Asks client to report specific thoughts.
The therapist asks the client to report, as close to verbatim as possible, specific thoughts that the client experienced either in the session or in a situation which occurred prior to the session. In order for the rater to score this item, the therapist must have attempted to elicit the client's specific thoughts as verbatim as possible, rather than feelings, opinions in general or statements which only vaguely convey what she/he was thinking about. For example: T: "So you ended up at home rather than going to that party as you had planned. Do you remember what you were thinking?" C: "I remember feeling like I just didn't have the energy to go." T: "So you felt like you didn't have the energy...what thoughts went along with that feeling?" C: "I suppose I was thinking that I just wasn't going to be able to get up the energy to get myself over there." T: "Okay, I wonder if you might be able to remember the specific thoughts you had as you were thinking about whether or not to go to the party. Do you remember what those were?" C: "I remember thinking that it would involve so much effort to get cleaned up, and get dressed that it wasn't worth it." T: "Do you remember thinking that I wouldn't know anyone at this party and would be bored. Everyone else there would have someone to talk to."

43. Encourages client to distance him/herself from her/his thoughts, viewing them as beliefs rather than facts.
This item measures whether the therapist urges or challenges the client to consider her/his thoughts and beliefs as testable hypotheses about the world rather than as proven facts. The rater should also consider less direct therapist behaviors through which
the therapist encourages the client to view her/his thoughts or beliefs as testable hypotheses. For example: C: "If my boss knew I was coming here for mental health counseling she’d try to get rid of me." T: "What makes you think that?" C: "C’mon, would you want someone who’s unstable and running off for counselling to be working for you in a responsible position. Of course she’ll want me out." T: "You sound pretty convinced that your boss would want to get rid of you if she found out that you were receiving counselling. Is there any change that she might not react as negatively as you think she would?" C: "I don’t know, I suppose she might not, she’s surprised me before in the way she has reacted to things." T: "So there is at least some change that she wouldn’t want to get rid of you if she found out you were receiving counselling?" C: "Yeah, I guess she might not." T: "Do you see how thinking of it in the way is different from what you were saying at first? By leaving open the possibility that she might not react so negatively you are recognizing that you don’t know for sure what she’ll do, although you do have some hypotheses about what she’ll do that we may want to test out."

44. Helps client examine currently available evidence or information to test validity of client’s beliefs.

This item measures whether the therapist helps the client use evidence from: 1) the client’s past experience, or 2) her/his knowledge of the way the world works, to test the client’s beliefs. For example: C: "My friends are so tired of being with me and talking to me---I’m such a drag these days." T: "How do you know they’re tired of you?" C: "Wouldn’t you be tired of someone who’s always depressed?" T: "Well, I sure wouldn’t want to assume that I would be! Let’s take a minute and see what evidence you might have that your friends don’t want to be with you. What indications do you have that that’s true?" C: "Nobody’s called me lately to go out with them." T: "Have your friends been going out without you that you know of?" C: "I guess that they haven’t been going out as a group that much lately because people have been gone on vacations and things. They did go once without me and that I know of." T: "How do you know that?" C: "I didn’t find out ’til later because I had been out of town a few days and I didn’t get home ’til later that evening." T: "Would your friends have been able to get in touch with you if they tried?" C: "No, nobody was home." T: "It sounds like there are other possible reasons for why you haven’t received invitations lately to go out with your friends beside your initial belief that they are tired of being with you. Which explanation do you think accounts for them not calling to invite you out?"
45. Encourages client to test beliefs prospectively.

The therapist encourages the client to 1) engage in specific behaviors for the purpose of testing the validity of her/his beliefs or 2) make explicit predictions about external events so that the outcome of those events could serve as tests of those predictions or 3) review the outcome of previously devised prospective tests. This item reflects whether the therapist encourages the client to: 1) engage in prospective hypothesis testing to evaluate the validity or belief or 2) verbalize her/his predictions and arrange a test of those predictions so that the therapist and client will be able to determine their accuracy. A test may involve the patient’s deliberate engagement in specific behaviors for the purpose of determining the actual consequences. But, such behavioral experiments need not occur as long as a search for additional new information is involved or the outcome of a test of the client’s beliefs which the therapist and client devised in a previous session is reviewed. In rating this item only consider references to evidence which has just been gathered. For example: The client reported her belief that no man would ever want to enter a long-term relationship with her because she was unable to have children. The therapist helped her to come up with a way of testing her belief by polling a number of male co-workers about their anticipated reactions to such a "hypothetical situation", which she planned to present to them as a plot from a daytime soap opera. Another example: The client believed that her children thought that she was a 'poor mother' because she divorced her paraplegic husband. The therapist helped the client develop a plan to test out this belief. The plan entailed writing to her grown children asking for their honest evaluations of family life and her performance as a mother during their childhood.

46. Facilitates client’s consideration of alternative explanations for events.

This item measures whether the therapist encourages the client to consider possible explanations for an event besides the client’s initial explanations for that event. The term "event" should be interpreted broadly in rating the item. That is, not only does "event" refer to a specific physical occurrence but it can also include a client’s response to another’s behavior or her/his cognitions or beliefs. For example: C: "I guess I’m not smart enough for that kind of job." T: "How do you know that?" C: "Well, I didn’t get the job!" T: "Did you get a chance to talk to the interviewer about why that was?" C: "No." T: "Do you think there could be other factors involved—like the number of applications or their availability—that could have resulted in your not getting this particular job?" C: "Maybe." T: "What other factors aside from you not being smart enough do you think might have been involved in your not getting the job?" Another example: T: "So you
discovered after some time that your husband was, indeed, having an affair." C: "Yes. I was such a fool to believe him when he denied it." T: "You actually asked him and he said that he wasn’t involved sexually with anyone else?" C: "I asked him several times, because I knew something was up, and each time he very firmly said ‘No,’ I’m such a sucker--I should have known!" T: "It sounds like you did a great job of checking out your belief that he was having an affair. I wonder if there’s any other way of explaining your believing him besides that you are a fool. What do you think?" C: "He did lie to me...but I bought it!" T: "Did you have any reason not to? Had your husband lied often before?" C: "Never!" T: "So it might not be so much that you were a fool as that he deliberately deceived you and you were trusting, based on everything you knew about him."

47. Therapist and client practice rational responses to client’s negative thoughts or beliefs.

This item measures whether the therapist assists the client in practicing "rational responses" to her/his distored, negative beliefs. Rational responses represent more accurate or reasonable ways of thinking about an event or issue than the client’s original thoughts or beliefs. The rater should rate this item based on whether the therapist: 1) attempted to teach the client ways of responding to negative thoughts 2) demonstrated or participated in role plays for the purpose of increasing the client’s ability to respond rationally to her/his negative thoughts and beliefs. For example: T: "What were your thoughts after the incident?" C: "I’m really stupid. I can’t even make a reasonable meal. Can’t I do anything right?" T: "And how did you feel after that string of thoughts?" C: "Terrible, like a failure." T: "Let’s try to generate some responses to your thoughts that may be more reasonable than concluding you are a failure. Let’s pretend that I am generating those thoughts; you try to counter them with more reasonable thoughts. OK, I’ll be you. What would you say if I said, ‘I can’t make a reasonable meal’?" C: "Well, maybe that doesn’t mean you’re a failure." T: "All I know is that I screwed that meal up even though I tried to get it right." C: "Have you ever made good meals before that one?" T: "Yes." C: "How often do the meals you make turn out badly?" T: "About half the time, but that one was a total flop. I’m so stupid." C: "Well, if half the meals you make turn out ok, maybe you aren’t a total failure at cooking." T: "I guess that might be true, but I’m certainly not a success either." C: "I agree that there is room for improvement in your cooking, but even if all of your meals were a flop would that mean you were stupid? Are there any other things that you would need to consider in deciding whether you were stupid?"
48. Works with client to plan or practice alternative overt behaviors for the client to use both inside and outside therapy.

This item measures the extent to which the therapist works with the client to plan explicit behaviors for the client to engage in outside of the treatment session and/or to practice those behaviors. Alternative behaviors refer to overt (observable) behaviors rather than covert (i.e. cognitive) behaviors. For example: 1) The therapist helps the client to carefully develop a plan for the client to use in getting a new job or 2) The therapist discusses and "role plays" with the client how to interact with someone outside the therapy.

49. Provides rationale for teaching about the role of cognition in dysfunction.

The therapist discusses 1) the importance of evaluating the accuracy of the client’s beliefs, and 2) the possibility of changing the client’s inaccurate beliefs for the purpose of alleviating the difficulties. For example: T: "When a person is depressed, she is often overrun with negative thoughts and beliefs which are often inaccurate. In order to reduce the depression, it is very important to take a careful look at the accuracy of the thoughts and beliefs, and change them if they are inaccurate." or T: "We are certainly going to want to help you feel better. As a result, we will focus on the way you think to make sure that there are times that you aren’t viewing things inaccurately. If we discover that there are times that your beliefs are not in line with the way things really are, we will work to change your beliefs so that they are more accurate. How does that sound to you?"

50. Assigns and reviews homework.

The therapist provides and reviews homework which provides client with an opportunity to practice techniques out of session.

51. Engages in socratic questioning aimed at guiding client’s reasoning process.

This item reflects the therapist’s attempt to alter the client’s beliefs through socratic questioning: a pedagogical dialogue between "teacher" and "student" in which the "teacher leads the "student" to knowledge through questioning and inquiry. For example: T: "How likely is it that that’s going to happen?" or T: "What’s the likelihood that that’s going to generalize to other situations?" or T: How adaptive is it for you to think about it in that way?"
Appendix C
Preliminary Revision: The Beth Israel Adherence Scale

INTERPERSONAL-EXPERIENTIAL

1. Tracks client’s experience in a moment-to-moment fashion. (The act of following client’s perceptions, thoughts, feelings as they emerge in the moment. Therapist does not make reference to client processing that is not currently being experienced.)

2. Intervenes with skillful tentativeness. (Refers to quality of therapist attitude of exploration and subjectivity; therapist uses words like "perhaps", "it seems", "possibly").

3. Asks exploratory questions which probe for the feeling/experience underlying the client’s utterance including feelings about the feeling/experience or utterance itself – feeling ashamed about feeling this way, etc. (Therapist makes enquiries into what the client is or has experienced. "What does that feel like?, "What was it like for you when he went away", "What was that like for you?, "What’s your feeling about feeling so anxious?")

4. Directs or redirects the focus to the "here and now" (either with regard to the client’s experience or with regard to the relationship between the client and therapist.) ("What’s happening for you right now?", "What would satisfy you with me right now?" "What’s your fear of exploring those feelings with me right now?"

5. Metacommunicates by conveying own feelings to help client become aware of his/her role in the interaction or to probe for client’s internal experience (general metacommunication item) (Include acknowledging own role in the interaction. "I think I’ve been acting hostile towards you." "I feel shut out right now", "I’m feeling put down right now", "I feel like I’m playing a game of chess. Does that make any sense to you?")

6. Respects client as arbiter of experience. (Therapist maintains a humble, subjective, exploratory stance. Therapist is not the expert on the client’s feelings; s/he is facilitating their unfolding.)

7. Deepens client’s experience through evocative reflection. (Therapist takes the client’s either implicitly or explicitly expressed feelings and empathizes with these feelings to amplify/elaborate the client’s felt experience of them. "So, you’re feeling a bit shut down and angry", "So you’re feeling like no one really understands how hard it is for you.")

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8. Deepens client’s awareness/experience through in or out-of-session awareness exercise. (Often when the client has expressed an emotion, the therapist will say: "Try saying that to me directly", "Try saying, ‘I’m angry at you’" or "Over the week, be aware of when you get sad or close off and withdraw.")

9. Directs client’s attention in non-confrontational manner to specific client behaviors, subtle non-verbal communications or paralinguistics, to increase client’s awareness. (This can be an observation of facial expression, body movement or posture, or voice inflection, etc. Therapist does this in a supportive and non-judgmental manner. "I’m aware of a particular tone in your voice." or "When you say this, you have a very angry expression on your face."

10. Engages in empathic conjecture: Hypothesizing, exploring the nature of the client’s experience and then "checking in" after making the conjecture (often, but not always, interrogative). (The conjecture is about inner experience not about psychogenetic causes or patterns in behavior or experience. Therapist takes a "guessing" or "hypothesizing" stance with client and asks client to "check" therapist’s hunch with client’s experience. "And so this is when I guess the hopelessness sets in...Is that true for you?", "Powerful, right? It’s like the only power you have, right?"

11. Explores the HOW, or mechanism of a client’s defense, not the WHY. (Therapist focuses on the feelings underlying the client’s defense and NOT the reasons for them. The goal is not to establish causal links but to identify experience in the feelings which elicit certain defenses. "Are you aware of controlling your feelings in any way?" "What are you avoiding?" "Are you aware of stopping your feelings right now?" "How do you stop your feelings?"

12. Facilitates individuation and/or self-assertion. (Therapist encourages the client to either ask for what s/he wants or to express his/her feelings directly to therapist. "Do you have a sense of what you want from me right now?", "I wonder if you could tell me how disappointed you are in my now?"

BRIEF-ADAPTIVE

13. Interprets and/or explores client’s resistance or defenses. (Any interpretation provides a new understanding or offers a label of an inner state; it presupposes knowledge by the speaker of the client’s experience and places it in the speaker’s frame of reference. "You try to avoid situations which make you feel confused." "When you feel anxious, you tend to withdraw."

14. Explores and elucidates the unconscious aspects of major maladaptive patterns, thoughts, and behaviors. ("What’s that need
you have to feel frustrated?" "Why do you think you do that?" "What's that about when you act that way?" "Why do you think you're so frightened of competition?" "When you feel scared, you act hostile. Why do you think that is?" Here the therapist is probing for the unconscious aspects of the client's behavior/feelings.)

15. **Frames symptoms in a relationship context.** (Therapist shows client that particular symptoms are associated with aspects/events in client's relationships. Symptoms are believed to be a result of previously dysfunctional relationships. Forgetting is a "symptom" of memory dysfunction; anxiety and depression are also examples of symptoms, e.g. therapist notices that every time a client's attractiveness is mentioned, she feels very sad. Father would show little interest when client would get recognition for an achievement or attribute, etc. Therapist says, "You felt depressed in response to your father's losing interest in you. And now you feel sad with me because you perceive that I, too, have lost interest in you."

16. **Interprets/explores maladaptive patterns by linking components of a conflict.** (Therapist provides a construction that links different components of an internal conflict. For example, drives or wishes can be linked with anxiety which can be linked with defensive processes which can be linked with affect. "You felt anxious and that made you pick a fight with your wife" "You want to leave but you are afraid so you stay."

17. **Interprets/explores maladaptive patterns by linking dynamics with parental/significant figures in the past to others in the present not including therapist.** (i.e carrying past parental relationship dynamics into the present in a way that is not productive.) ("One of the things we've learned from looking at your relationship with your mother is that you tried to do the accommodating thing in order to get her approval. It seems that you do a similar thing with Bob, never crossing him, so that he won't be angry with you."

18. **Interprets/explores maladaptive pattern by linking dynamics with others (past and present) to current dynamics with therapist.** (Therapist tries to show the client that patterns that existed in relationships with significant others are similar to patterns in the relationship with the therapist. "So you used to rely on John on a daily basis, and now you can't so that cause he's gone so you feel like you are starting to rely on me for those things."

19. **Interprets other aspects of client's behavior or experience.** (Not captured in other items - **General interpretation.** (It sounds like you have trouble figuring out who you are and what you want out of your life, separate form what your parents want.")
20. **Reflects the content of client’s statement.** (Therapist attempts to understand the meaning of the content of what client has said and reflects this back to the client. It is often a summary of what the client has just said rather than a reflection of feeling. Therapist conveys that client’s meaning has been understood.)

21. **Frames symptoms as coping attempts.** (The therapist recognizes and points out that particular symptoms can be understood as faulty and costly attempts at problem-solution. "You really want someone to soothe you but nobody is there so you eat as a way of feeling better.")

22. **Confronts client, suggesting that he/she is saying, feeling or thinking something different than what the client claims.** ("You say that you are not angry and yet your expression looks angry." "You say that you are not anxious, but you are talking very quickly and you’ve been twisting your hands back and forth in the way you told me you do when you’re nervous.")

23. **Defines/identifies/specifies the maladaptive pattern.** ("You have a tendency when you’re feeling scared to pull back and we’ve seen how this happens in your close friendships and in your relationships with people at work" "When you get angry with people you care about, you have a tendency to react impulsively. This has been happening for a long time in relationships with people you are close to. We need to understand what this pattern is about.")

24. **Links resistance (to the therapeutic process) to the maladaptive pattern.** ("You’re tuning out here with me just like you tune out elsewhere when things get tough" – links behavior with the therapist to behavior in other situations/with other people. "You’re shutting down with me now just like you do at home witty your family when you get angry.")

**COGNITIVE-BEHAVIORAL**

25. **Probes for client’s underlying beliefs or personal meaning behind client’s thoughts.** ("What does that mean to you?" "What does that thought mean to you?" "If you think that he won’t want to talk with you, what does that mean to you?")

26. **Helps client identify cognitive distortions, errors that were present in his/her thinking.** (Magnifying or minimizing; catastrophizing; personalizing; generalizing. "Do you see how this all-or-none thinking usually decreases the number of options you see?")

27. **Engages in didactic persuasion.** ("This plan we were talking about allowed you to test out the predictions you had. Do you see how you were able to disprove those predictions and thus get more
accurate information?")

28. **Asks client to report specific thoughts.** ("What thoughts do you have about that?" "What are your thoughts about that feeling?" "Let's see what the specific thought is that you have about his.")

29. **Encourages client to distance him/herself from his/her thoughts, viewing them as beliefs rather than facts.** ("What's that belief about?", "What is that thought?" - NOT, "What do you think" or "What do you believe?" BUT, more "this or that thought", "this or that belief.")

30. **Helps client examine currently available evidence or information to test the validity as well as realistic consequences of the client's beliefs.**

31. **Explores the advantages and disadvantages of dysfunctional attitudes.** ("What's the advantage to believing that?" "How useful is the belief that you will never get ahead?" "Is there a disadvantage to that thinking style?")

32. **Facilitates client's consideration of alternative explanations for events.** ("Is there any other explanation for this event than the one you've come up with so far?" "What would be another way to explain why Bill reacted in that strong way?" "What about considering another perspective on this situation and seeing if it fits" "Are there other factors which could have played a role in your not getting the position?")

33. **Therapist and client practice rational responses to client's negative thoughts and beliefs.** (Rational responses represent more accurate or reasonable ways of thinking about an event or issue than the client's original thought or belief. "Let's try to generate some thoughts that may be more reasonable than concluding that you are a failure. "I'll come up with the negative thoughts and you try to counter them with more reasonable thoughts. What would you say if I said that I can't make a decent meal?"

34. **Works with client to plan or practice alternative overt behaviors for the client to use both inside and outside of therapy.** (Overt behaviors refer to observable behaviors rather than covert or cognitive behaviors. The therapist may help the client to develop a plan for getting a new job. The therapist discussed and role-played with the client how to interact with someone outside of therapy.)

35. **Assigns and reviews homework.** (The therapist goes over with the client the previous assignment from the week before. The therapist discusses with the client the assignment for the coming week.)
36. Engages in *socratic questioning* aimed at guiding client's reasoning process. ("And what do you think would happen if you did that?" "Where is that kind of thinking going to take you?" "How likely is that to happen?" "Where's the evidence for that?" This is guided questioning. This often involves "disputing" or "challenging" the client's beliefs or ideas.)