Therapists' Adherence To Manualized Treatments In The Context of Ruptures

by

Dalia Spektor

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Dissertation Committee:
Dr. Jeremy Safran
Dr. Christopher Muran
Dr. Doris Chang
Dr. Jose Casanova
Abstract

The overall goal of this study was to investigate therapists' technical behavior during ruptures. Therapists who were trained in Brief Relational Therapy (BRT) and Cognitive Behavioral Therapy (CBT) participated in this study. Therapists' mean scores of adherence to BRT, CBT, and Brief Adaptive Psychotherapy (BAP) were correlated with outcome, defined by two patient self-report outcome measures: a measure of psychiatric symptoms (SCL-90-R) and a measure of interpersonal distress (IIP-64). Results suggest that BRT and CBT therapists were significantly more adherent to their respective treatments; however BRT therapists appear to be more adherent to their treatment than CBT therapists. Findings indicate that relational therapists' utilization of BRT interventions is correlated with a decrease in overall psychiatric symptoms. Findings also suggest that relational therapists' use of CBT interventions is correlated with a decrease in psychiatric symptoms. Furthermore, results show that BRT therapists' use of BAP interventions is correlated with an increase in psychiatric symptoms as well as interpersonal distress. No significant or sizeable effects were observed in the CBT group. These findings have important implications for future research and training of therapists' technical behavior during ruptures.
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Introduction and Literature Review

Therapists’ Adherence to Manualized Treatments in the Context of Ruptures

Researchers investigating the process of change in psychotherapy have demonstrated what clinicians have intuited for many centuries: the therapeutic relationship, or the therapeutic alliance, is the strongest predictor of change in psychotherapy outcome research (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). In response to these findings, a generation of research has emerged investigating the factors that aid in the development and maintenance of a strong therapeutic alliance.

Findings have shown that the therapeutic alliance is vulnerable to change and that deteriorations in the alliance can be detrimental to the process and outcome of therapy (e.g., Safran, Crocker, McMain, & Murray, 1990). These findings inspired a number of researchers to investigate ruptures, or strains, in the therapeutic alliance in order to clarify the factors involved in effectively repairing ruptures in therapy.

Research findings on therapists’ technical behavior during ruptures have indicated that the process of recognizing and attending to ruptures is not an easy task for even experienced clinicians. For one, many therapists are not aware of some of the problems in the alliance (Regan & Hill, 1992; Hill, Thompson, Cogar, & Denman, 1993) and even if they do become aware of their patients’ negative feelings, the ways in which they respond to these feelings are not always helpful.

On the other hand, interpersonal and relational theories have informed clinicians and researchers on the ways in which therapists can address ruptures in beneficial ways.
For example, research in contemporary forms of psychodynamic therapy has indicated that therapists can respond in effective ways during ruptures. Findings from these studies demonstrate that therapists’ use of relational interventions that address problems in the alliance, specifically in relation to the therapist, can be beneficial to the outcome of therapy (Marziali, 1984; Foreman & Marmar, 1985; Kivlighan & Schmitz, 1992; Gaston, Marmar, Gallagher, & Thompson, 1991; Safran & Muran, 1996).

On the basis of these findings, researchers have placed greater emphasis on developing integrative treatment manuals and training therapists to adhere to relational interventions during ruptures. Although recent developments in the field of psychotherapy integration have been promising, research findings on the benefits of therapists’ adherence during ruptures have not been as encouraging. Research has shown that therapists’ rigid adherence to treatment manuals may contribute to problems in the therapeutic alliance and the outcome of therapy.

For example, a number of researchers of psychodynamic therapy have observed that therapists’ increase in their use of transference interpretations resulted in problems in the alliance (Piper, Azim, Joyce, & McCallum, 1991; Piper, Ogrodniczuk, Joyce, McCullum, Rosie, O’Kelly, & Steinberg, 1999). Furthermore, studies on the effects of training in psychodynamic therapy have demonstrated a link between therapists’ frequent use of complex communications and negative process (Strupp, 1989; Henry, Strupp, Butler, Schacht, & Binder, 1993).

Likewise, research in cognitive behavioral therapy has demonstrated similar
findings. Researchers discovered that therapists increased their adherence to specific interventions in cognitive behavioral therapy during alliance strains and that this, in turn, contributed to deteriorations in the alliance and outcome (Castonguay, Goldfried, Wiser, & Raue, & Hayes, 1996).

These findings suggest that therapists’ strict adherence to treatment manuals during ruptures may be detrimental to outcome; however, whether therapists’ strict adherence to these specific interventions or whether the specific interventions themselves are implicated in poor outcome has not been determined.

Based on the studies so far, it can be inferred that therapists’ rigid adherence contributes to problems in the alliance. Another interpretation for the findings, however, is that certain interventions (e.g., dynamic and cognitive behavioral interventions) are not effective during ruptures. According to this line of reasoning, the degree of therapist adherence is not the source of the problem; rather it is the interventions to which therapists adhere.

Thus, on the basis of theories on rupture resolution and research findings demonstrating the benefits of therapists’ use of relational interventions during ruptures, it can be inferred that therapists’ adherence to relational interventions during ruptures would contribute to good outcome, regardless of the degree of therapist adherence. Additional research is necessary in order to clarify the relationship between therapists’ adherence to relational, cognitive behavioral and dynamic interventions and outcome during ruptures. The present study is a step in that direction.
This study will investigate therapists’ technical behavior during ruptures. Therapists in two treatment groups (relational therapy and cognitive behavioral therapy) will be investigated. Therapists’ utilization of relational, cognitive behavioral, and dynamic interventions, will be correlated with outcome.

The literature review, which follows, begins with a historical outline of the theoretical conceptualization of the therapeutic alliance. Empirical findings on the therapeutic alliance are reviewed.

Theoretical and empirical research on ruptures is presented, with a particular focus on writings on rupture resolution. An outline of the historical development of treatment manuals is provided; features of treatment manuals as well as their advantages and disadvantages are highlighted. Furthermore, research on therapist adherence to treatment manuals in the context of ruptures is reviewed. The literature review concludes with a statement of purpose and a list of the research hypotheses generated by this dissertation.

The Therapeutic Alliance

The therapeutic alliance, which is also referred to as the therapeutic relationship or the working alliance, has taken a predominant place in psychotherapy research in the last two decades; however, the concept of the alliance was developed more than 70 years ago. This will be discussed below, followed by a review of the empirical research.

Conceptualizations of the therapeutic alliance. The therapeutic alliance originated in early psychoanalytic literature. Sigmund Freud (1912) acknowledged the value of the
analyst's role in permitting the client to form an attachment to the analyst (vis-à-vis transference). Freud perceived the attachment between the therapist and patient as a distortion of reality. He believed that it was the therapist's job to interpret the erroneous perceptions that the client transferred onto the therapist and that analyzing these perceptions was critical to the therapy and to the patient's improvement. Thus, while a good relationship was essential to the therapeutic process, it was a source of interpretation for the therapist. Later, however, Freud modified his earlier perception of the therapist-patient relationship from a distortion of the real relationship to include a reality-based attachment in which healing takes place.

Sterba (1934) and Zetzel (1956) provided the groundwork on which the concept was developed. Sterba wrote of the need for the analyst to form an "alliance" with the patient's ego against the forces of unconscious impulses in order to make progress in analysis. Sterba was first to emphasize the importance of rationality and objectivity in therapy. Zetzel distinguished between the "transference neurosis," which she defined as a manifestation of resistance, and the "therapeutic alliance," which she considered to be an essential component of successful psychoanalytic treatment.

Bibring (1954) suggested that the therapeutic situation represents a "new object relationship." In other words, the patient is able to form an attachment to the therapist that is different from those the patient formed during past childhood experiences, suggesting that the perception of the relationship is malleable rather than fixed.
Greenson (1967) extended the ego psychological view that emphasized the real aspects of the relationship as opposed to the transference manifestations of the patient’s reactions to the therapist. Greenson (1971) developed the notion of the working or therapeutic alliance. His model consisted of three components: transference, the working alliance, and the real relationship. Greenson conceptualized the “working alliance” as the ability of the patient and therapist to work together in treatment over the course of therapy, with the understanding that the relationship transforms through several stages with the active participation of the patient and therapist.

The writings of Gill (1979, 1982) have advanced the conceptualization of the therapeutic relationship, noting that just as a client’s unconscious and conscious responses affect the ongoing process, so do those of the therapist. Unlike the views held by classical analysts, Gill argued that there are two subjectivities in the consulting room and that both influence one another’s perception of the relationship.

Although traditional conceptualizations of the alliance placed emphasis on the importance of a strong therapeutic relationship in psychotherapy, they did not view the alliance as a sufficient mechanism of change. The emphasis was placed on specific interventions that were necessary in order for change to develop. Following the more traditional conceptualizations of the alliance, theorists refined the concept of the therapeutic relationship and offered a new way of thinking about the mechanism of change.

Luborsky (1976) advanced the concept of the alliance, suggesting it is a dynamic rather than a static entity, and is malleable and responsive to the changes of therapy.
Luborsky identifies two types of “helping alliance”: Type 1 characterizes the early stages of therapy and is more evident in the beginning stages of treatment. Type 2 emerges later in treatment and essentially is more responsive to changes in the therapeutic process.

In 1979, Edward Bordin proposed a broader definition of the working alliance, one that would lead to the development of a transtheoretical construct. Bordin suggests that the alliance is primarily a conscious “here-and-now” relationship that is generic to all helping processes. Bordin’s transtheoretical definition of the alliance is made up of three interlocking components: bonds, tasks, and goals. These components are theorized to facilitate therapy and are beneficial therapeutic agents in their own right.

Briefly, “tasks” refer to the behaviors that inform the therapeutic process. In an effective treatment both patient and therapist must perceive these tasks as efficacious and important and both must agree to perform them. “Goals” refer to the patient and therapist’s perception of outcome. A positive alliance is characterized by the therapist’s and the patient’s mutual agreement and valuing of the goals of the treatment. Finally, the concept of “bonds” includes issues of mutual trust, acceptance, positive personal attachment and confidence. The quality of the alliance is a function of the degree to which the patient and therapist are able to negotiate an agreement about the tasks and goals in the therapy and this, in turn, mediates the quality of the bond.

Bordin’s conceptualization of the alliance placed emphasis on the interdependent relationship between the specific technical aspects of therapy and the non-specific, therapeutic effects. Furthermore, Bordin suggested that the quality of the alliance is mediated by this complex, multidimensional, and interdependent relationship.
The conceptualization of the alliance as an emergent property of the therapeutic relationship suggests the alliance can fluctuate over time (Safran & Muran, 2000) and that the fluctuations themselves provide opportunities for negotiating the alliance, thought to be critical to the change process. The importance of the alliance to psychotherapy change influenced researchers to focus more specifically on the key components believed to facilitate the strengthening of the alliance. Next, empirical findings on the therapeutic alliance and outcome are reviewed.

*Research on the therapeutic alliance.* There have been two meta-analyses on the alliance-outcome relationship. In the first meta-analysis, Horvath and Symonds (1991) reviewed 20 studies published between 1978 and 1990, and found a statistically significant correlation of .26 between alliance and outcome.

In the second meta-analysis, Martin and colleagues (2000) found a correlation of .22, accounting for 5% of the variance in outcomes. These studies demonstrate that the alliance accounts for more variability in outcome than specific factors (which account for roughly 0%) and, that problems in the alliance, if not resolved, can result in unilateral termination by the patient (Samtsag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1990; Tryon & Kane, 1993; Tryon & Kane, 1995).

It appears some therapists are better able than others at facilitating a strong alliance (Najavits & Strupp, 1994). Researchers have observed greater evidence of problems in the alliance (i.e., hostile interactions and complex communications) in poor outcome cases than in good outcome cases (e.g., Henry, Schacht, & Strupp, 1986; Coady, 1991). In light of these findings, researchers investigating ruptures in the therapeutic
alliance study the processes involved in repairing ruptures as they occur. Theories and research on ruptures are reviewed next, with a particular focus on writings on rupture resolution.

*Ruptures in the Therapeutic Alliance*

Safran and Muran (1996) define ruptures as “deteriorations in the relationship between therapist and patient” (p. 447). Safran and Segal (1990) explain that ruptures are inevitable and that “most therapy cases are characterized by at least one or more ruptures over the course of therapy” (p. 154). Furthermore, Safran and Muran (1996) assert that ruptures may vary in intensity, duration, and frequency, depending on the uniqueness of the patient-therapist dyad. In addition, Safran and Muran characterize ruptures as patient behaviors or communications that can be identified as interpersonal markers, indicating critical points in therapy for further exploration. These findings underscore the importance of investigating factors involved in recognizing and repairing alliance strains.

The practice of resolving ruptures in the alliance can be difficult for both clinicians and patients. For example, Rennie (1994) conducted a qualitative analysis of patients’ interactions to their therapists during ruptures. Rennie’s findings suggest that patients avoid expressing negative feelings towards their therapy and/or therapist because they believe that protecting their therapists’ feelings keeps the relationship in tact.

Regan and Hill (1992) asked patients and therapists to discuss thoughts or feelings they had difficulty expressing in treatment. They found for both patients and therapists, negative thoughts and feelings were often left unsaid. In addition, they discovered therapists were only aware 17% of the time of their patients’ holding back.
Rhodes, Hill, Thompson, and Elliott (1994) performed a qualitative analysis in which they asked therapists to reflect on misunderstanding events from their own treatment. They found although some patients were able to express their negative feelings towards their therapists, those who were not able to talk openly about the misunderstood events were able to successfully hide their feelings, the misunderstandings were left unresolved, and patients terminated treatment.

Interpersonal and relational theories have informed clinicians and researchers on the ways in which therapists can effectively intervene during ruptures. An overview of interpersonal and relational theory is provided next.

**Interpersonal conceptualizations of ruptures.** Interpersonal theory provides a framework for understanding ruptures. Safran (1990a, 1990b) explains that ruptures are likely to emerge when a therapist inadvertently engages in a maladaptive interpersonal cycle that is characteristic of the patient’s early childhood experiences. This has the effect of confirming the patient’s dysfunctional interpersonal schema.

For example, a therapist who responds to a patient’s blaming and attacking behavior in a defensive manner, namely with his or her own counter-hostility, would thereby confirm the patient’s view of others as hostile and, consequently, obstruct the development of a good therapeutic relationship. Similarly, a therapist who responds to his or her patient’s in-session avoidant behaviors by withdrawing confirms the patient’s view of others as distant, aloof, and emotionally unavailable, thereby perpetuating a vicious cycle. Viewed from this perspective, ruptures are conceptualized as interpersonal markers.
that exist in the interactions between therapist and patient, not merely in the patient’s psychopathology.

Relational conceptualizations of ruptures. The 1980’s marked the emergence of relational thinking in contemporary psychoanalytic theories (Mitchell, 1988). Relational theory is integrative in nature; it synthesizes theories from diverse areas such as American interpersonal theory, British object relations theory, self-psychology, as well as existential and postmodern theories. Relational theory places emphasis on the interpersonal and intersubjective nature of therapeutic interaction, which stands in contrast to the more traditional view of the alliance as aspects of a patient’s transference to the therapist. An interpersonal and intersubjective understanding of the alliance and of ruptures posits that both the patient and therapist contribute to the strengthening, as well as to the weakening, of the alliance.

Relational theory attempts to elucidate the very nature of being human. In Safran’s (1993) *Breaches in the therapeutic alliance: an arena for negotiating authentic relatedness*, Safran writes, “In life we must all inevitably negotiate the paradox that by the very nature of our existence we are both alone and yet inescapably in the world with others.” At the same time, Safran posits, “we are born in relationship with others and attain a sense of self only in relation to others” (pp. 14 - 15). Thus, at the very core of each relationship, is the negotiation of one’s sense of relatedness with another.

Research on Ruptures in the Therapeutic Alliance

Empirical support for interpersonal and relational approaches to the handling of ruptures can be found in research in contemporary forms of psychodynamic therapy.
Researchers have demonstrated that certain interventions that focus on exploring the here-and-now (Strupp & Binder, 1984) in-session process, including thoughts and feelings about the treatment relationship (Safran & Muran, 2000; Wachtel, 1993) may be more advantageous than interventions linking patient, therapist, and past others.

For example, Marziali (1984) found that interventions, which focus on the therapeutic relationship, contribute to the outcome of brief psychotherapy. Marziali demonstrated a positive association between more favorable outcomes and the frequency of therapists’ interpretations that associated thoughts, behaviors, and/or feelings toward the therapist.

Foreman and Marmar (1985) reported that psychodynamic therapists were able to improve the level of alliance by addressing the conflicted in-therapy relationships. In their study, they found that in cases with improving alliances, one of the more frequent interventions was therapists’ exploration of the client’s problematic feelings in relation to the therapist, and linking the problematic feeling with the therapist to the client’s defenses.

In addition, Kivlighan and Schmitz (1992) looked at counselor technical activity with improving working alliances and continuing poor-working alliances. They were able to demonstrate a positive correlation between specific counselor interventions and improving alliance dyads. They observed that interventions that were more challenging and thematically focused on the interactions within the relationship (here-and-now) were found to be more related to the increasingly improving alliance dyads, than with the continuing poor alliance dyads.
Furthermore, Gaston and colleagues (1991) found that therapists who focused on clients' problematic relationships improved the alliance, in contrast to those who focused on the problematic content alone. It appears that interventions that overemphasize patients' problems come at the expense of exploring patients' feelings about the therapeutic relationship and are seemingly not as effective in addressing problems in the alliance.

These findings indicate that the process of recognizing and addressing ruptures in a non-defensive manner is a critical component to the process of repairing ruptures. In recent years, a number of researchers have begun designing and developing a model for identifying ruptures in order to provide guidelines for the process of rupture repair.

_A model for rupture resolution._ Safran and Muran (1996, 2000) and colleagues' relational model was developed at the Brief Psychotherapy Research Program for the purpose of identifying ruptures and stipulating the repair process. Their relational model, guided by the task-analytic paradigm for psychotherapy research (Greenberg, 1986; Rice & Greenberg, 1984; Safran, Rice, & Greenberg 1988), conceptualizes the repair of ruptures as opportunities for negotiating the therapeutic alliance and as crucial to the process of change.

The model, Brief Relational Therapy (BRT), identifies two elements critical to the resolution process: (1) the principle of metacommunication and (2) a stage-process model of rupture resolution in the alliance. In this context, metacommunication refers to the therapist's self-reflection and communication about the current interaction between patient and therapist. The stage-process model outlines a “schematic representation”
characteristic of stages that commonly emerge when ruptures are resolved. In the process of exploring, understanding, and resolving alliance ruptures, the patient develops a modified interpersonal schema that is capable of being more interpersonally related. Furthermore, the working through of the rupture and the negotiation of the relationship is the very essence of change itself (Bordin, 1979, 1994; Safran & Muran, 2000). Over the years, research on BRT has resulted in refining the model. Findings coming out of studies investigating the effectiveness of the model are promising.

Research on the rupture resolution model. Muran and colleagues (2005) conducted a study comparing BRT to two short-term psychotherapies: a form of psychodynamic therapy and another of cognitive behavioral therapy. These researchers were able to demonstrate that although the three therapies were equally efficacious, BRT was superior to the other two therapies with relation to patients’ drop-out rates, providing further support for BRT.

In a later smaller-scale study, researchers identified poor alliance cases at risk for treatment failure and compared the three treatments with these patients. Findings from this study demonstrate that certain interventions such as exploring patients’ negative feelings towards the therapy/therapist in a non-defensive manner contribute to resolving ruptures in the alliance and improving weakened alliances.

As previously noted, patients are often reluctant to talk openly about their negative feelings towards their therapists (Rennie, 1994; Regan & Hill, 1992; Hill et al., 1993). Training in BRT teaches therapists to use interventions that focus on exploring the
feelings in the here-and-now of the therapeutic relationship, and how to facilitate an open
discussion about the rupture in a way that prevents unnecessary anxiety for the patient.

There has been greater interest among researchers and psychotherapists to
integrate relational and interpersonal interventions into various forms of psychotherapies
and to develop integrative forms of treatment manuals. The movement toward
psychotherapy integration has been charted in various traditions. For example, this
movement has been traced in psychoanalytic theory (Mitchell, 1988; Eagle, 1984), as
reflected among some integrative forms of psychodynamic and interpersonal therapies
(e.g., Wachtel & McKinney, 1992).

Likewise, the cognitive tradition has witnessed a reformulation in its
conceptualization of change toward an interpersonal perspective, with the recognition of
the alliance as a mechanism of change in its own right (e.g., Arnkoff, 1983; Goldfried,
1982; Jacobson, 1989; Safran, 1984a, 1984b). These changes have important implications
for future research, in terms of development of treatment manuals, as well as future
training of therapists in applying treatment manuals in ways that contribute to positive
treatment effects.

Research in therapist adherence to treatment manuals has yet to reach a
conclusion about the benefits of therapist adherence. Methodological and conceptual
problems with operationalizing treatment adherence pose barriers for researchers in this
area. Furthermore, there is evidence showing a link between therapists' adherence to
treatment manuals and problems in the alliance. Next, several issues that pertain to
treatment manuals are discussed. The review begins with a historical development of
treatment manuals; methodological and conceptual problems are addressed and a review of research on therapists' adherence to treatment manuals and its effects on the alliance and outcome is provided.

_Treatment Manuals_

_Historical development._ Initially, treatment manuals were developed for behavioral therapies (e.g., Wolpe, 1969). The historical and cultural beliefs of this time reflected several assumptions that were held by behaviorists. Namely, behaviorists argued that therapist variables, such as therapist warmth and friendliness, were much less important than treatment interventions and procedures. In addition, behavioral theorists believed that the treatment interventions could be executed with precision, and that psychotherapy research required quantification of the treatment interventions being administered.

As treatment manuals were developed for other non-behavioral treatments and became widespread, a greater emphasis was placed on therapist competence and skill in the acquisition and application of interventions. Furthermore, one of the more common modifications regarded the degree of flexibility in treatment guidelines (Beck & Emery, 1986; Klerman & Neu, 1976; Klerman, Weissman, Rounsaville, & Chevron, 1984; Luborsky, 1976, 1984; Strupp & Binder, 1982), while still continuing to place a strong focus on treatment interventions.

In the mid-to late-1980’s, there was considerable amount of enthusiasm among the psychotherapeutic community about the role that treatment manuals could potentially play in training therapists and in systematizing the ways in which therapists practice (e.g.,
Luborsky & DeRubeis, 1984; Strupp, Butler, & Rosser, 1988). Many believed that treatment manuals offered a systematic approach for investigating treatments by specifying and tracking the interventions used in psychotherapy (Luborsky & DeRubeis, 1984).

In the last decade or so, treatment manuals have become a standard for clinical training and their use is now a prerequisite for funded studies. Psychotherapy researchers are currently required to use treatment manuals to increase treatment purity. Furthermore, it is necessary for researchers to perform a manipulation test in order to assess the extent to which therapists adhere to the treatment manual and the extent to which they perform the intervention in a competent manner. The ability to monitor treatment adherence, also referred to as treatment fidelity or treatment integrity, can provide additional information about how treatments are implemented. Furthermore, checking therapist adherence can rule out treatment effects due to differences in the operationalization of the treatment (Waltz, Addis, Koerner, & Jacobson, 1993).

Features of Treatment Manuals

Treatment manuals require identifiable technical procedures that are applied to facilitate change. Although it is necessary to provide identifiable interventions in order for a treatment to be written into manual form, it is also essential to specify the general process of treatment. Thus, the manual provides various interventions as well as a general structure for the treatment. Beyond specific interventions and a general treatment structure, another element of treatment manuals is the availability of a highly developed and articulated treatment model. In other words, the manual should provide an underlying
set of propositions that therapists in training need to internalize for later use with their patients (Shaw & Dobson, 1988).

Advantages of Treatment Manuals

Internal validity. Treatment manuals provide a systematic approach for investigating treatments by specifying a set of identifiable procedures, ensuring that they exist and tracking them for their use in psychotherapy (Luborsky & DeRubeis, 1984). In addition, the use of treatment manuals encourages the scientific practice of replicating outcome studies, thereby validating the method at use.

Treatment integrity and treatment differentiation. The primary function of treatment manuals is to ensure that the prescribed interventions and procedures under investigation are employed by the therapist and that the manualized treatments entail distinctly different interventions from other treatment modalities. Thus, an important distinction in internal validity must be made between treatment integrity and treatment differentiation (Kazdin, 1986).

Treatment integrity refers to the extent to which the therapist conducts the treatment according to the demands of the treatment manual. One important aspect of treatment integrity has to do with the extent to which certain interventions are both prescribed and proscribed by the treatment manual. Most treatment manuals prescribe the intervention behaviors that are expected of therapists (Sechrest et al., 1979), such as: empathic listening, receptive silence, and friendliness. It is equally important for psychotherapy researchers to be cognizant of certain interventions that may be inconsistent with a treatment approach or may actually be proscribed.
Treatment differentiability refers to the unique features of the treatment and the extent to which it can be differentiated from other treatments. Treatment differentiation, in contrast to treatment integrity, refers to the extent to which the therapy under investigation can be differentiated from either the contrast therapy (if there is one) or other therapeutic interventions in general. It refers to the extent to which the manualized treatment is unique and can be uniquely identified by its interventions and techniques and rigorously tested in a variety of manners (Bergin & Suinn, 1975; Beutler, 1979).

_Treatment reliability._ Before any treatment can be broadly accepted, it is imperative that other researchers replicate the original outcome findings. Thus, one of the fundamental advantages of treatment manuals is that they facilitate such direct replication of the therapy. In addition, if the therapy can be replicated by various research groups, the ability to contrast the results from previous studies is enhanced.

_Treatment dissemination._ Another advantage with broader consequences occurs in the area of training. Manualized therapies allow for easier dissemination of treatment techniques. This is afforded with the process of didactic teaching and experiential procedures. From a research perspective, treatment manuals have the ability to make the training task clearer and more concise (Shaw, 1984). Although many methodological advantages exist with treatment manuals, there are also limitations.

_Disadvantages of Treatment Manuals_

_External validity._ Treatment manuals are often used in research settings, thereby limiting external validity. Due to the complexities and demands of clinical practice, therapists often tailor their approach to the particular needs of the patient and, therefore,
most therapists do not administer therapy “by the book” (Garfield, 1996). Given these clinical realities, very few therapists administer theoretically pure treatments in clinical practice (Norcross & Goldfried, 1992).

*Research costs.* Although costs occur in all psychotherapy research, some are specific to the development of treatment manuals (Dobson & Shaw, 1988). Development costs include the time required for the distillation of the treatment techniques, the time required to prepare the treatment manual, and the time required for the development of measures to assess treatment fidelity. Once the methods have been established, there are certain costs associated with using manualized treatments, including those of rigorous therapist training, those associated with monitoring therapy, those associated with feedback delivery to the therapists, and those resulting from the loss of therapy cases due to insufficient representation of the treatment manual.

*Schoolism.* Another criticism of treatment manuals is that they potentially promote schoolism, such that integrative approaches may be inadvertently devalued, as well as codifying a stagnant set of acceptable techniques (Najavits et al, 2000; Dobson & Shaw, 1988; Wilson, 1998).

*Therapist adherence versus therapist competence.* Waltz and colleagues (1993) define therapist adherence as the extent to which therapists use interventions and approaches prescribed by the treatment manual and avoid the use of interventions proscribed by the treatment manual.

There are several methods of assessing therapist adherence. The simplest method is using a checklist of techniques and rating the occurrence or nonoccurrence of
interventions that are prescribed or proscribed by the treatment manual (Waltz et al., 1993). A more detailed way of assessing adherence is with frequency ratings. Frequency ratings indicate the frequency or extensiveness of interventions used during the session rather than only their presence or absence.

Waltz and colleagues (1993) define therapist competence as the extent to which therapists conducting the interventions take the relevant aspects of the therapeutic context into account and respond appropriately to these contextual variables (Waltz et al., 1993). Unfortunately, treatment manuals seldom explicitly state criteria for assessing therapist competence and researchers often make the erroneous assumption that adherence to the treatment manual is equivalent to therapeutic skill or competence. This flawed belief fails to determine whether a treatment was actually given a fair test because a thorough investigation of the therapist’s competence is not assessed (Waltz et al., 1993).

Another disadvantage of treatment manuals and a frequently expressed concern is that manuals represent a “cookbook” approach that places too much emphasis on technical adherence, overvaluing fidelity at the expense of therapeutic competence (Binder, 1993). Furthermore, the emphasis placed on treatment fidelity oversimplifies the therapy process and can result in the misuse of techniques (Addis, 1997; Crits-Christoph, 1993). Thus, because treatment manuals place so much value on treatment techniques, they may underplay the need to assess and ensure therapist competence.

The benefits of therapists’ adherence to treatment manuals on the outcome of therapy are unclear as findings on this relationship have been inconclusive (e.g., Binder, 1993; Crits-Christoph et al., 1991).
Research on the Effects of Therapist Adherence to Treatment Manuals

In a study on the efficacy of two distinct manual-based psychotherapies and a drug counseling treatment, Luborsky and colleagues (1985) have been able to demonstrate that treatment purity (the ratio of prescribed to proscribed interventions) predicts symptom improvement and that manual-based treatments “provided significant correlations with outcomes” (p. 602). Furthermore, Rounsaville and colleagues’ (1988) review of findings from manual-based psychotherapy training programs in short-term interpersonal psychotherapy for depression, suggest that therapists’ adherence with the treatment manual is related to increased therapist efficacy.

On the other hand, treatment flexibility has been associated with good outcome, as well. Jacobson and colleagues (1989) compared treatment efficacy of standardized marital therapy vs. an individualized, “clinically flexible” treatment. Essentially, both treatments in their study were constructed from the same elements (e.g., behavior exchange, communication training, companionship enhancement, etc.); but the clinically flexible treatment, unlike the standardized one, was tailored to the couples’ needs. Although both treatments produced statistically significant improvements, the couples that were treated with the clinically flexible treatment were more likely to have maintained their gains six months after termination than the couples treated with the standardized treatment.

Research on therapists’ adherence during ruptures has suggested that therapists’ degree of adherence to treatment manuals may be contributing to problems in the alliance. For example, Piper and colleagues (1991) found that when therapists increased
their use of transference interpretations they experienced problems in the alliance, resulting in negative outcome for patients with a history of problematic high-quality object relations.

In their later work, Piper and colleagues (1999) examined a sample of dropouts and conducted a qualitative analysis of the last sessions prior to drop out. Piper and colleagues discovered that in the dropout cases, patients often would start treatment by expressing dissatisfaction with therapy and therapists would respond with transference interpretations. When patients would start to withdraw in the session, therapists tended to increase their adherence to the transference issues, further complicating the alliance.

Furthermore, Henry and colleagues (1993) assessed the effects of training in short-term dynamic therapy. Therapists were given a year of intensive training in a manualized form of psychodynamic treatment. The training focused on helping therapists detect and manage maladaptive interpersonal patterns enacted in the therapeutic relationship. Following their training, the therapists treated a cohort of patients. Findings showed that therapists were able to shift their work to correspond more closely with the treatment manual. At the same time, researchers found that when therapists attempted to handle alliance strains, they did so in a mechanical, rigid way. Rather than being able to treat their patients more skillfully, therapists failed to be empathic and supportive, resulting in negative outcomes.

Henry and colleagues (1993) concluded that “one of the apparent paradoxical results of training was that at the same time therapists were becoming more intellectually sensitized to the importance of in-session dyadic process, they were actually delivering
higher ‘toxic-dose’ of disaffiliate and complex communications” (p. 20).

Researchers in cognitive behavioral therapy demonstrated similar findings. Castonguay and colleagues (1996) investigated the predictive ability of several process variables on treatment outcome with 30 depressed patients who received CBT with or without medication. Two types of process variables were studied: (1) a variable that is unique to cognitive therapy and (2) two variables that CBT is presumed to share with other forms of treatment. The client’s improvement was found to be predicted by the two common factors measured: the therapeutic alliance and the client’s emotional involvement (experiencing). One unexpected finding was that a unique aspect of cognitive therapy (i.e., therapist’s focus on the impact of distorted cognitions on depressive symptoms) correlated negatively with outcome at termination.

In order to understand the negative relationship between the specific cognitive interventions and outcome, Castonguay and colleagues (1996) conducted descriptive analyses. These researchers found that therapists’ rigid adherence to certain cognitive behavioral interventions contributed to problems in the therapeutic alliance. Castonguay and colleagues write:

Some therapists dealt with strains in the alliance by increasing their attempts to persuade the client of the validity of the cognitive behavioral rationale, as the client showed more and more disagreement with this rationale and its related task. In other instances, the therapist treated these strains as a manifestation of the client’s distorted thoughts, which needed to be challenged. Such interventions led to repeated cycles characterized by the therapist’s perseverance in the application
of cognitive techniques and the client's increased unresponsiveness to the
treatment. (p. 502)

Findings from these studies indicate that therapists' strict adherence to their
treatment manual, in the context of ruptures, may have contributed to problems in the
alliance and outcome.

Another possibility is that specific interventions, such as certain dynamic and
cognitive behavioral interventions, are not effective during ruptures. This understanding
is based on interpersonal and relational theories that argue that traditional theoretical
conceptualizations of ruptures do not adequately address the relational component
inherent in ruptures and the resolution process. A brief explanation is offered next.

With respect to dynamic therapy, a traditional psychoanalytic theory of change
entails helping the patient work through his or her distorted, unconscious, and unreal
aspects of his or her reality until an objective reality is made possible. Traditionally,
psychoanalytic therapists viewed patients' reactions as transference manifestations. Thus,
psychoanalysts maintained that during these tenuous moments the only important
interventions were transference interpretations.

During a rupture the analyst would maintain an objective and neutral stance and
interpret the patient's negative reaction to the analyst without considering the
interpersonal aspects or his or her own contribution to the patient's negative feelings.

Several psychodynamic theorists have cautioned about the use of transference
interpretations during alliance strains, arguing that therapists' increase in transference
interpretations may not be helpful. Wachtel (1993) writes that transference interpretations “not infrequently...contain an implicit rebuke” (p. 70). In addition, Strupp (1989) has identified the “damaging consequences of communications that are experienced by patients as pejorative” (p. 717). Thus, when patients experience a rupture in the therapeutic alliance, therapists’ use of transference interpretations may be experienced as accusatory, rather than facilitative and may not be effective at resolving ruptures.

Similarly, in cognitive behavioral therapy, interventions prescribed for correcting alliance strains may not be effective. In short, the theory of change holds that the alliance serves as a basis for the application of interventions and that the techniques themselves, rather than the therapeutic relationship, facilitate change (Raue & Goldfried, 1994; Beck, 1995). Traditionally, theorists assumed that the therapeutic relationship would “remain a fait accompli” and that the work of therapy would not entail examining the vicissitudes of the therapeutic relationship, or necessitate repairing the setbacks or strains in the alliance (Newman, 1998).

During a rupture, a cognitive behavioral therapist would assume the role of a teacher, mentor or coach, and provide feedback in order to help the patient understand the nature of his or her problem. Traditionally, ruptures were conceptualized as patterns of the patient’s maladaptive interpersonal schema and a therapist’s job was to administer cognitive interventions that challenged the patient’s typical ways of looking at things.

Theorists and researchers (Newman, 1998; Castonguay et al., 1996) in cognitive behavioral therapy have posited that certain cognitive behavioral interventions may not be effective during ruptures. Hence, when therapists view patients’ perceptions as
distortions that need to be challenged, patients may experience the therapists as invalidating. Furthermore, when therapists respond by increasing their adherence to the same cognitive interventions, the initial problem may be exacerbated.

The main goal of this study is to assess the relationship between therapists’ utilization of treatment interventions during ruptures and outcome. The specific objectives are to investigate therapists’ use of relational, cognitive behavioral and dynamic interventions during ruptures and to assess the relationship between these types of treatments and outcome.

The potential deleterious effects of unresolved ruptures on the alliance and ultimately on outcome and the possible detrimental effects of therapists’ adherence to treatment techniques during ruptures exemplifies the need for continued research on the relationship between therapists’ adherence to treatment manuals and outcome. Findings have important implications for future developments of treatment manuals, as well as for training therapists to handle ruptures effectively.

*Statement of Purpose:*

The present study was designed to investigate therapists’ technical behavior during ruptures in two treatment conditions: Brief Relational Therapy (BRT) and Cognitive Behavioral Therapy (CBT). The aim of this study is to investigate BRT and CBT therapists’ utilization of relational, cognitive behavioral and dynamic interventions
during ruptures, and to assess the relationship between therapists’ adherence to these
treatments and outcome.

To investigate therapists’ technical behavior during ruptures, a validated measure
of therapist technique will be used to assess therapists’ utilization of relational, cognitive
behavioral and dynamic interventions during ruptures. In order to clarify the relationship
between treatment interventions and outcome, therapists’ use of these treatment
interventions will be correlated with outcome, as defined by two patient self-report
outcome measures: a measure of psychiatric symptoms (SCL-90-R) and a measure of
interpersonal distress (IIP-64).

Research Hypotheses:

1. It is expected that relational therapists will use relational interventions more
than will cognitive behavioral therapists. Furthermore, it is expected that cognitive
behavioral therapists will use cognitive behavioral interventions more than will
relational therapists.

2. It is expected that relational therapists will utilize relational interventions
significantly more than interventions from other orientations (e.g., cognitive behavioral
and dynamic interventions). Furthermore, it is expected that cognitive behavioral
therapists will utilize cognitive behavioral interventions significantly more than
interventions from other orientations (e.g., relational and dynamic interventions).
3. There is evidence suggesting that the use of relational interventions during ruptures has positive effects on outcome. Thus, it is predicted that therapists’ use of relational interventions will relate to good outcome in both relational and cognitive behavioral therapy.

4. It can be inferred that cognitive behavioral interventions are not adequate during ruptures. Thus, it is predicted that therapists’ use of cognitive behavioral interventions will relate to poor outcome in both relational and cognitive behavioral therapy.

5. It can be inferred that dynamic interventions are not adequate during ruptures. Thus, it is predicted that the use of dynamic interventions will relate to poor outcome in both relational and cognitive behavioral therapy.

Method

Design

The present study was based on data collected at the Brief Psychotherapy Research Program (BPRP) at Beth Israel Medical Center, which, until 2002, was investigating the effectiveness of time-limited psychotherapy in three treatment conditions: Brief Relational Therapy (BRT), Cognitive Behavioral Therapy (CBT), and Brief Adaptive Psychotherapy (BAP). A new design was implemented in 2002, in which each patient is assigned to a CBT treatment and therapists are introduced to relational principles and techniques at various points of therapy.
For the purposes of this study, data predating 2002 was investigated in order to compare the relationship between relational and cognitive behavioral therapists’ technical behavior during ruptures and also for the purposes of evaluating the relationship of relational and cognitive behavioral therapists’ utilization of relational, cognitive behavioral and dynamic interventions, according to outcome.

The present study was designed in a way that would allow research to investigate the effects of prescribed and proscribed interventions (i.e., relational, cognitive behavioral, and dynamic) in the context of “pure” treatments (i.e., relational therapy and cognitive behavioral therapy).

For the present study, therapists were recruited from Beth Israel Medical Center’s Department of Psychiatry. The patient population was recruited through advertisements in the local New York newspapers, *The New York Times* and *The Village Voice*, and met the inclusion criteria outlined by the research program. Participation is voluntary and includes consent forms for both therapists and patients.

Patients receive 30 sessions of treatment for a minimal fee determined on a sliding scale based on their annual income. Inclusion criteria for participation in the research include: (1) adults ranging in age between 18 and 65, and (2) agreement to participate in the research (i.e., therapists’ and patients’ signed consent form). Exclusion criteria for the research include: (1) organic brain disorder or mental retardation; (2) psychotic symptoms; (3) bipolar disorder; (4) active substance use; (5) active Axis III medical diagnosis; (6) history of violent behavior or impulse control problems; (7) active
suicidal and/or homicidal ideation and/or behavior and (8) inconsistent use of psychotropic medication within the last year.

Prior to participation, patients are screened for exclusion criteria during a comprehensive intake procedure that includes an initial phone interview, the completion of a packet of intake questionnaires, two structured clinical interviews (SCID-II: Spitzer, Williams & Gibbon, 1987), and an abbreviated Adult Attachment Interview (George, Kaplan & Main, 1985).

Treatment Conditions

Brief Relational Therapy (BRT: Safran & Muran, 2000). BRT is informed by a relational approach (Greenberg & Mitchell, 1984), which has its origins in psychoanalytic theory and has been influenced by movements in social-constructivism and intersubjectivity (Hoffman, 1991; Stolorow, 1988). BRT is integrative in nature; it draws from a number of theoretical traditions, such as interpersonal, self-psychology, and object-relations (Kiesler, 1986; Levenson, 1991; Strupp & Binder, 1984; Sullivan, 1953) and integrates principles from contemporary theories on cognition, emotion and experiential traditions (e.g., Guidano & Liotti, 1983; Greenberg, Rice, & Elliot, 1993; Perls, 1969; and Rogers, 1951).

The key aspects of the relational model, as defined by Safran and Muran (1995), emphasize: (1) a “two-person psychology,” which focuses on the value of therapist/patient joint exploration of their contributions to the relationship; (2) the belief that patients are arbiters of their own experience; (3) the therapist’s use of self-disclosure and Metacommunication to enhance collaborative exploration; and (4) emotional
immediacy achieved by using phenomenological (“here and now”) therapist interventions to explore the “particularities of the patient-therapist relationship,” without the therapist placing premature emphasis on the genetic past.

A central principle in BRT is the therapist’s use of Metacommunication (as noted above) and an emphasis on mindfulness in the therapeutic relationship. Metacommunication is a process of exploring the interaction that exists between the therapist and the patient. In contrast to other traditional treatments (e.g., cognitive behavioral and psychodynamic), the patient, rather than the analyst, is considered the arbiter of his or her own experience. In BRT, the role of the therapist is to explore tentatively the interpersonal interactions and to focus on the patient’s immediate emotional experience (Safran & Segal, 1990). The theory of change is conceptualized in terms of two principles: The first is referred to as “decentering,” a process of disembedding from the dysfunctional interpersonal cycle. The second can be understood as a process of “disconfirmation,” where a therapist and a patient create a new relationship that provides a corrective experience that challenges the patient’s previous maladaptive experiences of relationships.

*Cognitive Behavioral Therapy* (CBT: Turner & Muran, 1992). CBT has its theoretical origins in cognitive theory (e.g. Beck, 1976; Muran, 1991). It is a “self-schema-based model that depicts personality and behavior as organized by underlying belief systems about the self that have become structuralized” (Muran, 2000). These self-schemas are derived from individuals’ past experiences and are maintained by maladaptive behaviors that reinforce the distorted self-schema. A vicious cycle can result,
in which the patient behaves in ways that are maladaptive to him or her. This in turn reinforces the original distorted self-schema (Turner & Muran, 1992).

Beck (1976) defined maladaptive self-schemas as information processing distortions. The cognitive distortions result in "automatic thoughts" and are viewed to develop out of rigid belief systems or dysfunctional attitudes, representative of emotionally laden knowledge about the self. The theory of change posits that therapeutic change becomes possible when there is an emphasis on the exploration and challenge of the cognitive distortions and the automatic thoughts. The goal then is to replace the maladaptive thoughts with alternative responses that are more adaptive to the patient and can disconfirm the patient's self-schema (Turner & Muran, 1992).

Participants

Patients. Twenty-eight patients participated in the present study (14 patients in each treatment group). The principal selection criterion for patients included in NIMH grant-funded studies is the presence of a DSM-III-R or DSM-IV Axis II Personality Disorder diagnosis on Cluster C or a diagnosis of PD NOS. Patients seen in the Brief Psychotherapy Program may also carry diagnoses on Axis I, the most frequent being Mood Disorders or Anxiety Disorders.

Patient demographics. In the BRT treatment condition, 11 women and three men participated, ranging in age from 24 to 69 (M = 40.93, SD = 14.74). All of the patients were educated above the high-school level and over 70% had at least a college degree. Over 80% were employed. 71% were Caucasian, 14% Black or non-Hispanic and 14% were Asian.
In the CBT treatment condition, four women and 10 men participated, ranging in age from 25 to 57 (M = 41.14, SD = 10.53). All of the patients were educated above high-school level with over 80% having at least a college degree. Over 80% were employed. 93% were Caucasian and 7% were Black or non-Hispanic.

*Patient diagnostic characteristics.* In the BRT treatment condition, all of the patients except for one met criteria for an Axis I diagnosis (one met for major depression, recurrent; two met for dysthymia, primary; one met for panic disorder without agoraphobia; one met for social phobia; two met for generalized anxiety disorder; three were diagnosed with V codes for relational problems; one met for past major depressive episode). On Axis II, patients’ diagnoses were in Cluster C, with the exception of one patient who met criteria for an additional diagnosis in Cluster B, and three who received PD NOS diagnoses; (four met for avoidant; one met for obsessive compulsive; one met for histrionic; four met for PD NOS; one patient had missing data).

In the CBT treatment condition, all of the patients except for one met criteria for an Axis I diagnosis. All except one of the Axis I disorders were in the mood or anxiety spectrum (five met for dysthymia; one met for anxiety disorder NOS; one met for social phobia; three met for adjustment disorder, either with anxious, depressed, or NOS mood; one met for a V code for relational problems). On Axis II, patients’ diagnoses were primarily in Cluster C (two met for avoidant; one met for obsessive compulsive; one met for negativistic; two met for depressive; one met for passive aggressive; one was PD NOS; three patients had missing data).
Therapists. 23 therapists (13 therapists in the BRT group and 10 in the CBT group) participated, ranging in age from 26 to 52 (M = 35.96, SD = 6.52). Therapists included licensed psychologists, advanced psychology doctoral candidates, psychiatry residents, and social workers.

In the BRT treatment condition, nine women and four men participated, ranging in age from 26 to 43 (M = 34.5, SD = 5.50). On average, therapists had one year of clinical experience (M = 1.07, SD = 2.53), with zero to two completed cases in the treatment in which they were trained (M = .57, SD = .85).

In the CBT treatment condition, six women and four men participated, ranging in age from 28 to 52 (M = 37.54, SD = 5.50); clinical experience ranged in years from less than 1 to 21 (M = 6.64, SD = 7.62). On average, therapists completed more than two cases in the treatment in which they were trained (M = 2.50, SD = 3.77).

All therapists were either individually supervised by an expert in one of the two treatment modalities or were themselves experts in that particular treatment modality. In addition to the weekly sessions, all therapists attended group supervision for one-and-a-half hours per week. The intention of group supervision was to facilitate therapists' adherence to the treatment manual (Pollock et al., 1988; Safran & Muran, 2000; Turner & Muran, 1992), as well as to foster a supportive learning environment.

Research coders. Five coders participated in this study. The coders were advanced graduate students in clinical psychology programs. The coders received weekly training on the Beth Israel Adherence Scale. All coders attended adherence training for one-and-a-half hours per week.
Selection Procedure of Ruptures

In order to improve upon previous research methodologies, the present study implemented a design that stipulated clearly defined criteria for the selection of ruptures. The rupture sessions were selected on the basis of therapists’ indication of a rupture in a post-session self-report questionnaire. This applied methodology is an improvement on previous applied methodologies and has several advantages. First, the methodology increases internal reliability; second, it limits third-party-observer bias and, third, it increases generalizability across research settings.

For the purposes of this study, one rupture session was selected from the early stage of treatment (sessions 3 - 15) and one rupture session was selected from the late stage of treatment (16 - 30). The rationale for selecting ruptures across treatment was to provide a more representational account of therapists’ technical behavior over time.

Rupture sessions with a tension rating of “2” or higher were selected for investigation. A decision to have a cut-off criterion was made in order to increase internal reliability. In cases where there was more than one session from which to select, one session was randomly selected. A total of 28 sessions (14 sessions from the BRT group and 14 sessions from the CBT group) were selected.

Post Session Questionnaire (PSQ; Muran, Safran, Samstag, & Winston, 1991). The PSQ was compiled by researchers at BPRP as a measure for tracking psychotherapy process. The PSQ includes a section that asks the patient and therapist to indicate: 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 the
session’s end, and a brief open-ended description of the problem. For example, if a therapist answers “yes” to the inquiry regarding the presence of a rupture, he or she is asked to rate the intensity of the problem or tension on a 5-point scale (1 = mildly, 5 = extremely). They are also asked to indicate where in the session the rupture occurred (e.g., in the beginning, middle, or end of the session).

Each session’s total length was calculated in order to determine the precise location of this session third. Sessions in which the ruptures were noted at the beginning were sampled from the start of the session to minute 15. Mid-session ruptures began at the start of the second third and lasted for 15 minutes; end-session ruptures began 15 minutes from the end of the session. In sessions where therapists reported a rupture in multiple areas (e.g., beginning and middle), the therapists’ written report of the rupture guided the author’s identification of the rupture.

Once the rupture was identified, a second observer-rater verified the presence of the rupture. The rater was an advanced clinical student in a doctoral program and a fellow research extern at BPRP. The rater was instructed to watch the appropriate segment and determine the location of the rupture. The rater verified rupture sessions with 100% reliability.

Measures and Assessment Procedures

The Beth Israel Adherence Scale (BIAS; Patton, Muran, Safran, Wachtel, & Winston, 2000). The BIAS is an observer-based instrument that was developed at the research program and has demonstrated adequate psychometric properties, including
adequate internal consistency, interrater reliability, and discriminate validity (Santangelo et al., 1994; Patton et al., 2000).

The BIAS is a 44-item measure comprised of three modalities: Brief Relational Therapy (BRT); Cognitive Behavioral therapy (CBT), and Brief Adaptive Psychotherapy (BAP)—a form of short-term dynamic psychotherapy. These three modalities consist of 12 items that reflect each of the treatments’ prescribed interventions, totaling 36 specific therapist interventions. In addition, there are also eight non-specific items, or common factors (bringing the total to 44 items), that cut across all theoretical orientations. The specific treatment techniques and the common factors are randomly mixed and distributed throughout the scale.

BRT techniques. The BRT subscale derives its 12 items from the work of Safran and Segal (1990), Greenberg and Goldman (1988), and Santangelo (1995). The 12 items are as follows: (1) explores the “how” or mechanism of defense, (2) directs client’s attention in non-confrontational manner to specific client behaviors, subtle non-verbal communications or paralinguistics, to increase client’s awareness, (3) facilitates individuation and/or self-assertion, (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), (5) intervenes with skillful tentativeness, (6) tracks client’s experience in a moment-to-moment fashion, (7) engages in empathic conjecture, (8) asks exploratory questions that probe for the feeling/experience underlying the client’s utterance, (9) respects client as arbiter of experience, (10) deepens client’s awareness/experience through in-or out-of-session awareness exercise, (11) deepens
client's experience through evocative reflection, and (12) 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.

CBT techniques. The CBT subscale is based on a short-term, cognitive-behavioral treatment for personality disorders as described by Turner & Muran (1991). The CBT subscale is composed of 12 items that are informed by the works of Beck et al (e.g. Beck et al., 1979) as well as by the Collaborative Study Psychotherapy Rating Scale (CSPRS, Hollon et al., 1984) used in the NIMH Treatment of Depression Collaboration Study (Elkin et al., 1989). The 12 items are as follows: (1) assigns and reviews homework, (2) encourages client to distance him/herself from his/her thoughts, viewing them as beliefs rather than facts, (3) probes for client's underlying beliefs or personal meaning behind client's thoughts, (4) explores the advantages and disadvantages of dysfunctional attitudes, (5) helps client identify cognitive distortions or errors that are present in his/her thinking, (6) facilitates client's consideration of alternative explanations for events, (7) asks client to report specific thoughts, (8) engages in Socratic questioning aimed at guiding client's reasoning process, (9) engages in didactic persuasion, (10) helps client examine currently available evidence or information to test the validity, as well as realistic consequences of the client's beliefs, (11) therapist and client practice rational responses to client's negative thoughts and beliefs, and (12) therapist works with client to plan or practice alternative overt behaviors for the client to use both inside and outside of therapy.
**BAP techniques.** The BAP (BAP; Pollack, Flegenheirmer, & Kaufman, 1988) subscale has its theoretical origins in traditional psychoanalytic principles (e.g., Greenson, 1967). BAP employs a number of the traditional short-term psychotherapy techniques associated with Mann (1973) and Malan (1976) among others (as cited in Winston et al., 1991). It is an ego-psychological approach from classical psychoanalysis in its short-term focus and in its use of specific techniques (as cited in Pollack et al., 1990).

BAP therapists work to identify the “expectations, distortions and behaviors” as reflected by the major maladaptive pattern. Initially, therapists explore the transference in the context of the patient-therapist relationship, and then make connections to other individuals in the patient’s life. The practice of BAP is “continual working through of the pattern in the transference and in past and present relationships that leads to the cognitive and affective understanding that makes change possible” (Pollack et al., 1990, abstract). The 12 items are as follows: 1) general interpretation, 2) reflects content, 3) frames symptoms, 4) links resistance to the maladaptive pattern, 5) confronts patient, 6) links significant others from the past to the present relationship, 7) interprets defenses as resistance, 8) explores unconscious aspects 9) frames symptoms as coping, 10) explores maladaptive pattern, 11) links significant others from the past to the therapist, and 12) links parts of conflict.

**Rating Procedure**

Coders were instructed to consider every therapist intervention on two dimensions: frequency and clarity. In addition to coding the interventions on these two
dimensions, coders were instructed to consider a third factor—the item’s categorization in terms of the following three subcategories: (1) “global” items, which represent a defining aspect of the treatment and tend to occur frequently and pervasively, (2) “moderately occurring” items, which can occur not-at-all to frequently, and (3) “infrequent” items, which may occur infrequently, but are nevertheless substantive in nature. Coders were instructed to code the items according to their category of frequency. An infrequently occurring item of a treatment is a hallmark of the treatment and is not as routinely observed as global items of the treatment. For example, in CBT, the technique of assigning “homework” is considered an infrequent item and would be noted as such, thereby rendering a greater score.

The coding process proceeded in the following step-by-step manner: Coders listened to a segment and noted the presence of a specific item following each therapist intervention. Coders used a Likert-type scale that primarily assessed degree of occurrence: 1 = not at all; 2 = slightly; 3 = somewhat; 4 = moderately; 5 = considerably; 6 = extensively.

A notation of a check (√) representing the presence of an item, combined with either a minus sign (√-) for less than average clarity, or a plus sign (√+) for more than average clarity, was made in the margin for each item. Upon completion of a segment, the coder added the number of checks for each item, factoring in the clarity “markers” for each item, as well as the “weight” of the items.

The Beth Israel Adherence Scale provides raw scores for each treatment subscale (i.e., BRT, CBT, and BAP). These scores represent the degree of overall adherence to the
prescribed treatment. In this study, a greater frequency count—or the peak subscale of the specific treatment techniques—determines the specific treatment to which the therapist is considered adherent.

Coders performed adherence checks on a total of 56 sessions (28 sessions in both treatment groups). Recall two sessions were selected across treatment to assess early (sessions 3-15) and late (sessions 16-30) therapist adherence on the Beth Israel Adherence Scale. These scores were averaged across the early and late sessions, resulting in one adherence score per treatment subscale. The decision to average the two adherence scores was made after analysis of sessions indicated that there were no significant differences attributable to the sessions being rated.

**Outcome Measures**

Outcome was defined by two outcome measures: The Symptom Checklist-90-Revised, which assesses the severity of psychiatric symptoms, and the Inventory of Interpersonal Problems-64, which measures individuals’ degree of interpersonal distress.

*Symptom Checklist-90-Revised* (SCL-90-R; Derogatis, 1975a, 1975b). The SCL-90-R is a self-report, paper-and-pencil inventory designed to identify and measure overall psychiatric symptoms. It is comprised of 90 items presented in Likert-type format and designed to assess degree of severity. Adequate psychometric properties have been demonstrated (e.g., Derogatis, Rickels, & Rock, 1976).

The SCL-90-R has 12 sub-scales: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, Psychoticism, Positive Symptom Distress Index, Positive Symptom Total, and
Global Severity Index. The Global Severity Index (GSI) represents the mean item score and reflects the patient’s overall level of symptomatic distress. Researchers have reported a coefficient alpha of .95 and a test-retest reliability of .94 for the GSI of the SCL-90-R (Edwards, Yarvis, Mueller, Zingale, & Wagman, 1978).

Participants were instructed to report how much discomfort a specific problem has caused them during an indicated period of time, usually in the past seven days, including that day. Items are rated on a Likert-type scale from 0 to 4, indicating, respectively, *not at all, a little bit, moderately, quite a bit, and extremely.*

*Inventory of Interpersonal Problems-64 (IIP; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988).* The IIP-64 is a self-report, paper-and-pencil instrument, which measures degree of interpersonal difficulty and social adjustment. The 64-item questionnaire is set in Likert-type format, which reflects the degree of interpersonal distress. The questionnaire consists of items that measure things the patient may “do too much of” (e.g. *I am too sensitive to criticism*) and items that measure things that are difficult for the patient (e.g. *It is hard for me to trust other people*). The IIP-64 is scored based on the circumplex octants (arrogant-calculating; vindictive; cold; aloof-introverted; unassured-submissive; exploitable; warm-agreeable; and gregarious-extroverted) on a Likert-type scale from 0 to 4, with 0 representing *not at all* and 4 representing *extremely.* Adequate psychometric properties have been demonstrated (Safran, Muran, & Winston, 1992), including an internal consistency of .88 and sub-scale alphas from .68 to .84. It also has high test-retest consistency of .71 (Soldz, Budman, Demby, & Merry, 1995).
Interrater Reliability

Reliability between coders was assessed for significance using the Intraclass Correlation Coefficient (ICC: Shrout & Fleiss, 1979). The ICC is a measure of reliability that provides an estimate of the reliability of a rating that might be obtained by an independent coder and represents the generalizability of the rating. To determine the ICC, a random sample of coders is selected and each coder independently rates each target. The reliability coefficient indicates the degree to which any single coder can be used to represent the score. For this study, ICC (2, 2) reflected an estimate of how two coders would perform.

The 56 sessions were distributed among the five coders. Interrater reliability was assessed for 25% of the sessions. Thus, 15 of the 56 sessions were randomly selected and marked for reliability purposes. Each coder coded an additional three sessions for reliability purposes, totaling approximately 14 sessions per each coder.

Table 1 shows the ICC coefficients for the overall scale ranged from .64 to .90. When interpreter reliability fell below $r = .70$ between two coders, the group discussed and recalibrated the scores until agreement above $r = .70$ was met. The ICC coefficient for the overall scale is a mean of .75, which falls above Kraemer’s standard of an ICC cut-off of .70.
Table 1
ICC Means, Standard Deviations, Minimum And Maximum Scores By Overall Scale

\( (n = 15) \)

<table>
<thead>
<tr>
<th>Variable</th>
<th>( M )</th>
<th>( SD )</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Scale</td>
<td>.75</td>
<td>.09</td>
<td>.64</td>
<td>.90</td>
</tr>
</tbody>
</table>

Note. ICC: Intraclass correlation coefficient.

The above section concludes the discussion of methods and measurement apparatus used to address the primary goals of this study. The section that follows, reports the results of the hypotheses of this study.

Results

In order to test the hypotheses that BRT therapists will adhere to BRT interventions significantly more than CBT therapists (and vise versa), and utilize their prescribed treatment interventions significantly more than the proscribed interventions, an analysis of variance (ANOVA) was performed, using the General Linear Model program in SPSS, Version 11.5. This ANOVA had two factors: a within-treatment factor and a between-treatment factor. The within-treatment factor had three levels corresponding to therapists' adherence to treatment type interventions (i.e., BRT, CBT, or
BAP). The between-treatment factor had two levels corresponding to the treatment group (i.e., BRT or CBT).

In addition, the ANOVA provided a test of interaction of therapist adherence to treatment type and treatment group assignment. A preliminary analysis for the assumption of sphericity was performed using Mauchly's test. As Mauchly's test was statistically significant, the multivariate analysis of variance tests was performed. Table 2 displays the mean scores and standard deviations of therapists' adherence to treatment type and Table 3 shows the ANOVA of therapists' adherence to treatment type.

Table 2
Means and Standard Deviations for Adherence Scores by BRT and CBT Therapists to BRT, CBT, and BAP

<table>
<thead>
<tr>
<th>Treatment type</th>
<th>BRT Therapists</th>
<th>CBT Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=14)</td>
<td>(n=14)</td>
</tr>
<tr>
<td>BRT</td>
<td>$M=1.85$</td>
<td>$M=1.37$</td>
</tr>
<tr>
<td></td>
<td>$SD=0.35$</td>
<td>$SD=0.25$</td>
</tr>
<tr>
<td>CBT</td>
<td>$M=1.09$</td>
<td>$M=1.40$</td>
</tr>
<tr>
<td></td>
<td>$SD=0.07$</td>
<td>$SD=0.25$</td>
</tr>
<tr>
<td>BAP</td>
<td>$M=1.35$</td>
<td>$M=1.34$</td>
</tr>
<tr>
<td></td>
<td>$SD=0.14$</td>
<td>$SD=0.13$</td>
</tr>
</tbody>
</table>

*Note.* BRT = Brief Relational Therapy; CBT = Cognitive Behavioral Therapy; BAP = Brief Adaptive Psychotherapy.
As can be seen in Table 3, there were no statistically significant differences in therapists’ overall mean scores of adherence to the three treatment types combined; however, findings demonstrate a statistically significant effect for adherence to the specific treatment types. Furthermore, there was a statistically significant interaction effect between treatment group and treatment type.

As predicted, the tests of treatment type contrasts show that relational therapists utilized relational interventions significantly more than cognitive behavioral therapists. Furthermore, cognitive behavioral therapists utilized cognitive behavioral interventions significantly more than relational therapists. Interesting to note, therapists’ mean scores of adherence to BAP did not differ significantly from each other.
Table 3

Analysis of Variance for Treatment Group Adherence to Treatment Type

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Pillai’s trace</th>
<th>P</th>
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<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Between-subjects</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Group (TG)</td>
<td>1</td>
<td>.08</td>
<td>1.46</td>
<td></td>
<td>.24</td>
</tr>
<tr>
<td>Error</td>
<td>26</td>
<td>.05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Within-subjects</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Type (TT)</td>
<td>2</td>
<td>.97</td>
<td>21.25</td>
<td>.53</td>
<td>.00*</td>
</tr>
<tr>
<td>TG X TT</td>
<td>2</td>
<td>1.08</td>
<td>23.76</td>
<td>.58</td>
<td>.00*</td>
</tr>
<tr>
<td>Error</td>
<td>52</td>
<td>.05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Treatment Type by Treatment Group Contrasts</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BRT X TG</td>
<td>1</td>
<td>1.58</td>
<td>17.31</td>
<td>.00*</td>
<td></td>
</tr>
<tr>
<td>CBT X TG</td>
<td>1</td>
<td>.66</td>
<td>19.61</td>
<td>.00*</td>
<td></td>
</tr>
<tr>
<td>BAP X TG</td>
<td>1</td>
<td>.00</td>
<td>.05</td>
<td>.824</td>
<td></td>
</tr>
</tbody>
</table>

*Note. BRT = Brief Relational Therapy; CBT = Cognitive Behavioral Therapy; BAP = Brief Adaptive Psychotherapy.

*p < .001

To further explore the main effects for treatment type, a series of post-hoc tests of simple main effects contrasts were performed. As can be seen in Table 4, it was found
that within the BRT group, there were significant differences between adherence to BRT and each of the other treatments, with adherence to BRT having the highest value. Within the CBT group, however, there was no significant difference when it came to adherence to one form of therapy over another.
Table 4

Differences Between Adherence Scores to Treatment Type

<table>
<thead>
<tr>
<th>Type (I)</th>
<th>Type (J)</th>
<th>Mean Difference (I-J)</th>
<th>Std. Error</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>BRT Therapists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BRT</td>
<td>CBT</td>
<td>.75(*)</td>
<td>.09</td>
<td>.00*</td>
</tr>
<tr>
<td></td>
<td>BAP</td>
<td>.50(*)</td>
<td>.08</td>
<td>.00*</td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>-.75(*)</td>
<td>.09</td>
<td>.00*</td>
</tr>
<tr>
<td></td>
<td>BAP</td>
<td>-.25(*)</td>
<td>.06</td>
<td>.00*</td>
</tr>
<tr>
<td></td>
<td>BAP</td>
<td>-.50(*)</td>
<td>.08</td>
<td>.00*</td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>.25(*)</td>
<td>.06</td>
<td>.00*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CBT Therapists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BRT</td>
<td>CBT</td>
<td>-.03</td>
<td>.09</td>
<td>.73</td>
</tr>
<tr>
<td></td>
<td>BAP</td>
<td>.03</td>
<td>.08</td>
<td>.69</td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>.03</td>
<td>.09</td>
<td>.73</td>
</tr>
<tr>
<td></td>
<td>BAP</td>
<td>.07</td>
<td>.06</td>
<td>.28</td>
</tr>
<tr>
<td></td>
<td>BAP</td>
<td>-.03</td>
<td>.08</td>
<td>.69</td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>-.07</td>
<td>.06</td>
<td>.28</td>
</tr>
</tbody>
</table>

*Note. BRT = Brief Relational Therapy; CBT = Cognitive Behavioral Therapy; BAP = Brief Adaptive Psychotherapy.

*p < .001
As predicted, the degree of adherence of BRT interventions to CBT and BAP interventions is significantly greater in BRT, whereas the degree of adherence of CBT interventions to BRT and BAP interventions is not significantly greater in CBT. Figure 1 displays the graph of these interactions. It appears that relational therapists utilized BRT interventions significantly more than CBT and BAP interventions, whereas cognitive behavioral therapists utilized CBT, BRT, and BAP interventions with a similar rate of frequency. Thus, BRT therapists were most loyal to BRT whereas CBT therapists did not stay close to the treatment in which they were trained.
Figure 1
Means for Adherence Scores by BRT and CBT Therapists to
BAP, CBT, and BRT

Note. BRT = Brief Relational Therapy; CBT = Cognitive Behavioral Therapy;
BAP = Brief Adaptive Psychotherapy.

Prior to assessing the next set of hypotheses concerning treatment type and
outcome, a treatment outcome score was computed for both outcome measures, using a
standardized residual gain score for the interval: intake-termination. This method for
assessing treatment outcome partials out the variance attributed to initial or baseline ratings. It is considered a standard method for investigating outcome relationships (Henry, Strupp, Schacht, & Gaston, 1994).

In order to test the hypotheses that therapists' adherence to BRT will predict good outcome while therapists' adherence to CBT and BAP will predict poor outcome, a series of Pearson product-moment correlations were performed between treatment type and the unstandardized residual gain scores for both outcome measures across both treatment groups. For the following results, note that a negative correlation indicates reduction of symptoms and, therefore, is considered good outcome. Table 5 displays the results of the correlations. In sum, these results did not support the hypotheses. Although the results were statistically non-significant with this sample size, there was a medium effect size in the predicted direction between BRT and the SCL-90, $r(28) = -0.36, p = .08$. These findings suggest that with a larger sample size, therapists' utilization of BRT interventions during ruptures may contribute to a reduction of patients' psychiatric symptoms.
Table 5

Intercorrelations Between Measures of Treatment Outcome and Adherence to Treatment Type for BRT and CBT Therapists (N = 28)

<table>
<thead>
<tr>
<th></th>
<th>BRT</th>
<th>CBT</th>
<th>BAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCL-90</td>
<td>-.36</td>
<td>.13</td>
<td>.29</td>
</tr>
<tr>
<td>IIP-64</td>
<td>-.22</td>
<td>.11</td>
<td>.14</td>
</tr>
</tbody>
</table>

Note. SCL-90-R = Symptom Checklist Revised; IIP-64 = Inventory of Interpersonal Problems. BRT = Brief Relational Therapy; CBT = Cognitive Behavioral Therapy; BAP = Brief Adaptive Psychotherapy.

Next, in order to test the hypotheses in each group, a series of Pearson product-moment correlations were performed between treatment type and outcome in the BRT group first. Table 6 displays the results of these correlations. Once again, the results were non-significant; however, although findings were non-significant, there was a medium effect size in the predicted direction, $r(14) = -.41, p = .19$ between BRT and SCL-90-R, indicating that with a larger sample size, findings may support therapists’ use of BRT interventions during ruptures.
Furthermore, although non-significant, findings demonstrate a medium effect size in the opposite direction, $r(14) = -.43, p = .17$, between CBT and the SCL-90, indicating that results may be significant with a larger sample size.

Moreover, the results of the hypothesis that BRT therapists' utilization of BAP will contribute to poor outcome on the SCL-90 and IIP-64, were non-significant; however, although non-significant, there was a medium effect size in the predicted direction for SCL-90, $r(14) = .38, p = .22$ and a large effect size in the predicted direction for IIP-64, $r(14) = .47, p = .11$, which may suggest significant findings with a larger sample size (please refer to Table 6).
Table 6

Intercorrelations Between Measures of Treatment Outcome and Adherence to Treatment Type for BRT Therapists (N = 14)

<table>
<thead>
<tr>
<th></th>
<th>BRT</th>
<th>CBT</th>
<th>BAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCL-90</td>
<td>-.41</td>
<td>-.43</td>
<td>.38</td>
</tr>
<tr>
<td>IIP-64</td>
<td>-.23</td>
<td>-.22</td>
<td>.47</td>
</tr>
</tbody>
</table>

Note. SCL-90-R = Symptom Checklist Revised; IIP-64 = Inventory of Interpersonal Problems. BRT = Brief Relational Therapy; CBT = Cognitive Behavioral Therapy; BAP = Brief Adaptive Psychotherapy.

In the CBT treatment group, none of the hypotheses were supported and no sizeable effects were observed (please refer to Table 7). Interpretations of these findings will be discussed shortly.
Table 7

Intercorrelations Between Measures of Treatment Outcome and Adherence to Treatment Type for CBT Therapists (N = 14)

<table>
<thead>
<tr>
<th></th>
<th>BRT</th>
<th>CBT</th>
<th>BAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCL-90</td>
<td>-.13</td>
<td>-.02</td>
<td>.26</td>
</tr>
<tr>
<td>IIP-64</td>
<td>.06</td>
<td>-.09</td>
<td>-.01</td>
</tr>
</tbody>
</table>

*Note. SCL-90-R = Symptom Checklist Revised; IIP-64 = Inventory of Interpersonal Problems. BRT = Brief Relational Therapy; CBT = Cognitive Behavioral Therapy; BAP = Brief Adaptive Psychotherapy.*
Discussion

The overall goal of this study was to investigate relational and cognitive behavioral therapists' technical behavior during ruptures, and to examine the extent to which the use of both prescribed and proscribed interventions is associated with outcome. Consistent with the first hypothesis, relational therapists utilized BRT interventions significantly more than cognitive behavioral therapists. Furthermore, cognitive behavioral therapists utilized CBT interventions significantly more than relational therapists; however, while relational therapists utilized BRT interventions significantly more than CBT and BAP interventions, cognitive behavioral therapists did not utilize CBT interventions significantly more than other interventions. Relational therapists utilized prescribed interventions significantly more than proscribed interventions, whereas the difference between cognitive behavioral therapists' utilization of prescribed and proscribed interventions was non-significant.

The results concerning the relationship between treatment type and outcome were non-significant; however, with both treatment groups combined, a medium effect size in the predicted direction was observed between BRT and the SCL-90. Furthermore, several medium to large effect sizes were observed in the BRT treatment group. Consistent with the hypothesis, relational therapists' use of BRT interventions was found to correlate with good outcome on the SCL-90. Also consistent with the hypothesis, relational therapists' use of BAP interventions was found to relate to poor outcome on the SCL-90 and IIP-64. One of the unexpected findings was that relational therapists' use of CBT interventions
was found to relate to good outcome on the SCL-90. Several interpretations can be offered regarding these findings.

As for the difference in the proportion of prescribed to proscribed interventions in BRT and CBT therapy several explanations can be offered. First, the fact that relational therapists applied BRT interventions with more frequency than other interventions may be reflective of the emphasis of BRT training on dealing with alliance ruptures.

On the other hand, cognitive behavioral therapists may have opted to utilize interventions from other orientations because training in CBT does not place emphasis on resolving ruptures. Furthermore, it is possible that cognitive behavioral therapists may have recognized the utility of integrating certain interventions from other treatments and therefore responded with more flexibility to the rupture at hand.

As for the relationship between treatment type and outcome, consistent with the hypothesis, there is some evidence that BRT therapists' use of relational interventions during ruptures may be advantageous. Although the results were non-significant, there was a medium effect size, indicating that it may have been significant with a larger sample.

With regard to the relationship between BRT therapists' utilization of CBT interventions and outcome, although non-significant, results yielded a medium effect size in the unexpected direction: Results demonstrate that BRT therapists’ use of CBT interventions during ruptures may contribute to improved outcome. One tentative interpretation can be offered regarding this unexpected finding: Given the emphasis that BRT places on the therapeutic alliance and the robust findings demonstrating the
predictive abilities of the therapeutic alliance on outcome, it may have been that the relational aspects inherent in relational therapy mediated the impact of the cognitive interventions in a positive way.

The results concerning the relationship between BRT therapists’ use of BAP and outcome indicate that therapists’ use of BAP interventions may not be advantageous. Again, this finding was non-significant, but the large effect size indicates that it may have been significant with a larger sample. Previous theorists and researchers (e.g., Wachtel, 1993; Strupp, 1989) have suggested that certain dynamic interventions (e.g., transference interpretations) may be experienced by patients as punitive rather than helpful in the context of ruptures. The reason being, when a therapist responds to his or her patient’s negative reactions towards him or herself by administering interventions that link the patient’s past significant others to the therapist (transference interpretations), the patient may experience the interventions as invalidating. This would perpetuate the patient’s negative feelings towards his or her therapist and/or therapy itself.

As for the lack of significant findings and/or sizeable effects in cognitive behavioral therapy, several explanations can be offered. The finding that CBT therapists’ use of CBT interventions did not contribute to poor outcome may suggest that the hypothesis was misguided. Alternatively, given the fact that CBT therapists were integrating interventions from other orientations with a high rate of overlap, it may have been that their flexible application of the treatment manual reduced the negative impact of the CBT interventions. In their study, Castonguay and colleagues (1996) observed therapists to increase adherence to their treatment interventions, which contributed to
poor outcome. Unlike the therapists in the previous study, the therapists in the present study were observed to administer CBT interventions in a flexible manner. Thus, it is possible that because therapists in the present study were not rigidly adhering to their treatment manual, the use of CBT interventions was no longer associated with poor outcome.

CBT therapists’ use of relational interventions, hypothesized to contribute to good outcome, was not found to be related to good outcome. One possible explanation for the inconsistent finding is that although coders observed CBT therapists to utilize BRT interventions, there was no assessment of skillfulness or competence. It is possible that because CBT therapists did not receive formal training in relational concepts and in the delivery of relational interventions, the interventions may have been poorly executed.

Limitations and Recommendations for Future Research

With regard to the correlations between treatment type and treatment outcome, although results indicated several medium to large effect sizes, the lack of an adequate sample size may have contributed to the absence of significant findings.

Furthermore, we observed that the BRT group was dominated by women and the CBT group was dominated by men. This occurred even though patients were randomly selected into the treatment groups. However, the sample size was too small to adequately test whether this was a statistically relevant finding. Nevertheless, future research on ruptures in psychotherapy should look at whether there is a gender bias especially by technique; men and women may respond to ruptures in different ways.
Another limitation is that this study did not investigate therapists’ technical behavior during non-rupture sessions. Although the main goal of this study was to investigate therapists’ technical behavior during ruptures, the exclusion of non-rupture sessions limits the extent to which certain conclusions can be drawn about the effects of ruptures on therapists’ technical behavior. The failure to assess therapists’ adherence in non-rupture sessions prevents knowing whether BRT therapists’ high level of adherence or CBT therapists’ tendency to use a relatively high frequency of treatment prescribed interventions, reflects a specific response to dealing with ruptures, or a more general pattern of behavior for the relational and cognitive behavioral therapists throughout the treatment. This omission, as well as the lack of an adequate sample size, needs to be corrected in future research.

Conclusions

Findings indicated that while both relational and cognitive behavioral therapists tended to apply interventions from their treatment manuals with greater frequency, relational therapists tended to be more adherent to their treatment manual than cognitive behavioral therapists. Reasons for this may be attributable to differences in training in relational and cognitive behavioral therapy.

Furthermore, results show that in cognitive behavioral therapy, CBT therapists’ utilization of prescribed and proscribed interventions did not produce any meaningful effects; the reasons for the null findings may be related to issues associated with treatment adherence and competence.

In relational therapy, a subset of the findings yielded medium to large effect sizes.
Consistent with the hypothesis, there is some evidence suggesting that relational therapists' utilization of relational interventions may contribute to improved outcome, providing further support for previous findings in favor of therapists' use of relational interventions.

There is also some indication that relational therapists' use of cognitive behavioral interventions relates to good outcome—a finding that was unexpected. This finding may suggest that the relational aspects of BRT may have contributed to the positive effects of CBT on outcome. Finally, as was predicted, there is evidence demonstrating that relational therapists' use of dynamic interventions is related to poor outcome, suggesting that certain types of psychodynamic interventions may not be adequate during ruptures.
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interpretations, therapeutic alliance, and outcome in short term individual

Piper, W. E., Ogrodniczuk, J. S., Joyce, A. S., McCullum, M., Rosie, J. S., O’Kelly, J. G.,
& Steinberg, P. I. (1999). Predicting of dropping out in time-limited, interpretive

Documents.


**INSTRUCTIONS:**

Below is a list of problems people sometimes have. Please read each one carefully, and circle the number to the right that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Circle only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example below before beginning, and if you have any questions please ask about them.

<table>
<thead>
<tr>
<th>SEX</th>
<th>NAME: ____________________________</th>
<th>LOCATION: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EDUCATION: ____________________________</td>
<td>MARITAL STATUS: MAR__SEP__DIV__WID__SING</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE</th>
<th>ID. NUMBER</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>DAY</td>
<td>YEAR</td>
</tr>
</tbody>
</table>

**EXAMPLE**

HOW MUCH WERE YOU DISTRESSED BY:

<table>
<thead>
<tr>
<th>HOW MUCH WERE YOU DISTRESSED BY:</th>
<th>NOT AT ALL</th>
<th>A LITTLE</th>
<th>MODERATELY</th>
<th>QUITE A BIT</th>
<th>EXTREMELY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bodyaches</td>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**HOW MUCH WERE YOU DISTRESSED BY:**

1. Headaches
2. Nervousness or shakiness inside
3. Repeated unpleasant thoughts that won't leave your mind
4. Faintness or dizziness
5. Loss of sexual interest or pleasure
6. Feeling critical of others
7. The idea that someone else can control your thoughts
8. Feeling others are to blame for most of your troubles
9. Trouble remembering things
10. Worried about sloppiness or carelessness
11. Feeling easily annoyed or irritated
12. Pains in heart or chest
13. Feeling afraid in open spaces or on the streets
14. Feeling low in energy or slowed down
15. Thoughts of ending your life
16. Hearing voices that other people do not hear
17. Trembling
18. Feeling that most people cannot be trusted
19. Poor appetite
20. Crying easily
21. Feeling shy or uneasy with the opposite sex
22. Feelings of being trapped or caught
23. Suddenly scared for no reason
24. Temper outbursts that you could not control
25. Feeling afraid to go out of your house alone
26. Blaming yourself for things
27. Pains in lower back
28. Feeling blocked in getting things done
29. Feeling lonely
30. Feeling blue
31. Worrying too much about things
32. Feeling no interest in things
33. Feeling fearful
34. Your feelings being easily hurt
35. Other people being aware of your private thoughts

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### HOW MUCH WERE YOU DISTRESSED BY:

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
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<tbody>
<tr>
<td>36</td>
<td>Feeling others do not understand you or are unsympathetic</td>
<td>36 0 1 2 3 4</td>
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<td>37</td>
<td>Feeling that people are unfriendly or dislike you</td>
<td>37 0 1 2 3 4</td>
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<td>38</td>
<td>Having to do things very slowly to ensure correctness</td>
<td>38 0 1 2 3 4</td>
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<td>39</td>
<td>Heart pounding or racing</td>
<td>39 0 1 2 3 4</td>
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<td>40</td>
<td>Nausea or upset stomach</td>
<td>40 0 1 2 3 4</td>
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<td>41</td>
<td>Feeling inferior to others</td>
<td>41 0 1 2 3 4</td>
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<td>42</td>
<td>Soreness of your muscles</td>
<td>42 0 1 2 3 4</td>
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<td>43</td>
<td>Feeling that you are watched or talked about by others</td>
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<td>44</td>
<td>Trouble falling asleep</td>
<td>44 0 1 2 3 4</td>
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<td>45</td>
<td>Having to check and double-check what you do</td>
<td>45 0 1 2 3 4</td>
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<td>46</td>
<td>Difficulty making decisions</td>
<td>46 0 1 2 3 4</td>
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<td>47</td>
<td>Feeling afraid to travel on buses, subways, or trains</td>
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<td>48</td>
<td>Trouble getting your breath</td>
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<td>Hot or cold spells</td>
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<td>50</td>
<td>Having to avoid certain things, places, or activities because they frighten you</td>
<td>50 0 1 2 3 4</td>
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<td>51</td>
<td>Your mind going blank</td>
<td>51 0 1 2 3 4</td>
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<td>52</td>
<td>Numbness or tingling in parts of your body</td>
<td>52 0 1 2 3 4</td>
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<td>53</td>
<td>A lump in your throat</td>
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<td>54</td>
<td>Feeling hopeless about the future</td>
<td>54 0 1 2 3 4</td>
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<td>55</td>
<td>Trouble concentrating</td>
<td>55 0 1 2 3 4</td>
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<td>56</td>
<td>Feeling weak in parts of your body</td>
<td>56 0 1 2 3 4</td>
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<td>57</td>
<td>Feeling tense or keyed up</td>
<td>57 0 1 2 3 4</td>
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<td>58</td>
<td>Heavy feelings in your arms or legs</td>
<td>58 0 1 2 3 4</td>
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<td>59</td>
<td>Thoughts of death or dying</td>
<td>59 0 1 2 3 4</td>
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<td>60</td>
<td>Overeating</td>
<td>60 0 1 2 3 4</td>
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<td>61</td>
<td>Feeling uneasy when people are watching or talking about you</td>
<td>61 0 1 2 3 4</td>
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<td>62</td>
<td>Having thoughts that are not your own</td>
<td>62 0 1 2 3 4</td>
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<td>63</td>
<td>Having urges to beat, injure, or harm someone</td>
<td>63 0 1 2 3 4</td>
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<td>64</td>
<td>Awakening in the early morning</td>
<td>64 0 1 2 3 4</td>
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<td>65</td>
<td>Having to repeat the same actions such as touching, counting, or washing</td>
<td>65 0 1 2 3 4</td>
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<td>66</td>
<td>Sleep that is restless or disturbed</td>
<td>66 0 1 2 3 4</td>
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<td>67</td>
<td>Having urges to break or smash things</td>
<td>67 0 1 2 3 4</td>
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<td>68</td>
<td>Having ideas or beliefs that others do not share</td>
<td>68 0 1 2 3 4</td>
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<tr>
<td>69</td>
<td>Feeling very self-conscious with others</td>
<td>69 0 1 2 3 4</td>
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<td>70</td>
<td>Feeling uneasy in crowds, such as shopping or at a movie</td>
<td>70 0 1 2 3 4</td>
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<td>71</td>
<td>Feeling everything is an effort</td>
<td>71 0 1 2 3 4</td>
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<td>72</td>
<td>Spells of terror or panic</td>
<td>72 0 1 2 3 4</td>
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<td>73</td>
<td>Feeling uncomfortable about eating or drinking in public</td>
<td>73 0 1 2 3 4</td>
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<td>74</td>
<td>Getting into frequent arguments</td>
<td>74 0 1 2 3 4</td>
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<td>75</td>
<td>Feeling nervous when you are left alone</td>
<td>75 0 1 2 3 4</td>
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<td>76</td>
<td>Others not giving you proper credit for your achievements</td>
<td>76 0 1 2 3 4</td>
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<td>77</td>
<td>Feeling lonely even when you are with people</td>
<td>77 0 1 2 3 4</td>
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<tr>
<td>78</td>
<td>Feeling so restless you couldn't sit still</td>
<td>78 0 1 2 3 4</td>
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<td>79</td>
<td>Feelings of worthlessness</td>
<td>79 0 1 2 3 4</td>
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<td>80</td>
<td>The feeling that something bad is going to happen to you</td>
<td>80 0 1 2 3 4</td>
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<td>81</td>
<td>Shouting or throwing things</td>
<td>81 0 1 2 3 4</td>
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<td>82</td>
<td>Feeling afraid you will faint in public</td>
<td>82 0 1 2 3 4</td>
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<td>83</td>
<td>Feeling that people will take advantage of you if you let them</td>
<td>83 0 1 2 3 4</td>
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<td>84</td>
<td>Having thoughts about sex that bother you a lot</td>
<td>84 0 1 2 3 4</td>
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<td>85</td>
<td>The idea that you should be punished for your sins</td>
<td>85 0 1 2 3 4</td>
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<tr>
<td>86</td>
<td>Thoughts and images of a frightening nature</td>
<td>86 0 1 2 3 4</td>
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<td>87</td>
<td>The idea that something serious is wrong with your body</td>
<td>87 0 1 2 3 4</td>
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<td>88</td>
<td>Never feeling close to another person</td>
<td>88 0 1 2 3 4</td>
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<td>89</td>
<td>Feelings of guilt</td>
<td>89 0 1 2 3 4</td>
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<tr>
<td>90</td>
<td>The idea that something is wrong with your mind</td>
<td>90 0 1 2 3 4</td>
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Appendix B

Inventory of Interpersonal Problems
IIP-64

Here is a list of problems that people report in relating to other people. Please read the list below, and for each item, consider whether that problem is a problem for you with respect to people in your life. Then select the number that describes how distressing that problem is and circle that number.

EXAMPLE

How much have you been distressed by this problem?

It is hard for me to:

0. get along with my relatives.

<table>
<thead>
<tr>
<th>Not At all</th>
<th>Moderately</th>
<th>Extremely</th>
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<tr>
<td>0</td>
<td>1</td>
<td>2</td>
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Part I. The following are things you find hard to do with other people.

It is hard for me to:

1. trust other people.

2. say “no” to people.

3. join in groups

4. keep things private from other people.

5. let other people know what I want.

6. tell a person to stop bothering me.

7. introduce myself to new people.

8. confront people with problems that come up.

9. be assertive with another person.

10. let other people know when I am angry.

11. make a long-term commitment to another person.

12. be another person’s boss.

13. be aggressive with other people when the situation calls for it.
14. socialize with other people.
15. show affection to other people.
16. get along with other people.
17. understand another person's point of view.
18. express my feelings to other people directly.
19. be firm when I need to be.
20. experience a feeling of love for another person.
21. set limits on other people.
22. be supportive of another person's goals in life.
23. feel close to other people.
24. really care about other people's problems.
25. argue with another person.
26. spend time alone.
27. give a gift to another person.
28. let myself feel angry at somebody I like.
29. put someone else's needs before my own.
30. stay out of other people's business.
31. take instructions from people who have authority over me.
32. feel good about another person's happiness.
33. ask other people to get together socially with me.
34. feel angry at other people
35. open up and tell my feelings to another person.
36. forgive another person after I've been angry.
37. attend to my own welfare when somebody else is needy.
38. be assertive without worrying about hurting the other person's feelings.
39. be self-confident when I am with other people.
Part II. The following are things that you do too much.

40. I fight with other people too much. 0 1 2 3 4
41. I feel too responsible for solving other people’s problems. 0 1 2 3 4
42. I am too easily persuaded by other people. 0 1 2 3 4
43. I open up to people too much. 0 1 2 3 4
44. I am too independent. 0 1 2 3 4
45. I am too aggressive toward other people. 0 1 2 3 4
46. I try to please other people too much. 0 1 2 3 4
47. I clown around too much. 0 1 2 3 4
48. I want to be noticed too much. 0 1 2 3 4
49. I trust other people too much 0 1 2 3 4
50. I try to control other people too much. 0 1 2 3 4
51. I put other people’s needs before my own too much. 0 1 2 3 4
52. I try to change other people too much. 0 1 2 3 4
53. I am too gullible. 0 1 2 3 4
54. I am overly generous to other people. 0 1 2 3 4
55. I am too afraid of other people. 0 1 2 3 4
56. I am too suspicious of other people. 0 1 2 3 4
57. I manipulate other people too much to get what I want. 0 1 2 3 4
58. I tell personal things to other people too much. 0 1 2 3 4
59. I argue with other people too much. 0 1 2 3 4
60. I keep other people at a distance too much. 0 1 2 3 4
61. I let other people take advantage of me too much. 0 1 2 3 4
62. I feel embarrassed in front of other people too much. 0 1 2 3 4
63. I am affected by another person’s misery too much. 0 1 2 3 4
64. I want to get revenge against people too much. 0 1 2 3 4
THERAPIST POST-SESSION QUESTIONNAIRE

Complete immediately after session. Please answer all questions.

Your patient’s initials _______  Session number _______

Your initials _______  Date of session _______

PART A

1. Please rate how helpful or hindering to your patient this session was overall by circling the appropriate number below.

   1  2  3  4  5  6  7  8  9
   Extremely hindering  Neutral  Extremely helpful

2. Please rate to what extent your patient’s problems are resolved.

   1  2  3  4  5  6  7  8  9
   Not at all  Moderately  Completely

PART B

1. Did you experience any problem or tension in your relationship with your patient during the session?

   Yes_____  No_____ 

2. If so, about where in the session did this problem begin?

   Beginning_____  Middle_____  End_____

3. Please rate the highest degree of tension you felt during the session as a result of this problem.

   1  2  3  4  5
   Low  Medium  High
4. To what extent was this problem addressed in this session?

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<tr>
<td>Not at all</td>
<td>Somewhat</td>
<td>Very much</td>
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5. To what degree do you feel this problem was resolved by the end of the session?

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<tr>
<td>Not at all</td>
<td>Somewhat</td>
<td>Very much</td>
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6. Please describe the problem briefly:

PART C

Please circle the appropriate number to show how you feel about this session.

This session was:

- Bad 1 2 3 4 5 6 7 Good
- Safe 1 2 3 4 5 6 7 Dangerous
- Difficult 1 2 3 4 5 6 7 Easy
- Valuable 1 2 3 4 5 6 7 Worthless
- Shallow 1 2 3 4 5 6 7 Deep
- Relaxed 1 2 3 4 5 6 7 Tense
- Unpleasant 1 2 3 4 5 6 7 Pleasant
- Full 1 2 3 4 5 6 7 Empty
- Weak 1 2 3 4 5 6 7 Powerful
- Special 1 2 3 4 5 6 7 Ordinary
- Rough 1 2 3 4 5 6 7 Smooth
- Comfortable 1 2 3 4 5 6 7 Uncomfortable
PART D
The following items reflect your working relationship with your patient based on your most recent session. Please rate each item by circling the appropriate number in terms of how you felt about this session.

1. My patient and I agreed about the things he/she needs to do in therapy to help improve his/her situation.

   1  2  3  4  5  6  7
   Never Sometimes Always

2. My patient believed that what we are doing in therapy gave him/her new ways of looking at his/her problem.

   1  2  3  4  5  6  7
   Never Sometimes Always

3. My patient believed that I like him/her.

   1  2  3  4  5  6  7
   Never Sometimes Always

4. My patient believed that I did not understand what he/she is trying to accomplish in therapy

   1  2  3  4  5  6  7
   Never Sometimes Always

5. My patient was confident in my ability to help him/her.

   1  2  3  4  5  6  7
   Never Sometimes Always

6. My patient and I worked toward mutually agreed-upon goals.

   1  2  3  4  5  6  7
   Never Sometimes Always
7. My patient felt appreciated by me.

1 2 3 4 5 6 7
Never Sometimes Always

8. We agreed on what is important for him/her to work on.

1 2 3 4 5 6 7
Never Sometimes Always

9. My patient and I seemed to trust one another.

1 2 3 4 5 6 7
Never Sometimes Always

10. My patient and I seemed to have different ideas on what his/her problems are.

1 2 3 4 5 6 7
Never Sometimes Always

11. We have established a good understanding of the kind of changes that would be good for him/her.

1 2 3 4 5 6 7
Never Sometimes Always

12. My patient believed the way we were working with his/her problem was correct.

1 2 3 4 5 6 7
Never Sometimes Always
PART E
Please rate how well each of the following sets of four adjectives, taken all together, describes YOUR PATIENT in the session just completed.

1. ASSERTIVE-FORCEFUL-PERSISTENT-INDUSTRIOUS 1 2 3 4 5 6 7
2. TRICKY-BOASTFUL-CONCEITED-CRAFTY 1 2 3 4 5 6 7
3. UNSOCIAL-INTROVERTED-DISTANT-SHY 1 2 3 4 5 6 7
4. MEEK-INCONSISTENT-UNPRODUCTIVE-UNAUTHORITATIVE 1 2 3 4 5 6 7
5. UNDECEPTIVE-UNARGUMENTATIVE-NONEGOTISTICAL-UNDEVIOUS 1 2 3 4 5 6 7
6. KIND-TENDER-FORGIVING-COOPERATIVE 1 2 3 4 5 6 7
7. COLDHEARTED-IMPOLITE-UNSYMPATHETIC-UNCORDIAL 1 2 3 4 5 6 7
8. FRIENDLY-OUTGOING-CHEERFUL-APPROACHABLE 1 2 3 4 5 6 7

PART F
Please check any of the following adjectives to describe how you felt in this session with your patient. A check beside the word means “Yes.” You may check as many or as few adjectives as you would like.

1____HELPFUL 11____SURPRISED 21____HAPPY
2____TIRED 12____ANGRY 22____THREATENED
3____ENTHUSIASTIC 13____RECEPTIVE 23____ANXIOUS
4____OBJECTIVE 14____STRONG 24____OVERWHELMED
5____MANIPULATED 15____BORED 25____RELAXED
6____MOTHERLY 16____CAUTIOUS 26____CONFUSED
7____DISAPPOINTED 17____EMBARRASSED 27____INDIFFERENT
8____INTERESTED 18____AFFECTIONATE 28____ALOOF
Progress Note: Please write a few sentences about the session.
Appendix D

BETH ISRAEL ADHERENCE SCALE

1. **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. (Rate on freq/clarity - "not at all" to "extensively.")

2. **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 from what your parents want." (Rate on freq/clarity - "not at all" to "extensively.")

3. **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 and experience 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?" (Rate on freq/clarity.)

4. **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 or precis of what the client has just said rather than a reflection of feeling. Therapist conveys that client's meaning has been understood. (Rate on freq/clarity.)

5. **Therapist's communication style.** How interesting is the therapist's style of communication? Consider the vividness of his/her language, the originality of the ideas, the liveliness of the manner of speaking. Rating: "1"=dull, uninteresting; "3"=less interesting than average; "6"=very interesting. Adapted from CSPRS, Hollon, 1984.

6. **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 nonjudgmental manner. "I'm aware of a particular tone in your voice." "When you say this, you have a very angry expression on your face." (Rate on freq/clarity.)

7. **Encourages client to distance him/herself from his/her thoughts, viewing them as beliefs rather than facts.** Therapist urges or challenges the client to consider the thoughts as beliefs which may or may not be true. Therapist urges the client to consider his/her thoughts as testable hypotheses rather than given facts. This item can be coded if the therapist makes direct statements to this effect OR if the therapist less directly
encourages this, as well. "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," "do you see how thinking of it in this way allows you to see it as a hypothesis that you have, rather than a carved-in-stone fact?" (Rate on freq/clarity.)

8. **Facilitates individuation and/or self-assertion.** Therapist encourages the client either to 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 me now?" (Rate on freq/clarity.)

9. **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." (Rate on freq/clarity.)

10. **Therapist conveys competence.** Did the therapist convey that s/he has understood the client's problems and is able to help the client? (ref. Hollon, 1984.)

11. **Probes for client's 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 doesn't want to talk to you, what does that mean to you?," "It sounds like you believe that in order to feel good about yourself, you must be liked by everybody." (Rate on freq/clarity.)

12. **Links resistance (to the therapeutic process) to the maladaptive pattern** E.g., "You're tuning out here just like you do when things get tough". Links behavior in session with behavior elsewhere. "You're shutting down with me now just like you do at home with your family when you get angry." (Rate on freq/clarity.)

13. **Explores the disadvantages and advantages 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?" (Rate on freq/clarity.)

14. **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?" (Rate on freq/clarity.)
15. **Therapist involvement.** How involved is the therapist with the process? Consider the range from detached to involved. (Hollon, 1984)

16. **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 very angry," "You say that you are not anxious and yet you've been twisting your hands back and forth in a way that you told me you do when you're nervous." (Rate on freq/clarity.)

17. **Helps client identify cognitive distortions, errors that were present in his/her thinking.** Magnifying, maximizing, catastrophizing, personalizing, generalizing. "Do you see how this all-or-none thinking actually decreases your options?," "It sounds like you believe that the only possible result of your effort is going to be failure. Is there a more accurate way of looking at this problem? Do you see how you are singling out the worst possible case scenario?" (Rate on freq/clarity.)

18. **Intervenes with skillful tentativeness.** Refers to quality of therapist attitude of exploration and subjectivity; therapist uses words like "perhaps," "it seems," "possibly." (Rate on freq/clarity.)

19. **Facilitates client's consideration of alternative explanations for events.** Did the therapist help the client consider alternative explanations for events besides the client's initial explanation? "What would be another way to explain why Bill reacted in this way?," "What about considering another perspective on the situation?," "Are there other factors which could have played a role in your not getting the position?" (Rate on freq/clarity.)

20. **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." (Rate on freq/clarity.)

21. **Interprets and/or explores client's resistance or defenses.** An interpretation provides a new understanding or offers a label of an inner state; it presumes 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." (Rate on freq/clarity.)

22. **Therapist warmth.** Did the therapist convey warmth?
23. **Tracks client's experience in a moment-to-moment fashion.** The act of following client's perceptions, thoughts, and feelings as they emerge in the moment. Therapist does not make reference to client processing that is not currently being experienced. (Rate on freq/clarity.) (GLOBAL BRT item.)

24. **Asks client to report specific thoughts.** Asks client to report specific thoughts as verbatim as possible. In order to code this item, it must be specific and verbatim. "What specific thoughts do you have about that?," "Let's get to the thought that you're having about this feeling." (Rate on freq/clarity.)

25. **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?" (Rate on freq/clarity.)

26. **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. (Rate on freq/clarity.)

27. **Engages in Socratic questioning aimed at guiding client's reasoning process.** This is guided questioning which may involve disputing or challenging the client's beliefs or ideas. "And what do you think would happen if you did that?," "How likely is that to happen?," "Where's the evidence for that?" "Where is that kind of thinking going to take you?" (Rate on freq/clarity.)

28. **Rapport.** How much rapport was there between the therapist and client? How well did they get along? "1"=total absence of rapport; "6=excellent rapport. (Hollon, 1984)

29. **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 inquiries 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?" (Rate on freq/clarity.)

30. **Frames symptoms as coping attempts.** The therapist recognizes and points out that particular symptoms can be understood as faulty and costly attempts at problem solving. "You really want someone to soothe you but nobody is there so you eat as a way of feeling better." (Rate on freq/clarity.)
31. **Engages in didactic persuasion.** The stance is teaching, guiding, persuading. It is a goal-directed stance that is meant to, through examining evidence, convince the client that his/her way of thinking is erroneous. "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?" (Rate on freq/clarity.)

32. **Defines/Identifies/Specifies the maladaptive pattern.** "You have a tendency when you're feeling scared to pull back. We've seen how this happens in your friendships and with people at work." "When you get angry with people you are close to, you have a tendency to react impulsively. This has been going on for a long time, and we need to understand what this pattern is about."

33. **Receptive silence.** (a/k/a receptive listening) Did the therapist appear to allow silence to continue, using minimal encouragements such as "uh-huh," "mm-hmm," and "okay" as a means of encouraging the patient to talk? Allows pt space to communicate. (Hollon, 1984)

34. **Helps client examine currently available evidence or information to test the validity and realistic consequences of the client's beliefs.** Therapist helps the client use evidence from 1) client's past experience, 2) his/her knowledge of the way the world works, to test his/her beliefs for validity. This can also be applied when the therapist looks at the realistic consequences of an event with the client. "Let's look at what actually happened and see if your belief still holds," "What's the evidence for the belief that your friends can't stand you?" (Rate on freq/clarity.)

35. **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. (Rate on freq/clarity - GLOBAL item.)

36. **Interprets/Explores maladaptive patterns by linking dynamics with others (past and present) to current dynamics with the 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 do that because he's gone, so you feel like you are starting to rely on me for those things." (Rate on freq/clarity.)

37. **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." (includes 2-chair exercise.) (Rate on freq/clarity.)
38. **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 loser." "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?" (Rate on freq/clarity.)

39. **Supportive encouragement.** Was the therapist supportive of the client by acknowledging the gains during therapy or by reassuring the client that gains will be forthcoming? Must be concrete. "1"=not at all; "6"=extremely. (Hollon, 1984)

40. **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," or "So you're feeling like no one really understands how hard it is for you." (Rate on freq/clarity.)

41. **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 develop a plan for getting a new job. This may involve role playing, etc. (Rate on freq/clarity.)

42. **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 to so you stay." (Rate on freq/clarity.)

43. **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).** Includes 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?" (Rate on freq/clarity.)

44. **Set and follow agenda.** Did the therapist work collaboratively with the client to formulate and follow a specific agenda for the session? (Rate on freq/clarity.)
Appendix E

Definitions of the Treatment Scales:

**BRIEF RELATIONAL THERAPY**

1. **Tracks client's experience in a moment-to-moment fashion.** The act of following client's perceptions, thoughts, and 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 inquiries into what the client is or has experienced. "What does that feel like?" "What was that like for you when he went away?" "What was it like for you when he went away?" "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).** Includes 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," or "So you're feeling like no one really understands how hard it is for you."
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 nonjudgmental manner. "I'm aware of a particular tone in your voice." "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 and experience 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 either to 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 me now?"
13. **Interprets and/or explores client's resistance or defenses.** An interpretation provides a new understanding or offers a label of an inner state; it presumes 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 to 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 patterns by linking dynamics with others (past and present) to current dynamics with the 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 do that because 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 from 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 or precis 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 solving. "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 very angry," "You say that you are not anxious and yet you've been twisting your hands back and forth in a way that 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. We've seen how this happens in your friendships and with people at work," "When you get angry with people you are close to, you have a tendency to react impulsively. This has been going on for a long time, and we need to understand what this pattern is about."

24. **Links resistance (to the therapeutic process) to the maladaptive pattern** E.g., "You're tuning out here just like you do when things get tough". Links behavior in session with behavior elsewhere.
COGNITIVE-BEHAVIORAL THERAPY

25. Probes for client's 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 doesn't want to talk to you, what does that mean to you?," "It sounds like you believe that in order to feel good about yourself, you must be liked by everybody."

26. Helps client identify cognitive distortions, errors that were present in his/her thinking. Magnifying, maximizing, catastrophizing, personalizing, generalizing. "Do you see how this all-or-none thinking actually decreases your options?," "It sounds like you believe that the only possible result of your effort is going to be failure. Is there a more accurate way of looking at this problem? Do you see how you are singling out the worst possible case scenario?"

27. Engages in didactic persuasion. The stance is teaching, guiding, persuading. It is a goal-directed stance that is meant to, through examining evidence, convince the client that his/her way of thinking is erroneous. "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. Asks client to report specific thoughts as verbatim as possible. In order to code this item, it must be specific and verbatim. "What specific thoughts do you have about that?," "Let's get to the thought that you're having about this feeling."

29. Encourages client to distance him/herself from his/her thoughts, viewing them as beliefs rather than facts. Therapist urges or challenges the client to consider the thoughts as beliefs which may or may not be true. Therapist urges the client to consider his/her thoughts as testable hypotheses rather than given facts. "What's that thought about?," "What is that thought?," NOT "What do you think?" or "What do you believe?"

30. Helps client examine currently available evidence or information to test the validity and realistic consequences of the client's beliefs. Therapist helps the client use evidence from 1) client's past experience, 2) his/her knowledge of the way the world works, to test his/her beliefs for validity. This can also be applied when the therapist looks at the realistic consequences of an event with the client. "Let's look at what actually happened and see if your belief still holds," "What's the evidence for the belief that your friends can't stand you?"

31. Facilitates client's consideration of alternative explanations for events. Did the therapist help the client consider alternative explanations for events besides the client's initial explanation? "What would be another way to explain why Bill reacted in this way?," "What about considering another perspective on the situation?," "Are there other factors which could have played a role in your not getting the position?"
32. **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 loser."

33. **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 develop a plan for getting a new job. This may involve role playing, etc.

34. **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.

35. **Engages in socratic questioning aimed at guiding client's reasoning process.** This is guided questioning which may involve disputing or challenging the client's beliefs or ideas. "And what do you think would happen if you did that?," "How likely is that to happen?," "Where's the evidence for that?"

36. **Explores the disadvantages and advantages 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?"
NON-SPECIFICS

37. **Therapist's communication style.** How interesting is the therapist's style of communication? Consider the vividness of the language, the originality of the ideas, the liveliness of the speech.

38. **Therapist conveys competence.** Did the therapist convey that s/he has understood the client's problems and is able to help the client?

39. **Therapist involvement.** How involved is the therapist? Consider the range from detached to involved.

40. **Therapist warmth.** Did the therapist convey warmth?

41. **Rapport.** How much rapport was there between the therapist and client? How well did they get along?

42. **Receptive silence.** Did the therapist appear to allow silence to continue, using minimal encouragements such as "uh-huh," "mm-hmm," and "okay" as a means of encouraging the patient to talk?

43. **Supportive encouragement.** Was the therapist supportive of the client by acknowledging the gains during therapy or by reassuring the client that gains will be forthcoming?

44. **Set and follow agenda.** Did the therapist work collaboratively with the client to formulate and follow a specific agenda for the session?
Please rate each of the following 44 items on a 1 - 6 scale based on both the general scoring directions and the directions for each individual item. Note that although the overall rating criterion for most of the items is the same (a frequency/clarity rating ranging from "not-at-all" to "extensively"), there is some deviation from this for several of the items. For example, item 5, (Th.'s communication style) is evaluated on its degree of interest ("dull" to "very interesting"), not on its frequency. The coder can refer to the accompanying description of the items to review the rating criteria for each item.

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Description</th>
<th>Scale (1-6)</th>
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<tbody>
<tr>
<td>1</td>
<td>Homework</td>
<td>1 2 3 4 5 6</td>
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<td>2</td>
<td>General interpretation</td>
<td>1 2 3 4 5 6</td>
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<td>3</td>
<td>Explores &quot;how&quot; of defense</td>
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<td>4</td>
<td>Reflects content</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>5</td>
<td>Th.'s communication style</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>6</td>
<td>Non-verbal</td>
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<td>7</td>
<td>Distance</td>
<td>1 2 3 4 5 6</td>
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<td>8</td>
<td>Individuation</td>
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<td>9</td>
<td>Frames symptoms</td>
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<td>10</td>
<td>Th. conveys competence</td>
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<td>11</td>
<td>Probes meaning</td>
<td>1 2 3 4 5 6</td>
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<td>12</td>
<td>Links resist./mal. patt.</td>
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<td>14</td>
<td>Here and Now</td>
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<td>Cognitive distortion</td>
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<td>Tentative</td>
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<td>19</td>
<td>Alternative explanation</td>
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<td>22</td>
<td>Therapist warmth</td>
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<td>Probe feeling</td>
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<td>39</td>
<td>Th.'s supportive encour</td>
<td>1 2 3 4 5 6</td>
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<td>40</td>
<td>Evocative reflection</td>
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<td>41</td>
<td>Plan/Practice altern. behs.</td>
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<td>42</td>
<td>Links parts of conflict</td>
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<tr>
<td>43</td>
<td>Metacommunication</td>
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<tr>
<td>44</td>
<td>Set and follow agenda</td>
<td>1 2 3 4 5 6</td>
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Appendix G

Adherence Rating Key
Frequency + Clarity

- **Global Items**
  - *Frequent & Pervasive* (i.e., BRT: ‘tracks client’s experience moment-to-moment’)
  - Rate 1 point lighter
  - \(\sqrt{\sqrt{\sqrt{3}}} = 3\)
  - \(\sqrt{\sqrt{\sqrt{2}}} = 2\)
  - \(\sqrt{\sqrt{\sqrt{4}}} = 4\)

- **Moderately-Occurring Items**
  - (i.e., CBT: ‘helps client track cognitive distortions’; BAP: links resistance to therapeutic process’)
  - Rate as occurs
  - \(\sqrt{\sqrt{\sqrt{4}}} = 4\)
  - \(\sqrt{\sqrt{\sqrt{3}}} = 3\)
  - \(\sqrt{\sqrt{\sqrt{5}}} = 5\)

- **Infrequent, but Substantive Items**
  - *Infrequent modality-specific interventions* (i.e., CBT: ‘assigns & reviews homework’; BRT: ‘deepens client’s experience through awareness exercises’)
  - Rate 2-3 points heavier
  - \(\sqrt{\sqrt{\sqrt{4}}} = 4\)
  - \(\sqrt{\sqrt{\sqrt{4-5}}} = 4-5\)
  - \(\sqrt{\sqrt{\sqrt{3}}} = 3\)

*check denotes frequency, the marker denotes clarity of each therapist utterance.*
\(\sqrt{\sqrt{\sqrt{-}}} =\) less than average clarity, \(\sqrt{\sqrt{\sqrt{\sqrt{-}\sqrt{-}}} =}\) average clarity, \(\sqrt{\sqrt{\sqrt{\sqrt{\sqrt{+}}} =}\) more than average clarity
Appendix H

BRIEF PSYCHOTHERAPY RESEARCH PROGRAM
BETH ISRAEL MEDICAL CENTER

Therapist Consent Form

Purpose of program

The purpose of this study is to explore the factors that contribute to the success of psychotherapy. The type of psychotherapy used in this study is a time-limited (30 session), cognitive-behavioral therapy, designed for personality disorders, and incorporates relational principles in the management of the therapeutic alliance.

Conditions of participation

As a therapist taking part in this study, you will practice psychotherapy in this therapeutic modality. Therapy consists of weekly, individual, fifty-minute sessions. Each therapist is responsible for videotaping therapy sessions, for completing a post-session questionnaire after every session, and for making patient assessments during the admission, mid-phase, and termination phases of therapy. Some of this data, as well as information obtained from videotaped recordings of sessions, may be used by the research staff for scientific purposes, such as professional publications or educational presentations in the transcribed, audiotaped, or videotaped format. Therapists are also required to attend weekly individual and group supervision meetings. Certain patient information, such as patient post-session questionnaires, will be kept confidential.

Questions

If you have any questions, you may contact the Brief Psychotherapy Research office at 420-3819 or Chris Muran, Ph.D. at 420-4662. You may request a copy of this form at any time.

Therapist Date

Witness Date

Principal Investigator Date
INSTRUCTIONS


Purpose and Nature of Program

You are invited to participate in a study involving three forms of short-term and time-limited psychotherapy: (a) cognitive-behavioral therapy, (b) brief adaptive psychotherapy, and (c) brief relational psychotherapy. We are attempting to learn more about different aspects of short-term psychotherapy so that you and others like you can receive the benefit of the best available treatment.

Treatment Conditions

If you decide to participate you will be randomly assigned to one of the three forms of short-term psychotherapy. All three forms of psychotherapy incorporate (a) high levels of therapist activity, (b) an approach focused on specific targeted problem areas, and (c) a treatment protocol of 30 sessions. The three psychotherapies, which have all proven to be significantly effective, differ primarily in some of the specific techniques employed; no one treatment approach has proven superiority over the others.

SIGNATURE OF PATIENT
DATE
RELATIONSHIP TO PATIENT:

SIGNATURE OF INVESTIGATOR
DATE

SIGNATURE OF PERSON GIVING PERMISSION
DATE

VALID UNTIL

DISTRIBUTION: ORIGINAL TO CLINICAL RECORDS. MAKE COPIES FOR SUBJECT (OR PERSON GIVING PERMISSION), INVESTIGATOR AND PHARMACY (WHEN APPLICABLE)
If you decide to participate in this study you will be asked to do the following:

1. Not to participate in other psychotherapy or take psychoactive medication while receiving treatment in this program.
2. Be available for 30 sessions.
3. Take two evaluation interviews and complete a package of questionnaires to evaluate how you are doing in treatment:
   a. Before beginning treatment
   b. Midway during treatment
   c. At termination of treatment
   d. Six months after treatment is completed
4. Complete a post-session questionnaire after each session.
5. Agree to have evaluation and treatment sessions videotaped.
6. Consent to have information obtained from videotaped recordings of sessions used for scientific purposes, such as research study, professional publication, educational presentations in transcribed, audiotaped, or videotaped format by the program staff.

Possible Risks
We know of no inherent risks associated with these treatments. Each type of treatment may cause some emotional discomfort at times, but this is generally considered a natural part of the therapeutic process.

Confidentiality
Information that is obtained in connection with this study that can be identified with you, including evaluation materials and videotaped recordings, will be held in the strictest confidence and would be voluntarily disclosed only with your explicit permission. We will share such information only with other members of our research and treatment team at Beth Israel. The only exception is the post-session questionnaire, which will not be available to your therapist and which will be identified solely by your identification number that will be provided at the onset. This exception is made because some of the material in this questionnaire pertains to your relationship with your therapist. While it is possible that at some point in the future selected excerpts from your sessions will be either presented or published for scientific purposes, adequate precautions will be taken to maintain complete confidentiality, according to the customary professional ethics of Beth Israel Medical Center.

Possible Benefits
All treatment groups offer possible benefits to you because they follow principles that have been tested and proven effective for some time. We are attempting to study what aspects of the different treatments contribute to or detract from their efficacy, particularly in terms of specific types of people and specific types of problems. Thus, your participation may be beneficial to you and others in the future.

Withdrawal
You may withdraw or cancel your participation at any time and you are under no obligation to participate. If you choose not to participate or withdraw at a later date, you will not jeopardize your future care by doing so. In this event you will be provided with standard Beth Israel care on the usual basis.

Questions
If you have any questions, you may contact J. Chris Muran, Ph.D., Program Director at 420-3819. If you have any unsatisfied complaints you may contact Jo Ann Tancer, Patient Representative at 420-3818. You may request a copy of this consent form at any time. You may also request feedback regarding aspects of the study upon your termination of treatment.