Conversational Model (CM) Adherence scale and its reliability; Therapist adherence to CM in a trial comparing CM and Dialectical Behaviour Therapy in the treatment of people with borderline personality disorder.

Bernard Borromeo Goldman (B Juris, LLB, B Soc Sci (Hons))

Submitted on 9 January 2011 in partial fulfilment of the requirements for a Professional Doctorate in Clinical Psychology

School of Psychology, University of Newcastle

The contents of the thesis relate to my own work, taking into account normal candidate-supervisor relations, and has not been submitted to any other institution.

Bernard Goldman.

Acknowledgements

I wish to acknowledge the assistance of Professor Mike Startup who was principal supervisor in this thesis, assisted in the development of the Newcastle Adherence Scale for the Conversational Model, and co-rated 22 sessions in this study. I also wish to acknowledge the assistance of Dr Carla Walton who was my secondary supervisor and, with Dr Nick Bendit, provided advice on the development of the Newcastle Adherence Scale for the Conversational Model. I also wish to acknowledge the support of my family and my colleagues in this project.

CONTENTS

TABLE OF TABLES

The following Tables are found in this thesis:

CRITICAL REVIEW

Abstract

Scope:

The demonstration of therapist adherence to therapy manuals is crucial for the validity of the conclusions that may be drawn from the outcomes of randomized controlled trials of psychotherapy. This research focused on rating adherence to a psychodynamic therapy called the Conversational Model (CM) in a trial which is being conducted at the Centre for Psychotherapy, Newcastle, comparing the effectiveness of Dialectical Behaviour Therapy (DBT) and the CM in the treatment of people with a diagnosis of Borderline Personality Disorder. The study also measured whether there was any change in the use of interventions in the CM over the course of therapy and whether the use of interventions varied depending on the clinical experience of the therapist. In addition the study tested the association between adherence to the CM and the therapeutic working alliance.

Purpose:

The main purpose of the study was to develop a reliable adherence scale for CM as practised at the Centre of Psychotherapy. On the basis that the instrument was reliable, the instrument was used to measure the implementation of various interventions over the course of therapy as well as measure any difference in the use of interventions depending on the experience level of the therapist. A secondary purpose was to explore associations between the therapist-client alliance and adherence to therapy.

Method:

The items reflecting interventions from Exploratory therapy (a form of CM) in the Sheffield Psychotherapy Rating Scale (SPRS)(Shapiro & Startup, 1990) were used as a basis for developing the Newcastle Adherence Scale for the Conversational Model (NASCoM). The NASCoM is made up of prescribed CM interventions (15), proscribed interventions (8), and facilitative conditions (2). It was piloted on recordings of 12 sessions of CM and 2 sessions of DBT, and then applied by two raters independently to recordings of 12 sessions of CM and 10 sessions of DBT. Finally, one rater undertook further ratings on adherence of an additional 37

sessions to make a total of 59 sessions tested for adherence to CM. As the adherence scale allowed for the measurement of extensiveness of interventions, the study also tested whether there was any significant change in the use of some of the interventions in the CM over the course of therapy and whether the use of interventions varied depending on the clinical experience of the therapist. In addition it tested whether there were significant associations between adherence to key humanist/experiential items (called client-centred interventions) and three factors that make up the working alliance as defined by Bordin (1979), namely, therapist agreement on tasks and goals and therapist and client bond.

Results:

High levels of inter-rater agreement both within and between therapies were found for most items in the NASCoM. Generally, inter-rater agreement was not significant when items were used infrequently in session. However, inter-rater agreement for these items was generally high. Using Discriminant Analysis, the therapies were distinguished perfectly. A factor analysis of the items in the NASCoM which had significant inter-rater agreement showed three factors reflecting, in part, three components of the CM, namely, psychodynamic, addressing the therapeutic relationship, and humanist/experiential components. A significant association was found between adherence to client centred interventions and client and therapist agreement on tasks. Contrary to what was predicted, no significant association was found between adherence to client centred interventions and the clients' reports of bond with the therapist. Using repeated-measures ANOVAs, no significant changes were found in use of interventions over the course of therapy. However, changes pointed in the direction predicted for the use of explanatory statements which is a CM item used in the NASCoM.

Conclusions/Implications:

The study shows that despite the challenges of developing an adherence scale for psychodynamic therapies, the findings contribute to a body of research that supports the development of adherence scale for such therapies. The findings also support further research on the association between adherence to treatment and the working alliance, with a significant association found between adherence to key CM

interventions and one aspect of the working alliance, namely, therapist and client agreement on the tasks of therapy. In addition, the findings show how adherence scales can be used to explore processes in therapy by measuring the use of selected CM interventions over the course of therapy.

Overview

A regional specialist centre for the treatment of Borderline Personality Disorder and eating disorders is currently conducting a Randomised Controlled Trial (RCT) comparing the effectiveness of Dialectical Behaviour Therapy (DBT) with the Conversational Model (CM) in the treatment of people with Borderline Personality Disorder (BPD). DBT and CM treatments have been subject to outcome studies and both treatments have been found to improve patient outcome for people diagnosed with BPD. This is the first known trial where DBT and CM have been compared with each other. The validity of the outcomes of RCTs is dependent on the therapists adhering to their particular therapy. While DBT has an adherence scale, the CM, as used in the treatment of BPD, does not have such a scale. This research involved the development and testing of a scale to measure adherence to CM in this RCT. The Scale was called the Newcastle Adherence Scale for the Conversational Model (NASCoM). As the NASCoM also measured extensiveness of interventions used in CM, this research measured the use of interventions over the course of CM treatment, undertook an exploratory factor analysis, as well as tested the associations between adherence and the therapeutic alliance as defined by Bordin (1979).

Definition of BPD

Borderline Personality Disorder is classified in the *Diagnostic and Statistical Manual of Mental Disorders–Text Revision* (American Psychological Association, 2000) (hereinafter called "*DSM-IV-TR"*) by nine symptoms of which at least five symptoms are required for a diagnosis of BPD. Lieb, Zanarini, Schmahl, Linehan, and Bohus (2004) have summarised the nine symptoms of BPD into four categories which are as follows. Firstly, there are the affective criteria which involve the experience of intense and unstable emotions including chronic feelings of emptiness. Secondly, there are the cognitive criteria which include unstable sense of self as well as dissociative symptoms and stress-related paranoid ideation. Thirdly, behavioural criteria include recurrent suicidal or self-harming behaviours. Finally, the fourth

category relates to interpersonal relationships such as making desperate attempts to avoid abandonment which may include self-harming and/or suicidal behaviour. Interpersonal relationships can also be marked by unstable relationships involving oscillation between idealization and devaluation.

Prevalence rates for BPD

The prevalence rate for people with BPD varies from study to study: from 0.7% in a prevalence study in the Norwegian population (Torgersen, Kringlen, & Cramer, 2001) to 3.9% in a study in New York State (Crawford et al, 2005 cited in Lenzenweger, Lane, Loranger, & Kessler, 2007). In a National Comorbidity Survey Replication across the United States, BPD was estimated in the general population to be 1.4% (Lenzenweger, et al., 2007). However, more importantly, Widiger and Weissman (1991) claim that on their review of existing data, 15% of in-patients in psychiatric wards have BPD and Gross, et al. (2002) found a prevalence rate of 6.4% in urban primary care practices. It follows from the prevalence findings, and the nature of the symptoms experienced by those with BPD, as set out in the *DSM–IV-TR,* that considerable health resources are used to treat people with BPD. An Australian study by Stevenson, Meares, and D'Angelo (2005) estimated the costs of not effectively treating those with BPD. Their cost analysis in 2005 showed that the Government funds around $18,000 per annum per patient with BPD. Findings also have shown that those with BPD are highly represented in our prison populations. For example, in a study by Black, et al. (2007), 29.5% of the prison population met the criteria for diagnosis of BPD. These findings suggest that people with BPD use considerable resources in our legal and health systems. Further, the impact of BPD behaviours on the life aspirations of the sufferer, as well as on those living with people with BPD, are distressing.

Treatment for BPD

In light of the above prevalence studies and the costly impact of BPD on people's lives and the public purse, it is not surprising that a number of treatments, besides

CM and DBT, have been developed in recent years for the treatment of BPD. At least four other psychodynamically oriented treatments have been developed to address BPD and have been found to be effective (see also Dixon-Gordon, Turner, & Chapman, 2011). They are Transference Focus therapy (Clarkin, Levy, Lenzenwerger & Kernberg, 2007), Dynamic Deconstructive therapy (G. A. Goldman & Gregory, 2009), Mentalisation-based treatment (Bateman & Fonagy, 2009; Katerud & Bateman, 2010), and General Psychiatric Management (McMain, et al., 2009). The challenge for these therapies, as with all therapies, is providing evidence of the treatment's effectiveness to support their use. Yet psychodynamic therapies have traditionally been regarded as therapies which are difficult to show empirical support (Chambless & Ollendick, 2001; Perepletchikova, Treat, & Kazdin, 2007).

Treatment Integrity

One of the building blocks for showing that a treatment has empirical support is ensuring that a treatment is delivered as specified and that interventions that are proscribed in treatment are not used. The task of testing to see if treatments are delivered as specified has been called adherence testing, testing for treatment integrity, or treatment fidelity (see Waltz, Addis, Koerner, & Jacobson, 1993). Treatment fidelity is generally regarded as having three components. The first component is rating adherence to a particular therapy. In order to rate adherence there needs to be a manual (or agreement on practice) as well as a rating scale of the various interventions used in the treatment and those interventions proscribed. The second component of treatment fidelity is being able to distinguish one treatment from the other treatment used in a comparison trial. Generally, the first and second components go together. The third component of treatment integrity requires assessing whether the treatment is undertaken competently. Adherence testing rates whether interventions are used or not regardless of whether they were delivered appropriately or skillfully. The measurement of therapist competencies is a qualitative measure of the therapists' ability to implement the prescribed interventions in a skillful manner. This third arm of integrity testing does not form part of this research.

The first component of adherence testing involves rating interventions which are prescribed by a particular therapy as well as rating the existence of interventions which are proscribed by that therapy. These proscribed interventions usually involve interventions from a comparison treatment (Perepletchikova, Treat, & Kazdin, 2007). Within the prescribed interventions, Waltz, Addis, Koerner, and Jacobson (1993) identifed unique, essential, and acceptable interventions. Unique interventions are those interventions unique to the treatment being tested for adherence and not found in the comparison treatment. Essential interventions are those interventions essential to the treatment being tested but can be used in the comparison treatment. Acceptable interventions are those that are not proscribed but are neither essential nor unique to the therapy being tested for adherence. Proscribed interventions are those unacceptable to the treatment being rated.

The main purpose of assessing treatment integrity in RCTs of psychotherapy is to provide empirical support that the clinical interventions in a particular treatment are carried out in accordance with its manual or in accordance with agreed practice for that treatment. Without such evidence, one cannot be confident about the results of a RCT. Perepletchikova, Treat, and Kazdin (2007) pointed out that if a treatment is not carried out in accordance with its unique skill set, it is not possible to make any safe conclusions about the effectiveness of the particular treatment. For example, if the therapist using CM also uses a range of DBT interventions, one will not be able to make any conclusion about the effectiveness of CM as the DBT interventions may have contributed to the effectiveness of the treatment. Further, they noted that failure to adhere to the interventions prescribed in the treatment will make it difficult to replicate the treatment in the future; thus affecting the external validity of the study. They also stated that without adherence, unsystematic error may be introduced which, in turn, will affect the statistical conclusion validity of the results of the study.

Despite the importance of treatment integrity as part of the research methodology for showing that a treatment is empirically supported, it is rarely reported in the literature (Randall & Biggs, 2008). Perepletchikova, Treat, and Kazdin (2007) found that treatment integrity procedures were implemented significantly more for skill-building treatments such as Cognitive Behaviour Therapy (CBT) compared to psychodynamic and non-directive counselling treatments. They argue that CBT

treatments are easier to operationalise in manuals and therefore easier to monitor compared to psychodynamic treatments. They state that psychodynamic interventions are frequently complex, process oriented and generally involve exploration of underlying themes and patterns in patients' lives. As a result, psychodynamic therapies value flexible and spontaneous responses to the patient's content. In contrast, directive interventions such as teaching techniques for symptom reduction or implementing an agreed plan of interventions are easier to classify and rate.

Whether or not it is more challenging to create adherence scales for psychodynamic therapies compared to skill building therapies, there is a need to undertake such work. Funding agencies and insurance companies require that the treatments used are evidence-based (Chambless & Ollendick, 2001; Guthrie, 1999). Two adherence scales for psychodynamically oriented therapies for BPD have been developed and tested in recent years. Kolla, et al. (2009) developed the General Psychiatric Management Adherence Scale for a therapy called General Psychiatric Management (GPM) which is a psychodynamically informed therapy. The Scale was used in a randomised trial where GPM was compared with DBT (McMain, et al., 2009). The Scale was tested by measuring therapists' and clients' agreement as to what interventions were undertaken in therapy. It appears that testing for discrimination between GPM and DBT did not take place. An adherence instrument has also been developed for Dynamic Deconstructive therapy for treatment resistant clients with BPD and has been found to have good inter-rater reliability for Dynamic Deconstructive Therapy with a sample of ten participants (G. A. Goldman & Gregory, 2009). The reason for good inter-rater reliability may be partly due to the items in the Dynamic Deconstructive Therapy adherence scale largely measuring directive interventions and information collection interventions undertaken by the therapist. Such interventions are arguably easier to rate compared to rating the therapist's delivery of process-oriented interventions such as attuning emotionally to the client or facilitating awareness of feelings in the client where the context of client and therapist statements needs to be taken into consideration by the rater.

Comparative treatments used in this study

Overview of treatments

The current research on adherence forms part of a larger study comparing two long-term-treatments, CM and DBT. An outline of DBT and CM and the evidence supporting their effectiveness is provided in the next two sections. The development and testing of an adherence instrument requires an understanding of the therapy being rated, namely, CM. An understanding of CM also facilitates the categorisation of interventions in the adherence scale as unique, essential, or acceptable to the particular therapy. There is also a need to understand the other therapy being compared in the trial, namely, DBT, as the adherence instrument should include proscribed interventions from that therapy.

Dialectical Behaviour Therapy

Outline

Linehan, the founder of DBT, posited that the central difficulties for people with BPD are the physiological difficulty in regulating their emotions in combination with a history of being raised in an invalidating environment (Linehan, 1993). Linehan argued that the client's childhood environment limited the client's social skill acquisition which then impeded their capacity to regulate their predisposition to respond emotionally in an intense way to various stimuli. Dialectical Behaviour Therapy involves the concurrent delivery of therapeutic services to the client with a diagnosis of BPD in four mediums: weekly individual psychotherapy, group therapy, telephone counseling, and consultations amongst individual and group therapists about client's progress. (The DBT sessions being rated in this study come from the weekly individual psychotherapy sessions.)

DBT group work focuses on building the client's skills so that the client can cope more effectively with their experience of distress, build capacity for emotional regulation, and develop interpersonal skills (Linehan, 1993). A fourth area of group work is the development of the client's mindfulness skills. The use of telephone

counseling from a therapist trained in DBT allows the client to call on assistance so they can apply the above skills when they most need to practise them.

In light of the presence of frequent crises for this client group, there is an agreement with the client at the outset of therapy that certain behaviours are given priority in individual therapy. The priorities are in the following order: addressing self-harming behaviours; client behaviours that interfere with therapy; quality of life–interfering behaviours, and finally increasing behavioural skills (Scheel, 2000). Clients in DBT are provided with diary cards to complete between sessions. The review of the diary card is usually the first task considered in session and the above hierarchy is used in reviewing the information on the diary card to set the agenda for the session.

Evidence for the effectiveness of DBT

The results of the first studies on the treatment of BPD were published in the early 1990s. Linehan, Armstrong, Suarez, Alimon, and Heard (1991) undertook a randomized controlled trial of female patients who met the criteria of BPD (and not other personality disorders or other Axis I disorders) and who had engaged in past and recent parasuicidal behaviour. In summary, 20 patients undertook DBT whereas 22 patients were engaged in treatment as usual (TAU), though nine patients in the TAU group also received some form of individual therapy. Treatment was of one year duration. It was found that DBT participants had significantly less in-patient hospital days and significantly fewer parasuicidal acts than the TAU group at the end of the treatment. However, in a review of this study, Scheel (2000) noted that there was no evidence for finding DBT superior to the TAU on general aspects of life such as feelings of hopelessness, depression, suicidal ideation, overall life satisfaction, or the patients' ratings of social adjustment.

Further evidence for the efficacy of DBT for persons with BPD is found in a one-year follow up study by Linehan, Heard, and Armstrong (1993) of 41 of the original participants in the above-mentioned study by Linehan, Armstrong, Suarez, Alimon, and Heard (1991). Twenty participants were in the DBT group and 21 participants in TAU. The study by Linehan et al (1993) confirmed that some gains

made in DBT continued one year after therapy; however, DBT did not maintain significant improvements in parasuicidal acts in the last six months of that year.

A larger study was conducted by Linehan, et al. (2006) of 101 participants where the control group were treated by non-behavioural psychotherapy experts with experience working with “difficult” clients. Suicide attempts and use of inpatient services were significantly less for the DBT group than for those patient treated by the non-behavioural psychotherapy experts. Yet there was no difference in self-harm between groups. This finding is consistent with the one-year follow-up in the study by Linehan, Heard and Armstrong (1993) and more recently in a study by Carter, Willcox, Lewin, Conra, and Bendit (2010). However, Carter et al found days in bed and quality of life were significantly improved for the DBT group compared to the group in TAU.

In the following two studies comparing DBT with other therapies, suicidal and self-harming behaviours significantly decreased for DBT clients. In a study by Clarkin, Levy, Lenzenwerger and Kernberg (2007), DBT was compared with Transference-focus Therapy and Supportive Therapy. It was found that DBT was associated with improvement in global functioning, social adjustment and reductions in parasuicidal behaviour, depression, and anxiety. However, Clarkin, et al. (2007) also found that Transference-Focus Therapy showed significant reductions in anger, irritability, and verbal and direct assault, whereas DBT did not. Finally, in a recent published RCT which compared the efficacy of DBT and General Psychiatric Management, both treatments showed significant reductions in the frequency and severity of suicidal and self-harming behaviours (McMain, et al., 2009). The study also found that for both treatments that there were significant reductions in anger, depression, and improvement in interpersonal functioning but no significant improvements in health status relating to quality of life.

The results of the above studies show some variability in outcomes when using DBT especially in relation to other symptoms of distress such as experiences of anger. The variability in the above results also extends to reduction of self-harming behaviours. Nevertheless, a recent review of 19 randomized control trials of therapies treating BPD found DBT to be the only well established treatment for BPD (Dixon-Gordon, Turner, & Chapman, 2011). Further, a meta-analysis of 16 trials, of

DBT of which eight were controlled trials, found moderate global effect and a moderate effect size for suicidal and self–injurious behaviours (Kliem, Kroger, & Kosfelder, 2010).

Conversational Model

Outline

The CM has its genesis in the work of Robert Hobson who outlined the CM in his book, *Forms of Feeling* (Hobson, 1985). Hobson's individual therapy was not directly oriented to any particular mental condition. However, Hobson's clinical work was generally with clients with symptoms consistent with BPD (Stevenson & Meares, 1992). Guthrie (1999) states that Hobson's therapy, and in particular his development of Psychodynamic Interpersonal Therapy (which is a short-form version of the CM), finds its theoretical bases in psychodynamic principles, and interpersonal and humanist/experiential concepts (see also Shapiro & Startup, 1992).

Not dissimilar to Linehan's formulation of the aetiology of BPD, Hobson (1985) posited that disturbance in a client's relationships may arise out of lack of opportunity in the client's environment to learn a language which allows feelings to be expressed or understood. The CM aims to assist the client to find a language which allows the client to converse with the therapist about their feelings in a way that can be used by the client in other significant relationships. The therapy aims to assist the client to change relational behaviours that have impaired them in the past or may cause or maintain various distressing symptoms (for example, avoidance of intimacy).

Hobson (1985) intended that his approach would differ from, what was at the time, a more typical psychodynamic role of therapist neutrality. Hobson promoted the use by the therapist of a collaborative "we" rather than "you" in his conversational therapy to promote a conversation between the client and therapist rather than an interview of the client. Hobson also encouraged use of tentative statements about what is happening with the client rather than the therapist making definitive interpretations of the client's experience. Consistent with this approach, Hobson suggested that the therapist should create an atmosphere of mutual correction of any misunderstandings between client and therapist. Hobson promoted the

exploration of the client's feelings in an active experiential way in therapy. He emphasised the importance of the therapist observing the client's non-verbal language as another means of exploring the client's feelings. He regarded the therapist's task as being to encourage the client to stay with his or her feelings. Hobson also promoted the value of developing a symbolic attitude with the client through a waiting for what may emerge in therapy either by way of the client's use of metaphor or image.

Hobson (1985)'s CM, with its focus on the exploration of client's feelings and their relationships, has an obvious application to the person with BPD whose life is marked with concerns about emotional regulation especially in the context of relationships. Hobson also promoted a development in the client of being "alone and together". He found that when the client can experience being alone, he or she will be able to experience togetherness which does not involve fusion with another person. Hobson suggested that intimacy fails when clients have felt a sense of loss or abandonment in their relationships. Hobson's goal for therapy of "being alone and together" is apposite for the client with BPD who experiences unstable relationships and feedings of abandonment.

Meares (2005) has applied Hobson's approach specifically to the field of clients with BPD in his work, *The Metaphor of Play.* The client with BPD frequently reports a history of living in an invalidating environment especially in childhood (Meares, 2005). Meares posits that in such environments, the child is often discouraged from expressing or discussing their feelings. Rather, Meares states that the child learns to be vigilant in identifying any threatening external stimuli such as facial expressions and threatening gestures of in the people around them. Meares also states that in such environments a child may develop "disordered sense of self" and experience feelings of "emptiness". Stevenson and Meares (1992) posit that invalidating social environments and poor attachment inhibit development of a "sense of self" in the person with BPD which in turn limits their capacity to develop long-term stable relationships. Gunderson (1996)'s clinical experience also identified one of the key aspects of BPD as an intolerance for aloneness. The inability to maintain relationships and intolerance of aloneness creates a vicious cycle of mental suffering for the person with BPD.

Meares (2005) promotes the use of various therapeutic techniques, also promoted by Hobson (1985), to facilitate the client's inner world such as the therapist responding to the symbolic content of the client. Meares also promotes the use of various techniques to assist the therapist to attune to the client's feeling content with the aim of encouraging the client to explore and work with their feelings. Meares points out that due to the fragility of the client with BPD it is important to attend to any ruptures in therapy which are frequently due to a failure by the therapist to attune to the client's emotional state. Stevenson and Meares (1992) state that one of the tasks of the therapist is to facilitate the client to work through these ruptures (called "disjunctions" in CM) in order to maintain the therapeutic relationship. They claimed that by resolving disjunctions collaboratively, the client develops a capacity to resolve their difficulties in other relationships.

Evidence for the effectiveness of the Conversational Model

A study conducted by Stevenson and Meares (1992) involved the provision of two sessions of the Conversational Model per week for one year to thirty participants. The findings showed significant reductions in several areas such as violent behaviours, use of drugs, medical visits and hospital admissions, self-harm episodes, and time away from employment. (Stevenson, Meares and D'Angelo (2005) found that the gains were maintained in a five year follow-up of all 30 participants. A later replication study by Korner, Gerull, Meares and Stevenson (2006) compared a TAU group of 30 participants with 30 clients treated under similar conditions as in the study by Stevenson and Meares (1992). They also found similar significant improvements in patient functioning. A further study conducted by Korner, Gerull, Meares and Stevenson (2006) found that 30 participants who had two years of therapy made additional gains in comparison to 30 participants who had only one year of therapy. The rationale provided by Korner and colleagues for such gains is that clients with BPD experience emptiness and that longer-term treatment enables the participants to address this experience more comprehensively.

Comparison of DBT and CM

CM is a non-directive therapy where the therapist responds to the client's content. Hobson (1985) discouraged therapists from being directive or questioning the client. In contrast, individual sessions of DBT involve reviewing homework set from the previous session and working through client content in a prioritized way. CM is a psychodynamic therapy where the therapist task is to attune to the client's emotions. Another task of CM is to assist clients find insight into areas of their life such as patterns in their relationships (including the client-therapist relationship) or connections with their childhood experiences. In contrast, DBT is a cognitive behavioural therapy oriented to teaching skills to the clients so that they can cope more effectively with distress and regulate their emotions more effectively. In CM, psychoeducation and teaching psychological techniques are not part of the model.

Development of the Newcastle Adherence Scale of the Conversation Model (NASCoM)

While researchers of DBT have the benefit of an adherence instrument called Dialectical Behavior Therapy Adherence Manual (Linehan & Korslund, 2003), no instrument has been available to rate therapists' adherence to CM specifically for the treatment of BPD. However, attempts were made in the above studies on the CM to improve therapist adherence to the CM without rating adherence. In three of these studies, the authors noted that supervision of therapists who provided CM was undertaken by way of audiotapes (Korner, Gerull, Meares & Stevenson, 2006; Stevenson & Meares, 1992; Stevenson, Meares & D'Angelo, 2005) as well as joint supervision across supervisors of CM (Stevenson & Meares, 1992).

Stevenson and Meares (1992) stated that ideally a manual for adherence to therapy should be used. However, at that time they regarded such a process as complex "since the therapeutic field is 'intersubjective'" and that a "therapeutic response cannot be judged as 'correct' before it is made" (p. 359). Stevenson and Meares then provided an example of a therapist responding to a client by way of an interpretation of the client's behaviour which then led to a disjunction in therapy.

They regarded the therapist response as “correct” in that the interpretation was accurate but not correct because it led to a disjunction. It would seem from their example that Stevenson and Meares possibly confused therapists’ competency with treatment adherence when considering the challenges of developing an adherence scale. Despite their concerns, they recognized the value of developing an adherence manual that would address a limited range of CM interventions.

Sheffield Psychotherapy Rating Scale

While there has been no scale to rate adherence to CM for patients with a diagnosis of BPD to date, a scale was developed by Shapiro and Startup (1990) to rate adherence to a therapy based on Hobson’s CM called Exploratory Therapy (later called Psychodynamic Interpersonal Therapy (see Guthrie, 1999; Shapiro et al, 1994). The scale, called the Sheffield Psychotherapy Rating Scale (SPRS), was used in the Second Sheffield Psychotherapy Project (Shapiro & Startup, 1992). The participants in that Project were diagnosed with major depression. They were treated for either 8 or 16 weekly sessions of therapy. Shapiro and Startup (1992) found satisfactory inter-rater reliability for most of the ratings of the exploratory items in the SPRS. They also found that the ratings contributed significantly to discrimination between Exploratory Therapy and Prescriptive Therapy (the latter therapy largely involving cognitive behavioural interventions) (see also Startup & Shapiro, 1993).

Adaptation of the Sheffield Psychotherapy Rating Scale

The CM used in this current study is adapted from Hobson’s CM by Meares (2004, 2005) for people with a diagnosis of BPD. Perepletchikova, Treat and Kazdin (2007) have raised but not answered the question whether integrity measures need to be devised for each treatment. However, if adherence testing is to promote internal and external validity of treatment under study, adherence needs to relate to the therapy as practised in the study. It is arguable that the CM in this study is sufficiently distinct from Exploratory Therapy used in Shapiro and Startup (1992); so that a new adherence scale was required. Meares (2004) adapted the principles of

CM as developed by Hobson for people with BPD who have been found not to be as high functioning as people suffering depression (see Gunderson, et al., 2011). As a result, Meares (2005) developed a long-term therapy of at least 12 months duration where the therapists' tasks were to attend closely to the client's emotions from moment to moment with the aim of building a therapeutic relationship and facilitating the development of the inner world of the client. Meares emphasises the importance of addressing any issues arising out of the therapeutic relationship in CM as he had found people with BPD generally have experienced a long history of unstable relationships and on that basis there is an expectation that their experiences will impact negatively on the therapeutic relationship (Meares, 2005). As a result of the formulation of the CM by Meares, the Newcastle Adherence Scale for the Conversation Model (NASCoM) and manual was created specifically for rating adherence to CM with people with BPD. A copy of the NASCoM and its manual are found at Appendix 2. A summary of the NASCoM is also found at Table 1 of the draft journal article.

Researchers such as Perepletchikova, Treat and Kazdin regard psychodynamic therapies more difficult to rate than skill building therapies (see Perepletchikova, Treat & Kazdin, 2007). Nevertheless, Shapiro and Startup (1992) found good inter-rater reliability for items in the SPRS reflecting interventions from Exploratory Therapy. On that basis, it is hypothesised that the NASCoM will be able to rate interventions in the CM reliably. Further, as CM is a psychodynamically oriented therapy and DBT is a cognitive behaviour therapy, it is also hypothesised that the ratings on NASCoM will be able to discriminate between these two therapies.

Factor analysis

Not only does the use of the NASCoM allow the researcher to measure adherence to CM, it is also a tool that allows the rater to quantify how much various CM interventions were used. Using the NASCoM, the rater is able to rate the extent to which interventions were used in CM; thus an exploratory factor analysis can be carried out on those items in the NASCoM which received significant inter-rater reliability. The CM as developed by Hobson (1985) was regarded as a combination

of three therapeutic orientations, namely, existential/humanist, psychodynamic, and interpersonal (Guthrie, 1999; Shapiro & Startup, 1992). It would follow that a factor analysis should reflect these three therapeutic influences. However, as stated earlier, Meares (2004,2005) emphasised the importance of the therapist addressing challenges to the therapeutic alliance and that emphasis is reflected in the NASCoM (see also Bendit, 2010). It is hypothesised that while the three therapeutic influences of CM will be present in a factor analysis of the CM items in the NASCoM, the adaptation by Meares of Hobson's CM in relation to addressing issues arising out of the therapeutic relationship would also be reflected in the factor analysis.

Measuring changes in interventions over the course of therapy

The measurement of the extent to which interventions are used can provide insight as to what interventions are being used over the course of therapy and therefore contribute to an understanding of the extent to which particular interventions may contribute to outcome. Specialist CM practitioners advised that certain interventions were likely to be used depending on the stage of therapy (Personal communications, Drs Bendit and Walton, 2010; see also Bendit, 2010). They advised that in the early phase of therapy, the principal role of the therapist was to attune to the emotional content offered by the client by use of interventions such as use of mutual language (i.e. therapist use of "we" and "I" instead of "you") and emotional attunement (i.e. using empathic reflection such as coupling or amplification). They predicted that as therapy unfolded, emotional attunement would continue to be used. However, they advised that the delivery of explanatory statements (which include making interpretations about the client's past and present circumstances) are discouraged in the early stage of therapy and would generally only be used when the therapist regards the therapeutic relationship as robust and that the client can tolerate such explanations.

The CM specialist practitioners' rationale for explanatory statements being used with varying emphases depending on the course of therapy was largely based on the work of Meares (2004, 2005). Meares states that the focus of the CM is to be sensitively aware of the client's emotional state. For Meares, understanding of the

client's feelings has precedence over finding the meaning of what the client is saying. He states that the use of psychodynamic interpretations follows in so far as they assist the clients to develop their awareness. Meares says that the use of such interpretations could be damaging for the client with BPD as the client may experience the interpretation as an intrusion (see also Hobson, 1985). However, as the client grows to feel more comfortable in the therapeutic relationship, it was expected that therapists would be able to offer insight about the client-therapist relationship as well as the client's other relationships. It was also expected that as the client develops a greater sense of their internal world they would be more likely to use metaphors which the CM therapist is expected to promote (Bendit, 2010; Hobson, 1985; Meares, 2005). On that basis, it is expected that the use of explanatory statements and metaphors would increase over the course of therapy when the client-therapist relationship should be on a stronger foundation than in the earlier stage of therapy. On the other hand, there is no expectation that interventions such as use of emotional attunement and mutuality would decrease over time.

Bendit and Walton (Personal communications, 2010) also advised that they expected that experienced CM therapists would use explanatory statements more frequently compared to those therapists who were training in the use of CM or had less experienced using the CM. They state that the delivery of explanatory statements requires a level of analysis of the client's words and actions which comes with experience in practising CM. Any delivery of explanatory statements is also made with some risk of jeopardizing the therapeutic relationship (Meares, 2005). In contrast, it was anticipated that there would be little difference, as far as the level of experience was concerned, in how therapists would use emotional attunement or related interventions such as the use of mutuality over the course of therapy. These latter interventions largely involve staying attuned with the client in a non-confrontation, non-directive way.

It was hypothesised that CM therapists over the course of therapy would increasingly use explanatory statements and promote the client's use of metaphor. It was also hypothesized that experienced CM practitioners would delivery explanatory statements more frequently than practitioners with less experience.

Adherence to CM and the Working alliance

This current study was also designed to explore associations between therapist adherence to aspects of the CM and the working alliance. The working therapeutic alliance, as described by Bordin (1979), is made up of three components: (a) therapist and client agreement on goals, (b) therapist and client agreement on tasks, and (c) a bond between the therapist and client. While the therapist in CM discusses goals with the client at the outset of therapy, it is not a focus of therapy (Personal communications, Walton, 2011). Rather than a focus on symptom relief, the CM therapist is expected to stay with the client's content and foster a therapeutic alliance. On that basis, it is not expected that the adherence to CM will have a significant association with client and therapists agreement on goals.

As stated earlier, there is a focus in CM on the therapist being emotionally attuned to the client. Meares (2005) outlined three techniques to deliver emotional attunement by way of coupling, amplification and representation. Further, Hobson (1985) strongly encouraged the therapist respond to the client's emotional content with mutuality and with tentativeness. It is on that basis that adherence to the delivery of emotional attunement with mutuality and tentativeness (called client centred interventions in this current study) was tested for associations with the working alliance as formulated by Bordin (1979). While there is no expectation that adherence to client centred interventions will associate significantly with therapist and client agreement on goals, it is anticipated that adherence to an essential aspect of CM, namely, the client centred interventions, should associated significantly with client and therapist agreement on tasks.

Further, the role of empathy (akin to emotional attunement in this current study) has been considered integral in the creation of bond between client and therapist (Norcross, 2011). In a study by Bachelor (1988), it was found that participants' perceived empathy as deepening the therapeutic bond. As the client centred interventions are about delivery of a range of empathic responses in a tentative and mutual way, it is expected that there will be a significant association with adherence to client-centred interventions and client bond. Further support for predicting a

relationship between adherence to client centred interventions and bond as well as agreement on tasks between client and therapist is found in a study by Bachelor, Meunier, Laverdiere, and Gamarche (2010) where clients with higher levels of attachment to their therapist showed stronger bonds with their therapist as well as agreement on tasks. As the client centred interventions in the CM are considered to facilitate attachment in the client-therapist relationship (see Meares 2005), it should follow that adherence to client centred interventions should also facilitate a working bond between client and therapist as well as agreement on tasks. In contrast, the use of interpersonal and psychodynamic interventions could potentially impair the alliance on the basis that the client may perceive the therapist's interventions as persecutory (Hobson, 1985; Meares, 2005; Piper, Joyce, McCallum, Azim, & Ogrodniczuk, 2002). As there appears to be no reports that delivery of psychodynamic or interpersonal insights has strengthened the therapeutic alliance, no predictions have been made in this current study on adherence to their delivery and the therapeutic alliance.

It is hypothesized that there will be a significant association between adherence to client centred interventions and therapist and client agreement on tasks but not on goals. It is also hypothesized that there will be a significant association between adherence to client centred interventions and client's report of bond with the therapist.

Postscript to the critical review

References to the draft journal article, supplement to journal, and appendix (with additional method section and results)

The next part of this thesis is the draft journal that will be submitted for publication. As some of the findings, relating to the change in use of interventions over the course of therapy, were not significant, the findings and the methodology used are found in Appendix 1. As the Factor Analysis of the CM items was based on a sample of ten subjects tested three times over the course of therapy, those findings and methodology are found as a supplement to the draft journal article. These two areas

of analysis are both considered in the extended discussion along with the findings reported in the draft journal article.

References for Critical Review

American Psychological Association (2000). *The dignostic and statistical manual of mental disorders - Text Revision.* (4th ed.). Washington DC: Author.

Bachelor, A. (1988). How clients perceive therapist empathy: A content analysis of "received" empathy. *Psychotherapy, 25*, 227-240.

Bachelor, A., Meunier, G., Laverdiere, O., & Gamarche, D. (2010). Client attachment to therapist: Relation to client personality and symptomatology, and their contributions to the therapeutic alliance. *Psychotherapy theory, Research, Practice, Training, 47*, 454-468.

Bateman, A., & Fonagy, P. (2009). Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. *American Journal of Psychiatry, 166*, 1355-1364.

Bendit, N. (2010). Training Manual for Conversational Model used at the Centre of Psychotherapy, Newcastle, Australia. Centre of Psychotherapy, Hunter New England Health Service.

Black, D. W., Gunter, T., Allen, J., Blum, N., Arndt, S., Wenman, G., et al. (2007). Borderline personality disorder in male and female offenders newly committed to prison. *Comprehensive Psychiatry, 48*(5), 400-405.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research and practice, 16*, 252-260.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52*, 685-716.

Clarkin, J. F., Levy, K. N., Lenzenwerger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for Borderline Personality Disorder: A multiwave study. *The American Journal of Psychiatry, 164*, 922-928.

Dixon-Gordon, K. L., Turner, B. J., & Chapman, A. L. (2011). Psychotherapy for personality disorders. *Internation Review of Psychiatry, 23*, 282-302.

Goldman, G. A., & Gregory, R. J. (2009). Preliminary relationship between adherence and outcome in Dynamic Deconstructive Therapy. *Psychotherapy Theory, Research Practice, Training, 46*, 480-485.

Gross, R., Olfson, M., Gameroff, M., Shea, S., Feder, A., Fuentes, M., et al. (2002). Borderline personality disorder in primary care. *Archives of Internal Medicine, 162*, 53-60.

Gunderson, J. G. (1996). The borderline patient's intolerance of aloneness: insecure attachments and therapist availability. *Am J Psychiatry, 153*(6), 752-758.

Gunderson, J. G., Stout, R. L., McGlashan, T. H., Shea, M. T., Morey, L. C., Grilo, C. M., et al. (2011). Ten-year course of borderline personality disorder: Psychopathology and function from the collaborative longitudinal personality disorders study. *Archives of General Psychiatry 68*, 827-837.

Guthrie, E. (1999). Psychodynamic interpersonal therapy. *Advances in Psychiatric Treatment, 5*, 135-145.

Hobson, R. F. (1985). *Forms of feeling: The heart of psychotherapy*. London: Tavistock Publications.

Katerud, S., & Bateman, A. (2010). Manual for mentalization-based treatment (MBT) and MBT adherence and competence scale, Version (05.04.10) individual

therapy. Department for Personality Psychiatry, Oslo University Hospital, Ullevaal.

Kliem, S., Kroger, C., & Kosfelder, J. (2010). Dialectical behavior therapy for borderine personality disorder: A meta-analysis using mixed-effects modeling. *Journal of Consulting & Clinical Psychology, 78*, 936-951.

Kolla, N. J., Links, P. S., McMain, S. F., Streiner, D. L., Cardish, R. J., & Cook, M. (2009). Demonstrating adherence to guidelines for the treatment of patients with borderline personality disorder. *The Canadian Journal of Psychiatry, 54*, 181-189.

Korner, A., Gerull, F., Meares, R., & Stevenson, J. (2006). Borderline personality disorder treated with the conversational model: a replication study. *Comprehensive Psychiatry, 47*(5), 406-411.

Lenzenweger, M. F., Lane, M. C., Loranger, A. W., & Kessler, R. C. (2007). DSM-IV Personality Disorders in the National Comorbidity Survey Replication. *Biological Psychiatry, 62*(6), 553-564.

Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M., & Bohus, M. (2004). Borderline personality disorder. *Lancet, 364*(9432), 453-461.

Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder*. New York: Guidlford Press.

Linehan, M. M., Armstrong, H. E., Suarez, A. D., Alimon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*, 1060-1064.

Linehan, M. M., Armstrong, H. E., Suarez, A. D., Alimon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. . *Archives of General Psychiatry, 48*, 1060-1064.

Linehan, M. M., Comptois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., & Heard, H. L. (2006). Two-year randomised controlled trial and follow-up of Dialectical Behavior Therapy vs Therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry, 63*, 757-766.

Linehan, M. M., Heard, H. L., & Armstrong, H. E. (1993). Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. *50*, 971-974.

Linehan, M. M., & Korslund, K. E. (2003). Dialectical Behavior Therapy Adherence Manual. In U. o. Washington (Ed.), *Univ of Washington*. Seattle: Univ of Washington.

McMain, S. F., Links, P. S., Gnam, W. H., Guimond, T., Cardish, R. J., Korman, L., et al. (2009). A Randomized Trial of Dialectical Behavior Therapy Versus General Psychiatric Management for Borderline Personality Disorder. *Am J Psychiatry, 166*(12), 1365-1374.

Meares, R. (2004). The Conversational Model: An Outline. *American Journal of Psychotherapy, 58*, 51-56.

Meares, R. (2005). *The metaphor of play: Origin and breakdown of personal being* (3rd ed ed.). East Sussex: Routledge.

Norcross, J. C. (2011). The therapeutic relationship. In B. L. Duncan, D. M. Scott, B. E. Wampold & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 113-143). Washington,DC: American Psychological Association.

Perepletchikova, F., Treat, T. A., & Kazdin, A. E. (2007). Treatment integrity in psychotherapy research: Analysis of the studies and examination of the

associated factors. *Journal of Consulting and Clinical Pyschology, 75*, 829-841.

Piper, W. E., Joyce, A. S., McCallum, M., Azim, H. F., & Ogrodniczuk, J. S. (2002). *Interpretive and supportive psychotherapies: Matching therapy and patient personality*. Washington, DC: American Psychological Association.

Randall, C. J., & Biggs, B. K. (2008). Enhancing therapeutic gains: Examination of fidelity to the model of the internsive mental health program. *Journal of Child and Family Studies, 17*, 191-205.

Scheel, K. R. (2000). The empirical basis of dialectical behavior therapy: Summary, critique, and implications. *Clinical Psychology: Science and Practice, 7*(68-86).

Shapiro, D. A., & Startup, M. J. (1990). *Raters' manual for the Sheffield Psychotherapy Rating Scale (Memo no. 1154)*. Sheffield: University of Sheffield.

Shapiro, D. A., & Startup, M. J. (1992). Measuring Therapist Adherence in Exploratory Psychotherapy. *Psychotherapy Research, 2*(3), 193 - 203.

Shapiro, D. A., Barkham, M., Rees, A., Hardy, G. E., Reynolds, S., & Startup, M. (1994). Effects of treatment duration and severity of depression on the effectiveness of cognitive/behavioral and psychodynamic/interpersonal psychotherapy *Journal of Consulting and Clinical Psychology, 62*, 522-534.

Startup, M., & Shapiro, D. A. (1993). Therapist treatment fidelity in prescriptive vs. exploratory psychotherapy *British Journal of Clinical Psychology 32*, 443-456

Stevenson, J., & Meares, R. (1992). An outcome study of psychotherapy for patients with borderline personality disorder. *Am J Psychiatry, 149*(3), 358-362.

Stevenson, J., Meares, R., & D'Angelo, R. (2005). Five-year outcome of outpatient psychotherapy with borderline patients. *Psychological Medicine, 35*(01), 79-87.

Torgersen, S., Kringlen, E., & Cramer, V. (2001). The Prevalence of Personality Disorders in a Community Sample. *Arch Gen Psychiatry, 58*(6), 590-596.

Waltz, J., Addis, M. E., Koerner, K., & Jacobson, N. S. (1993). Testing the integrity of a psychotherapy protocol: Assessment of adherence and competence. *Journal of Consulting & Clinical Psychology, 61*(4), 620.

DRAFT JOURNAL ARTICLE

Conversational Model (CM) Adherence scale and its reliability; Therapist adherence to CM in a trial comparing CM and Dialectical Behaviour Therapy in the treatment of people with borderline personality disorder.

Abstract

The demonstration of therapist adherence to therapy manuals is crucial for the validity of the conclusions that may be drawn from the outcomes of randomized controlled trials comparing therapies. This study involved the development and testing of an adherence scale for the purposes of rating adherence to a psychodynamic therapy called the Conversational Model (CM) in a randomized controlled trial which compared the effectiveness of Dialectical Behaviour Therapy (DBT) and the CM in the treatment of persons with a diagnosis of Borderline Personality Disorder (BPD). The Scale was found to have acceptable inter-rater agreement and was able to contribute significantly to the discrimination of DBT and CM in the study. As the adherence scale allowed for the measurement of extensiveness of interventions, the study also tested whether there was any association between adherence to selected scale items and the therapeutic alliance. A significant relationship was found between client and therapist agreement on tasks and therapist adherence to the delivery of client centred interventions in CM.

It is important when evaluating psychotherapies that therapist adherence to treatment is assessed. If the treatment is not carried out in accordance with its manual, it is not possible to make any definitive conclusions about the outcomes of the study. Perepletchikova, Treat and Kazdin (2007) found adherence testing was implemented significantly more in studies of skill-building treatments such as cognitive behaviour therapy than in non-skill building treatments such as psychodynamic therapy. They state skill-building approaches are “more straightforward and simple” (p 835) than psychodynamic treatments as the skill-building treatments focus on symptom reduction by means of techniques which form part of an agreed plan of interventions. In contrast to skill building therapies, Perepletchikova et al argue that psychodynamic treatments focus on insight and generally involve exploration of underlying themes and patterns in patients’ lives and consequently are less easy to rate than skill building therapies. Whether or not one agrees that it is more challenging to create adherence scales for psychodynamic therapies compared to skill building therapies, there is a need to undertake adherence testing for psychodynamic therapies. Adherence testing is one of the building blocks to providing evidence-based treatments. With funding agencies and insurance companies requiring evidence-based treatments, psychodynamic therapies risk becoming obsolete if they are not evidence-based (Chambless & Ollendick, 2001; Guthrie, 1999).

Two adherence scales for psychodynamically oriented therapies for Borderline Personality Disorder (BPD) have been developed and tested in recent years. Kolla, et al (2009) developed the General Psychiatric Management Adherence Scale for a therapy called General Psychiatric Management (GPM) which is a psychodynamically informed therapy. The Scale was used in a randomised trial where GPM was compared with DBT (McMain, et al., 2009). The Scale was tested by measuring therapists’ and clients’ agreement as to interventions undertaken in therapy by way of questionnaires administered during the course of therapy. It was not used to test for discrimination between GPM and DBT. An adherence instrument has also been developed for Dynamic Deconstructive therapy (DDT) for treatment resistant clients with BPD and has been found to have good inter-rater reliability with a sample of ten participants (Goldman & Gregory, 2009). While DDT is regarded as

psychodynamically oriented, the DDT adherence scale appears to focus on the directive components of that therapy.

The Conversational Model (CM) is another psychodynamically oriented therapy which has been used in treating people with a diagnosis of BPD. It was first developed by Hobson (1985) for the treatment of people who showed serious disturbances in their interpersonal relationships. Hobson's clients were frequently people whom would now be classified under the *Diagnostic and Statistical Manual of Mental Disorders–Text Revision* (American Psychological Association, 2000) (hereinafter called "DSM-IV-TR") as having a diagnosis of BPD (Meares, 2004; Stevenson & Meares, 1992). For Hobson, one of the key issues in therapy was to address the client's fear of aloneness or abandonment by learning to be "alone and together" (see also Gunderson, 1996). Meares described how the client may desperately attempt to address feelings of emptiness through a relationship with another (described as "fusion"). Hobson identified that the clients' desperate desire to escape feelings of abandonment often leads to a pattern of broken relationships and subsequent emotional distress. Further, Meares (2005) also posits that clients frequently miscue or misinterpret verbal or non-verbal signs in relationships as a result of poor learning and attachment in early childhood which impacts negatively on developing or maintaining relationships, including the relationship with the therapist (see also Hobson, 1985).

The CM, as developed by Hobson (1985), involves an integration of experiential/humanist, interpersonal, and psychodynamic interventions (see Shapiro & Startup, 1992). Hobson encouraged a collaborative approach by way of mutual feeling language (the therapist using "we" instead of "you"), the making of tentative statements, and avoidance of therapist questioning. He emphasised the importance of staying in the "here and now" of therapy such as focusing on client feelings and body language. Experiential/humanist interventions cluster around the therapist emotionally attuning to the client in a collaborative and tentative way. Interpersonal interventions include exploration of patterns in previous relationships. Psychodynamic interventions include the provision of explanatory statements which provide possible reasons or causes for clients' behaviours such as links with the client's childhood. A list of CM interventions rated in this study is found at Table 1.

While Hobson's focus was on interpersonal disturbance and its impact on mental well being generally, Meares (2005) adapted CM to those persons with a diagnosis of BPD. Significant reductions in violent behaviours, use of drugs, medical visits and hospital admissions, self-harm episodes, and time away from employment were found when CM was delivered twice weekly over one and two years (Stevenson & Meares, 1992). The gains made in therapy were found to continue in five year follow up of the same patients (Stevenson, Meares, & D'Angelo, 2005). A replication of the study by Stevenson and Meares (1992) also found similar gains (Korner, Gerull, Meares, & Stevenson, 2006).

There was no adherence testing in above-mentioned studies involving the CM. However, an adherence scale for a version of the CM, which at the time was called "Exploratory Therapy", was developed by Shapiro and Startup (1990). Exploratory Therapy was later called Psychodynamic Interpersonal Therapy (see Guthrie, 1999; Shapiro, et al., 1994). The adherence items for Exploratory Therapy formed part of a scale called the Sheffield Psychotherapy Rating Scale (SPRS). Shapiro and Startup (1992) found satisfactory inter-rater reliability for most of their ratings of exploratory items in the SPRS. A substantial number of the items in Table One reflect the exploratory items in the SPRS. Startup and Shapiro (1993) also found that the ratings contributed significantly to a discrimination of Exploratory and Cognitive Behaviour therapies compared in that study (see also Shapiro & Startup, 1992).

The testing of the SPRS by Shapiro and Startup (1992) involved a randomised trial of Exploratory Therapy and Cognitive Behaviour Therapy for patients diagnosed with a major depressive disorder. In contrast this current study involved the development of a scale to rate adherence to CM in the treatment of people with a diagnosis of BPD. The aim of this study was to develop an adherence scale for CM which would have acceptable inter-rater agreement and would be able to discriminate between CM and DBT used in a Randomised Control Trial currently being undertaken at a specialist centre for the treatment of BPD. (DBT is a cognitive-behavioural based therapy developed specifically for the treatment of BPD (Linehan, 1993).) On the basis of the findings in Shapiro and Startup (1992), it is hypothesised that an adherence scale for treatment of people with a diagnosis of BPD using the

CM would have reliable inter-rater agreement. Further, on the basis of the finding in Startup and Shapiro (1993), it is hypothesised that the adherence scale would be able to distinguish CM from DBT in the current randomised controlled trial.

The rating scale developed in this study also made provision for measuring the extent to which an intervention was used. As a result, this current study had two further aims. Firstly, it allowed for an exploratory factor analysis of the CM items in the scale. Secondly, it enabled the testing of any association between adherence to CM interventions and the therapist working alliance. The working therapeutic alliance, as described by Bordin (1979) is made up of three components: (i) therapist and client agreement on goals, (ii) therapist and client agreement on tasks, and (iii) a bond between the therapist and client. Bordin claimed that the three aspects of the alliance are found in all therapies with varying degrees of emphasis. Bachelor (1988) found that participants perceived empathy as deepening the therapeutic bond. The role of empathy has been considered integral in the creation of bond between client and therapist (see Norcross, 2011). As there is a focus in CM on the therapist emotionally attuning to the client, it was predicted that adherence to emotional attunement in a collaborative and tentative way will be positively associated with higher levels of bond as measured by the client. It was further predicted that such adherence should also lead to a positive association with agreement on tasks as measured by therapist and client. However, there was no expectation that adherence to emotional attunement would have a significant association with agreement on goals either by therapist or client.

Method

Ethics approval for this adherence study was obtained from the Human Research Ethics Committee of the University of Newcastle, Australia (Approval number – H-2010-1146).

Participants

Participants in this study had a diagnosis of BPD and were between 18-65 years of age, and had reported deliberate self-harm on at least three occasions in the previous 12 months before interview. Twenty participants were included in total. Diagnosis was made using the *Structured Clinical Interview for DSM-IV for Axis II Disorders* (First, Gibbon, Spitzer, Williams, & Benjamin, 1997) as well as an interview conducted by a consultant psychiatrist (fourth author in this study).

Twenty therapists were selected from 39 therapists involved in the study. (All sessions of the 39 therapists were intended to be recorded, however, there were occasional technological failures as well as occasions when therapists reported forgetting to record their sessions.) Of the 39 therapists, nine therapists conducted DBT only, ten conducted CM only, and ten therapists conducted both therapies. A priority was given to sampling all therapists practising in both modalities who were working with a substantial number of clients in the study (i.e. six therapists). Further, an equal number of therapists practising CM only and DBT only were selected (i.e. four therapists from each modality). Selection of the therapists practising in DBT or CM only was made on the basis of selecting therapists who had full sets of recorded sessions and were seeing more than one client in the study.

All therapists involved in the study were supervised on a weekly basis. All CM therapists were supervised by a faculty member of the Australian New Zealand Association of Psychotherapy (ANZAP) which is the principal training institute for the CM in Australia. All CM therapists had a minimum six sessions of training. Their training was augmented by external training sessions such as those provided by Russell Meares. Further, a substantial number of the therapists were studying for the Diploma of Adult Psychotherapy which involves CM training.

Process Measures

NASCoM

Rating scale: Adherence to the CM was evaluated using a 25-item observer measure created by the first and second authors after an extensive consultation process with the third and fourth authors. The third and fourth authors are experienced practitioners working at the Service where the study was conducted. The scale, called the Newcastle Adherence Scale for the Conversation Model (NASCoM), and its manual is available from the second author. A summary of the items in the NASCoM is found at Table 1. The first fifteen items in the NASCoM involve CM interventions which are reflected in the unpublished treatment guidelines used at the Service (Bendit, 2010). The next two items are facilitative conditions in therapy, namely, use of warmth and rapport. The remaining eight items are proscribed interventions which are unacceptable in CM. However, all the proscribed items either form part of DBT or are acceptable to DBT.

Similar to the Sheffield Psychotherapy Rating Scale (SPRS), each item in the NASCoM has a seven point Likert rating scale. However, the range in the NASCoM is from zero (representing non existence of a particular intervention in a session) to six (representing use of an intervention in 31% or more of the session. Unlike the SPRS, each point generally represents 5% of the session up to “6” which represents 31% or more of the session. The NASCoM Manual attempted to be as consistent as possible with the format of the SPRS manual where the following were provided: (1) the exact wording of the scale was reflected in the manual; (2) an elaboration of the item’s purpose and any definitions that seemed appropriate in relation to the item; (3) examples of adherent and non-adherent behaviour; and (4) advice on how to distinguish items in the Scale.

Pilot coding of 12 sessions was undertaken by the first two authors. The pilot phase allowed for an iterative process of amendments to the NASCoM and its manual in consultation with the third and fourth authors of this study so as to minimise ambiguities which were identified in the pilot rating period.

Working alliance inventory (WAI)

The study also used the WAI developed by Horvath and Greenberg (1989). The inventory is a 36-item scale designed to be completed by either the therapist, the client, or by independent observers. In this study, clients and therapists completed the WAI on three occasions (early in the first four months of therapy, the middle of the second four months of therapy, and toward the end of the last four months of therapy). The scale is divided into three subscales representing the three components of the alliance outlined by Bordin, namely, client and therapist agreement on goals and tasks, and the development of a bond between therapist and client. Each subscale consists of 12 items rated on a 7 point Likert scale (1 = never and 7 = always). The WAI has shown to have adequate reliability as well as having support for convergent, divergent and predictive validity (Raue, Castonguay, & Goldfried, 1993). In the present study, clients' self report ratings using the WAI showed adequate internal reliability using Cronbach's alpha of 0.79 for bond, 0.64 for task, and 0.69 of goals. Similarly, therapists' self-report ratings showed adequate internal reliability with 0.71 for bond, 0.64 for tasks, and 0.65 for goals. The internal reliability of the WAI was good with 0.83 for therapists' ratings and 0.86 for clients' ratings on the WAI.

Research Design

Twenty-two sessions were rated by the first two authors using the NASCoM. Ten sessions involved CM and 12 sessions involved DBT. The type of therapy was not disclosed to the raters until all ratings had been completed. The sessions were randomly selected on the basis that three phases of therapy were represented as equally as possible for each client in the study. The first six weeks of sessions were excluded from rating as the researchers wanted to ensure the ratings were on

sessions that truly represented the therapies as the investigators were aware that a number of the sessions in the first six weeks may involve assessment or extended assessment of the clients. After the initial six weeks of sessions, three sessions were randomly selected from the next four months, second four months, and final four months of therapy.

It was intended that ratings would be collected for 60 sessions representing 10 DBT clients and 10 CM clients with three sessions for each client selected from the three periods of therapy. One client's third phase of therapy became unavailable as the client failed to begin the last three months of therapy; so only 59 sessions were rated. It was anticipated that the greatest chance of non-adherence to therapy would take place where therapists were practising in both modalities albeit with different patients. On that basis, sessions of six therapists using both modalities were randomly sampled making a total of 36 sessions (i.e. 6 therapists x treatment in both therapies (2) x three sessions per client (3)). Sessions from the four therapists practising CM only and DBT only were sampled making a total of 24 sessions (i.e. four therapists in CM plus four therapists in DBT (8) x three sessions per client (3)).

Ratings

The sessions rated were audio taped as well as fully transcribed by the first rater and made available to the second rater. After 20 joint ratings were completed, the first author rated 15 sessions alone and then undertook a joint rating with the second author and then after another 15 sessions, a further joint rating session took place.

Raters

The raters, first and second authors of this study, are a psychologist and a clinical psychologist respectively. While the first author had six one-hour sessions of training in CM, neither rater had practised CM with clients with BPD. While the first author had attended group sessions of DBT, neither rater had been trained in DBT.

Statistical analyses

The data were analysed using SPSS (Version 19) for Windows SPSS Inc, Chicago, Il, USA). Inter-rater reliabilities were estimated as intraclass correlation coefficients (ICC) using Shrout and Fleiss (1979). A direct Discriminant analysis was performed using 21 items in the NASCoM to test whether ratings on these items could predict whether the therapy is CM or DBT. The facilitative items ('warmth' and 'rapport') and 'patterns in relationships' and 'acceptance of feelings' were excluded as these items did not have significant intraclass correlations. These four items were excluded in all subsequent statistical analyses discussed in this paper.

Exploratory factor analysis, using a principal axis factoring extraction with Direct Oblimin rotation, was used to examine the factor structure of the remaining 13 CM items in the NASCoM. Background and comprehensive results to the exploratory factor analysis are available as a supplement to this study. The three highest loading items on the first factor were made into a composite item called "client centred interventions". Adherence to client centred interventions was measured by the sum of adherence scores for these three items, namely, 'emotional attunement', 'tentativeness', and 'mutuality'. A linear mixed model was then used to test whether the therapist's adherence to client centred interventions was significantly associated with the client self reported measurement of the therapeutic bond. The study also used a linear mixed model to test whether there was an association between adherence to client centred interventions with client and therapist agreements on tasks and goals.

Results

Inter-rater agreement

The results of inter-rater agreement of adherence to CM items within CM and DBT modalities and between DBT and CM modalities are found in Column 1 and Column 2 of Table 2. In summary, there was good inter-rater reliability against a

number of key items used in the CM as well as for proscribed items in CM. As would be expected, reliabilities for the items were greater in most cases when both treatments were included in the analysis, reflecting the differences in delivery of therapy between the two modalities. The third column in Table 2 identifies the percentage of sessions jointly rated in which the item was absent in the CM. The fourth column outlines the percentage of sessions in which the item was absent in DBT.

When testing for inter-rater agreement between CM and DBT modalities, 13 of the 15 CM items were found to have significant levels of inter-rater reliability. When testing within CM modality, ten items received significant levels of inter-rater reliability. It is of note that the lack of reliability for non-significant items was largely due to the interventions being rated as “not present” giving them a “0” rating. With the five CM items which did not reach a significant inter-rater agreement within modality, rater disagreement was found in only one case greater than two points. Rater disagreement was generally no greater than one point difference for all items.

Only six CM items were jointly rated in 85% or more of the CM sessions. They were ‘receptive listening’, ‘tentativeness’, ‘mutuality’, ‘emotional attunement’, ‘facilitating awareness of emotions’, and the ‘use of explanatory statements’. ‘Exploration of patterns in relationships’ and ‘addressing issues in the therapeutic relationship’ were jointly rated in 50% of the CM sessions. ‘Attending to emotional avoidance’ and ‘emotional acceptance of situations’ and ‘use of metaphor’ were jointly rated less frequently.

Joint ratings for all proscribed items were found to be significant when using both therapies. Only ratings for two proscribed items were not significant when rating DBT sessions only. Further, as column 4 of Table 2 shows, the therapists doing sessions of CM rarely used the proscribed items. However, column 3 of Table 2 shows that the therapists doing sessions of DBT used the proscribed items in all sessions. Finally, the intraclass correlations for the two facilitative conditions, warmth and rapport, were not significant.

Discriminant analysis

A direct Discriminant Analysis was performed to test whether ratings on the NASCoM items could predict whether the therapist was using DBT or CM. A further reason for using Discriminant analysis was to identify which items were the strongest predictors of what therapy was being used in session. All ratings of the items in the NASCoM were included except for the four items that did not reach significant intraclass correlations. The discriminant function was significant (*Wilks lambda* = .072, $\chi^2(21) = 122.239$, $p < .0001$); 100 % of the cases were correctly classified (93.1% with cross validation). Only four items in the NASCoM exceeded a correlation of 0.33 in the Table of Communalities (see guidelines in Tabachnick and Fidell, 2001). Three of these items were proscribed items in CM (but found in DBT). They were 'information seeking', 'provision of psychological techniques', and 'homework'. The fourth item was 'emotional attunement', a key intervention for the CM. The discriminant analysis using these four items gave 98.3% correct classification (93.2% with cross validation) (Wilks lambda = .167, $\chi^2(4) = 98$, $p < .0001$).

Factor structure

Exploratory factor analysis was used to determine whether the NASCoM items reflect the theoretical framework of CM. Three factors were also identified using a Scree plot with eigenvalues greater than one**.** The first factor reflected the humanist /experiential interventions in the CM and accounted for 20.6% of variance. This factor was called 'client centred interventions' as it was made up of five items, namely, the use of 'tentativeness', use of 'mutuality', 'emotional attunement', 'receptive listening' and 'awareness of feelings' with the latter two items being dropped in further analysis due to their low loadings (less than at 0.430.) The second factor reflected the psychodynamic interventions in the CM and accounted for 15.65% of variance. The psychodynamic factor was made up of items called 'avoidance of feelings' and provision of 'explanatory statements'. The third factor reflected the therapist's efforts to address challenges to the therapeutic relationship. It accounted for 14.41% of variance. The therapist factor was made up of four items

involving addressing issues generally in the ‘therapist-client relationship’, as well as ‘disjunctions’ and ‘limitations of therapy’, and the use of ‘personal disclosure’ in the relationship. A fifth item, handling ‘frame changes’, which also related to the therapist-client relationship, was dropped because of its low loading.

Adherence and the therapeutic alliance

Linear mixed models were used to test the relationship between adherence by therapists using CM to client centred interventions (which represented the sum of adherence scores for emotional attunement, use of tentativeness and mutuality) and the clients’ self report measurement of bond and the therapists’ and clients’ self report measurement of agreement on goals and tasks. The relationship between client bond (as the outcome variable) and therapist adherence to client centred interventions (as predictor) was examined using a linear mixed model because both variables changed over time. A compound symmetry residual covariance structure was used for the repeated time measurements. The relationship between client bond and adherence to client centred interventions was not significant F (1, 26.168) = 0.099, p= .756. However, as predicted, there was a significant relationship with adherence to client centred interventions and agreement on tasks by the therapist: F (1, 21.585) = 7.348, p = .013) and agreement on tasks by the client F (1, 19.227) = 6.045, p = .024). Also as predicted, there was no significant relationship between adherence to client centred interventions and therapist agreement on goals F (1, 17.127) = 3.205, p = .091) and client agreement on goals F (1, 23.722) = 3.017, p = .095).

Discussion

Inter-rater agreement

The NASCoM was developed to assess adherence to CM as practised at a regional service in Australia which specialises in the treatment of people with a

diagnosis of BPD. The NASCoM showed good inter-rater reliability against a number of key items used in the CM for both within CM treatment and between CM and DBT treatments. As with the SPRS, these results are encouraging in showing that psychodynamic oriented therapies can be successfully tested for adherence.

The lack of significant inter-rater agreement on several items in the NASCoM can largely be explained by low ceiling effects in the ratings for those items. As outlined in the results section, agreement was rarely outside one point of variation on the items that were rated less than 5% of session. The exceptions were the two facilitative conditions, namely, warmth and rapport, which have struggled in other studies to reach acceptable inter rater agreement (see Godfrey, Chalder, Ridsdale, Seed, & Ogden, 2007; Hill, O'Grady, & Elkin, 1992).

Discriminant analysis

Discriminant analyses of the NASCoM items showed that CM can be perfectly distinguished from DBT. While these findings cannot be construed as showing that therapists were only using CM and not DBT and vice versa, it shows that their use of interventions was consistent with their particular therapy. However, further support for adherence by therapists using the CM is the data in Column 3 of Table 2 which shows that proscribed items were used rarely by therapists undertaking CM.

Factor analysis

Despite the small sample size in the exploratory factor analysis, a reasonably clear factor structure emerged which reflected the two of three therapeutic influences on CM, namely, experiential/humanist and psychodynamic approaches. The third influence on CM, interpersonal theapy, was only partly reflected in the third factor. It was made up of four items that relate to addressing issues in the therapeutic relationship but not interpersonal issues generally. The orientation of the third factor also reflects the priority given in the CM to addressing issues in the therapeutic relationship (see Bendit, 2010).

Adherence and the therapeutic alliance

It was hypothesised that therapist adherence in CM to client centred interventions would have a significant relationship with client perception of bond in the therapeutic alliance. No significant association between adherence to client centred interventions and the client's perception of a bond with the therapist was found. This is contrary to findings by Bachelor (1988) where it was found that clients regard the effect of empathic interventions as creating a bond between client and therapist. However, the study by Bachelor involved a qualitative content analysis of 27 clients and 25 non-clients' perceptions of the benefits of empathy rather than a quantitative study of an association between empathy and bond or alliance generally. One explanation for the present study's findings being contrary to that of Bachelor's findings is that the client groups were markedly different. This study involved clients diagnosed with borderline personality disorder (of which instability in relationships is a criteria for BPD in the *DSM-IV-TR)*. In contrast, Bachelor's study involved university students of which half were not seeking psychological treatment. While the findings are only associations (not causation), it may be that client centred interventions, in particular emotional attunement to the client by the therapist, was not sufficient for clients with BPD to develop a bond with therapist.

Limitations

One limitation in this study is the sample size. The exploratory factor analysis provided an explicable factor structure but the small sample increased the risk of it being incorrect (Costello & Osborne, 2005). Another possible limitation is the small number of sessions sampled for each client receiving therapy. As it was expected that the use of a number of interventions would be used occasionally, more sessions may have needed to capture these interventions.

Conclusion

This study developed and tested a scale to measure adherence to CM called the NASCoM. The NASCoM was found to have good inter-rater reliability and was able to distinguish perfectly CM from DBT. The development and testing of the NASCoM provides yet another small step in redressing the limited number of adherence studies for psychodynamic therapies.

References for the Draft Journal Article

American Psychological Association. (2000). *The dignostic and statistical manual of mental disorders.* (4th ed.). Washington DC: Author.

Bachelor, A. (1988). How clients perceive therapist empathy: A content analysis of "received" empathy. *Psychotherapy, 25*, 227-240.

Bendit, N. (2010). Training Manual for Conversational Model used at the Centre of Psychotherapy, Newcastle, Australia. Centre of Psychotherapy, Hunter New England Health Service.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research and practice, 16*, 252-260.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology, 52*, 685-716.

Costello, A. B., & Osborne, J. W. (2005). Best practices in exploratory factor analysis: Four recommendations for getting the most from your analysis. *Practical Assessment, Research & Evaluation, 10*, 1-9.

Faul, F., Erdfelder, E., Lang, A., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods, 39*, 175-191.

First, M., Gibbon, M., Spitzer, R. L., Williams, J. B. W., & Benjamin, L. S. (1997). *Structured Clinical Interview for DSM-IV Axis II Personality Disorders, (SCID-II).* . Washington, D.C: American Psychiatric Press, Inc.

Godfrey, E., Chalder, T., Ridsdale, L., Seed, P., & Ogden, J. (2007). Investigating the 'active ingredients' of cognitive behaviour therapy and counselling for patients with chronic fatigue in primary care: Developing a new process measure to assess treatment fidelity and predict outcome. *British Journal of Clinical Psychology, 46*(3), 253-272.

Goldman, G. A., & Gregory, R. J. (2009). Preliminary relationship between adherence and outcome in Dynamic Deconstructive Therapy. *Psychotherapy Theory, Research Practice, Training, 46*, 480-485.

Gunderson, J. G. (1996). The borderline patient's intolerance of aloneness: insecure attachments and therapist availability. *Am J Psychiatry, 153*(6), 752-758.

Guthrie, E. (1999). Psychodynamic interpersonal therapy. *Advances in Psychiatric Treatment, 5*, 135-145.

Hill, C. E., O'Grady, K. E., & Elkin, I. (1992). Applying the Collaborative Study Psychotherapy Rating to rate therapist adherence in Cognitive Behaviour Therapy, Interpersonal Therapy, and Clinical Management. *Journal of Consulting & Clinical Psychology, 60*, 73-79.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223-233.

Kolla, N. J., Links, P. S., McMain, S. F., Streiner, D. L., Cardish, R. J., & Cook, M. (2009). Demonstrating adherence to guidelines for the treatment of patients with borderline personality disorder. *The Canadian Journal of Psychiatry, 54*, 181-189.

Korner, A., Gerull, F., Meares, R., & Stevenson, J. (2006). Borderline personality disorder treated with the conversational model: a replication study. *Comprehensive Psychiatry, 47*(5), 406-411.

Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder.* New York:: Guidlford Press.

McMain, S. F., Links, P. S., Gnam, W. H., Guimond, T., Cardish, R. J., Korman, L., et al. (2009). A Randomized Trial of Dialectical Behavior Therapy Versus General Psychiatric Management for Borderline Personality Disorder. *Am J Psychiatry, 166*(12), 1365-1374.

Meares, R. (2004). The Conversational Model: An Outline. *American Journal of Psychotherapy, 58*, 51-56.

Meares, R. (2005). *The metaphor of play: Origin and breakdown of personal being* (3rd ed ed.). East Sussex: Routledge.

Norcross, J. C. (2011). The therapeutic relationship. In B. L. Duncan, D. M. Scott, B. E. Wampold & M. A. Hubble (Eds.), *The heart and soul of change: Deliverying what works in therapy* (2nd ed., pp. 113-143). Washington,DC: American Psychological Association.

Perepletchikova, F., Treat, T. A., & Kazdin, A. E. (2007). Treatment integrity in psychotherapy research: Analysis of the studies and examination of the associated factors. *Journal of Consulting and Clinical Pyschology, 75*, 829-841.

Raue, P. J., Castonguay, L. G., & Goldfried, M. R. (1993). The working alliance: A comparison of two therapies. *Psychotherapy Research, 3*, 197-207.

Shapiro, D. A., Barkham, M., Rees, A., Hardy, G. E., Reynolds, S., & Startup, M. (1994). Effects of treatment duration and severity of depression on the effectiveness of cognitive/behavioral and psychodynamic/interpersonal psychotherapy *Journal of Consulting and Clinical Psychology, 62*, 522-534.

Shapiro, D. A., & Startup, M. J. (1990). *Raters' manual for the Sheffield Psychotherapy Rating Scale (Memo no. 1154)*. Sheffield: University of Sheffield.

Shapiro, D. A., & Startup, M. J. (1992). Measuring Therapist Adherence in Exploratory Psychotherapy. *Psychotherapy Research, 2*(3), 193 - 203.

Shrout, P. E., & Fleiss, J. L. (1979). Intraclass correlations:Uses in assessing rater-reliability. *Psychological Bulletin, 86*, 420-428.

Startup, M., & Shapiro, D. A. (1993). Therapist treatment fidelity in prescriptive vs. exploratory psychotherapy *British Journal of Clinical Psychology 32*, 443-456

Stevenson, J., & Meares, R. (1992). An outcome study of psychotherapy for patients with borderline personality disorder. *Am J Psychiatry, 149*(3), 358-362.

Stevenson, J., Meares, R., & D'Angelo, R. (2005). Five-year outcome of outpatient psychotherapy with borderline patients. *Psychological Medicine, 35*(01), 79-87.

Tabachnick, B. G., & Fidell, L. S. (2001). *Using multivariate statistics*. Boston: Allyn and Bacon.

Waltz, J., Addis, M. E., Koerner, K., & Jacobson, N. S. (1993). Testing the integrity of a psychotherapy protocol: Assessment of adherence and competence. *Journal of Consulting & Clinical Psychology, 61*(4), 620.

Tables for Draft Journal Article

Table 1.

Newcastle Adherence Scale for the Conversational Model (NASCoM)

	Item	Item description
1	Receptive listening	... allow silence to continue (or use minimal encouragement as a means of encouraging the client to talk
2	Tentative style	... express his/her as views as tentative statements, open to correction, and inviting elaboration and feedback?
3	Language of mutuality	... use the language of shared endeavour ('I' and 'we' and the passive tense)?
4	Patterns in relationships	... draw parallels or point out patterns in two or more of the client's relationships for the purpose of helping the client understand how she/he functions in interpersonal relationships?
5	Therapeutic relationship	... addressing client's feelings about the therapeutic relationship
6	Emotional Attunement	... attune to the emotional cues or other words offered by the client by using either of the following micro-skills: coupling, amplification, or representation?
7	Awareness of Feelings	... encourage client to consider unspoken feelings of which the client may be unaware or avoiding.
8	Avoidance of Affect	... assist the client address any avoidances experienced by the client?
9	Acceptance of affect	... encourage the client to accept feelings of which the client is aware but which are painful or uncomfortable?

10	Explanatory Statements	... introduce explanatory statements which offer possible reasons for the client's behaviour and experiences
11	Metaphor	... encourage and elaborate the client's use of metaphor?
12	Personal disclosure	... respond to client's personal questions ...in a way that advanced a shared understanding of events and processes in therapy?
13	Limitations	... promote the client's exploration of feelings concerning the limits to therapy, and boundary, loss and internalisation issues related to termination?
14	Disjunctions	... address any disjunctions in therapy?
15	Frame Changes	... address frame changes?
16	Warmth	... convey warmth?
17	Rapport	How much rapport was there between therapist and client?
18	Agenda Setting	To what extent to the therapist set out an agenda for the session?
19	Directiveness	How much did the therapist direct or guide the session in an explicit way?
20	Providing reassurance	... provide reassurance to the client?
21	Advice giving	... provide non-psychological advice and undertake problem solving?
22	Psychological techniques	... offer psychological techniques to assist the client or suggest various types of practice of techniques between session?
23	Psycho-education	... provide psychoeducation around various issues affecting the client?
24	Information gathering	... gather information by way of questioning which was not for the purposes of clarification?
25	Homework assigned	... develop one or more specific assignments for the client to engage in between sessions?

- Unless otherwise stated, the text of every item begins with the phrase, “Did the therapist...”

Table 2.

Psychometric properties of items in the NASCoM

Item number	Abbreviated title	Reliability		Proportion of CM session absent[c]	Proportion of DBT sessions absent[d]
		Between modality[a]	Within Modality[b]		
1	Receptive listening	.90	.86	6.6%	8.3%
2	Use of tentative style	.82	.78	6.6%	8.3%
3	Use of language of mutuality	.84	.85	0%	8.3%
4	Identifying Patterns in relationships	.37 [ns]	.52 [ns]	50%	75%
5	Therapeutic relationship	.83	.90	50%	75%
6	Emotional Attunement	.91	.80	0%	0%
7	Awareness of Feelings	.58	.56 [ns]	13.2%	25%
8	Avoidance of Affect	.66	1.00	93.4%	91.6%
9	Acceptance of affect	.39 [ns]	ns	66.6%	83.3%
10	Explanatory Statements	.73	.68	13.2%	25%
11	Use of Metaphor	.88	.93	86.8%	83.8%
12	Personal disclosure	.75	-.82 [ns]	75%	75%
13	Exploration of Limitations	.88	ns	93.4%	91.6%
14	Disjunctions	.62	.78	86.8%	83.3%
15	Frame Changes	.91	.90	75%	83.3%

16	Warmth	.55	.21 [ns]	0%	0%
17	Rapport	.43 [ns]	.32 [ns]	0%	0%
18	Setting agenda	.81	.00 [ns]	100%	0%
19	Directiveness	.82	.1 [ns]	66.6%	0%
20	Providing assurance	.87	.2[ns]	86.8%	8.33%
21	Providing advice	.90	.78	86.8%	8.33%
22	Psych techniques	.95	.00[ns]	100%	0%
23	Psychoeducation	.95	.78	86.8%	0%
24	Providing information	.92	.80	50%	0%
25	Setting homework	.75	.00[ns]	100%	8.33%

[a]Inter-rater reliability based on sessions of both CM and DBT

[b] Inter-rater reliability for CM sessions alone;

[c] Proportion of CM sessions in which the component was rated as absent (i.e. mean rating of "0") by both raters

[d] Proportion of DBT sessions in which the component was rated as absent (i.e. mean rating of "0") by both raters

[ns] reliability not significant from zero

Supplement to draft journal article

[The factor analysis outlined in this supplement was not included in the draft journal article as the sample size was only ten clients tested three times over the course of therapy.]

Factor analysis

Exploratory factor analysis to examine the factor structure of the 13 of the 15 CM items of the NASCoM was used. Two items, acceptance of feelings and patterns in interpersonal relationships, were not included as they had not reached significant level of inter-rater agreement. Principal axis factoring extraction of the CM items was undertaken as the ratings for a number of the interventions used in the CM were not normally distributed (see Costello & Osborne, 2005). One item, called therapist use of client's metaphor, was discarded on the basis that it did not reach a minimum loading of .32 in the Table of Communalities (see Tabachnick & Fidell, 2001). A further factor analysis was then undertaken using principal axis factor extraction. As it was expected that the interventions were likely to correlate with each other, a Direct Oblmin rotation was used instead of an orthogonal rotation on the basis that oblique methods allow correlation amongst the factors (see Costello & Osborne). Three factors were retained where eigenvalues were greater than one with confirmation by way of Scree plot**.** The internal reliability for each subscale was also tested using Cronbach's alpha coefficient.

Factor analysis was appropriate based on the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy and the Bartlett Test of Sphericity. The KMO analysis yielded an index of 0.427*.* The BTS was significant (χ^2= 114.19, *df* = 78, *p* < .005). A principal axis factoring extraction with Direct Oblmin rotation identified five factors with eigenvalues close to or greater than 1.0. However, further analysis found a three factor which accumulatively accounted for 50.66% of the total variance. A Scree plot confirmed three factors. The factor loadings from the pattern matrix are

found at Table 1 of this Supplement. Correlations between the factors were quite low (.07 to .12) indicating oblique rotation was perhaps not necessary.

Reliability

Cronbach's alpha coefficients were not strong for internal reliability of the above three factors: 0.41 for interventions addressing the therapeutic relationship, 0.56, for psychodynamic interventions, and 0.61 for client centred interventions. Removal of items called 'receptive listening' and 'facilitating awareness of client feelings' from the factor, called client centred interventions, resulted in a reliability of .66 for the remaining three items. These two items were removed as they had low loadings (less than 0.415). A further analysis of internal reliability using DBT and CM sessions resulted in alpha coefficient of 0.87 for the client centred interventions, 0.44 for the psychodynamic interventions, and 0.39 for the interventions relating to the client therapist relationship.

Table for Supplement to the Draft Journal Article

Table 1

Factor loadings from the structure matrix

Item number	Abbreviated title	Factor		
		Client centred	Psychodynamic	Therapeutic relationship
1	Receptive listening	.36	.19	-.00
2	Use of tentative style	.64	-.21	-.08
3	Use of language of mutuality	.71	.12	.18
5	Therapist relationship	.02	-.02	.71
6	Emotional Attunement	.73	.08	-.04
7	Awareness of Feelings	.41	.29	.16
8	Avoidance of Affect	.07	.99	-.08
10	Explanatory Statements	.22	.79	.07
12	Personal disclosure	.07	.14	.58
13	Exploration of Limitations	-.03	-.01	.39
14	Disjunctions	.16	-.03	.43
15	Frame Changes	-.61	-.14	-.16

APPENDIX 1: ADDITIONAL METHODS AND RESULTS SECTION

Method

Participants

Exclusion criteria included those with disabling organic conditions, acute psychotic illness, developmental disability, an inability to speak or read English, currently using acute inpatient services, or a history of anti-social behaviour that posed a significant threat to staff. Although patients with drug and alcohol disorders were not excluded, clients had to commit to attending all therapy sessions without being under the effects of drugs or alcohol. Clients were also excluded if they had prior treatment with DBT or the CM.

Process measures

NASCoM scale

As a result of CM's different orientation from Exploratory Therapy, around 70% of the interventions in the SPRS were removed as they were not expected to be used in CM. The SPRS contained 59 items. Thirty of those items relate to a Cognitive Therapy scale and were excluded. Eight items from the SPRS come from a Facilitative Conditions scale of which two items were included in the NASCoM. Of the 16 exploratory items in the SPRS, 12 items were adapted to the NASCoM. The format of the NASCoM is as close as possible to that of the SPRS. However, while some items were similar to the items in the SPRS, the examples of adherent and non-adherent behaviour were different as they were oriented to the delivery of CM to people with BPD. Detailed tables of which items were included from the SPRS as well as items excluded from the SPRS are found at Appendix 2 (which contains the NASCoM and its manual).

Using the criteria for classifying items in an adherence scale by Waltz, Addis, Koerner and Jacobson (1993) interventions included unique, essential, acceptable, and proscribed items. Unique interventions are those interventions unique to CM relative to the DBT (e.g. the use of personal disclosure in CM is not found in DBT). Essential items are those interventions essential to CM but are acceptable to DBT (e.g. emotional attunement is essential to CM but acceptable to DBT). Acceptable items are those that are not proscribed but are neither essential nor unique (e.g. the facilitative conditions in CM, warmth and rapport, are acceptable to both DBT and CM). Proscribed interventions are those unacceptable to the treatment being rated. For example, use of psychoeducation is proscribed in CM. However, all the proscribed items either form part of DBT or are acceptable to DBT. Classification of each item is found at Table 3 of this Appendix.

Working alliance inventory (WAI)

Each subscale of the WAI consists of 12 items rated on a 7 point Likert scale (1 = 'never' and 7 = 'always'). An example of an item measuring goals is item 5, "The client/therapist have a common perception of his /her goals." An example of an item measuring tasks is item 2, "The client/therapist agree about the steps to be taken to improve his/her situation." Finally, an example of an item measuring bond is item 26, "The client/therapist and I have built mutual trust." Six of the twelve goal items, seven of the tasks items and nine of the bond items are positively valenced while the remaining items were negatively valenced.

The design for rating the 59 sessions is found at Table 1 of this Appendix.

Statistical analysis

Discriminant analysis (DA)

Logistic regression was not used as it was predicted that there would be a perfect separation with the outcome groups (see Tabachnick & Fidell, 2001). Further, logistic regression analysis would have struggled with the large number of items (23) and with limited number of cases (n= 59) (see Tabachnick & Fidell). In contrast, DA ideally fitted the study's hypothesis, namely, that the two therapies would be discriminated on the basis of the rating of the items in the NASCOM.

A direct DA was performed using all items in the NASCoM other than four items which were the two facilitative items, 'warmth' and 'rapport', and 'patterns in relationships' and 'acceptance of feelings'. These four items did not have significant intra class correlations. . Further, the use of warmth and rapport were considered styles of therapy which could be employed in either treatment. Direct discriminant function analyses were also performed on CM items (13) alone and proscribed CM items (8). All eight proscribed items were acceptable interventions in DBT.

Repeated Measures ANOVAs

Repeated measures ANOVAs were conducted to test whether there were significant differences in the 'use of explanatory statements' and the 'use of metaphor 'over the course of the three stages of therapy (modeled as time with three levels and within subject factor). Tests of within-subjects contrasts for linear and quadratic approaches were used as it was anticipated that there would be a linear increase for explanatory statements and metaphors over time. A mixed repeated measures ANOVA was also conducted to test whether there was any effect of therapist experience (defined as less than three years or more than four years

experience using the CM) on the use of explanatory statements (as a between subjects factor).

Linear mixed model analysis

Linear mixed model was used to test relationships between therapist adherence to client centred interventions and the three aspects of the working alliance inventory (Horvath & Greenberg, 1989) namely bond, agreement on tasks and agreement on goals. The choice of a compound symmetry covariance structure (over heterogeneous compound structure, first order autoregressive and first order autoregressive heterogeneous structures) for the repeated measurements over time was used after examining fit using Akaike's Information and Schwartz's Bayesian criteria. Correlations were not used to test association as the predictor and dependent variables were expected to change over the three stages of therapy and some client data relating to the therapeutic alliance scores was not available. Further, the level of correlation between repeated measurements generally ranged from 0.4 to 0.6.

Results

Inter-rater agreement

Table 2 to this Appendix sets out the intraclass correlations for DBT sessions in relation to proscribed items. These results show high levels of inter-rater agreement for the use of proscribed items when rating DBT sessions.

Table 3 to this Appendix sets out the mean rating (and SD) for the NASCoM items for CM and DBT sessions. It also sets out the difference between the means for each items, the *t*-value, and the significance level of the difference between the means.

Discriminant analysis

Using direct discriminant analysis, all ratings of the items in the NASCoM ratings, excluding the four items that did not reach significant intraclass correlations were entered. Discriminant function was significant (*Wilks lambda* = .072, $\chi^2(21)$ = 122.239, *p*< .0001); 100 % of the cases were correctly classified (93.1% with cross validation). CM items only were then included in a discriminant analysis (94.9% correctly classified; 83.1% cross validated) (*Wilks lambda* = .231, $\chi^2(13)$ = 74.013, *p*< .0001). The ratings on the eight proscribed items were also included in a separate discriminant analysis, 100% correctly classified (100% of cross-validated) (*Wilks lambda* = .097, $\chi^2(8)$ = 123.731, *p*< .0001).

Only four items in the NASCoM exceeded a correlation of 0.33 in the Table of Communalities(see guidelines in Tabachnick & Fidell, 2001). Three of these items were proscribed items in CM (but found in DBT) and resulted in significantly higher rating means in DBT. They were: 'information seeking', 'provision of psychological techniques', and 'homework' (see Table 3 for means and standard deviations of ratings for these items for CM and DBT sessions). The fourth item was a key intervention for the CM, emotional attunement, which had a significantly higher rating mean in CM sessions compared to DBT sessions(See also Table 3 for comparison of means). The discriminant analysis using these four items gave 98.3% correct classified (cross validation 93.2%) (Wilks lambda = .167, $\chi^2(4)$ = 98.363, *p* < .000).

Extensiveness of interventions over the course of therapy and their interaction with therapist experience

Repeated measures ANOVAs were conducted on the 'use of explanatory statements' in the NASCoM in relation to those participants undertaking CM for the purpose of testing the following two hypotheses. The first hypothesis was that the use of explanatory statements would increase over the three stages of therapy. Secondly, it was hypothesised that use of explanatory statements would differ significantly depending on whether the therapist was experienced (defined more than

three years in CM) or less experienced (defined as less than three years in CM). The third hypothesis is that the change over time would differ according to therapist experience. There was no significant change over the three stages of therapy in the use of explanatory statements: using Greenhouse-Geisser adjustments F (1.37, 10.95) = 0.38, p = 0.61); nor was there any significant difference in use of explanatory statements depending on therapist experience: (F (1, 8) = 2.38, p = 0.16). Further, there was no significant interaction between the use of explanatory statements over the course of therapy depending on whether the therapist was experienced or not: F (1.37, 10.95) = .21, p = 0.73. It was also hypothesised that use of metaphor would increase over the course of therapy. However, there was also no significant change in use of metaphors over the course of therapy using Greenhouse-Geisser adjustment: F (1.46, 11.68) = 0.60, p = 0.51).

Despite these non significant findings, the mean ratings for 'explanatory statements' shows that the use of this intervention increased over the three stages and varied depending on therapist experience as predicted. The use of explanatory statements by CM therapists showed an upward increase of use over the course of therapy from M = 1.10 in first phase to M = 1.20 in the second phase to M = 1.50 in the final phase. There was also an increase use of the intervention by the more experienced therapists. In the first stage M = 0.80 for therapists with less than three years cf M = 1.40 for more experienced therapists. In second stage M = 0.6 for less experienced therapist whereas M = 1.80 for experienced therapists. In third stage M = 1.00 for less experienced therapists cf M = 2.00 for more experienced therapists.

A post hoc power analysis using G*Power 3 (Faul, Erdfelder, Lang, & Buchner, 2007) was conducted on repeated measures ANOVAs for change in use of explanatory statements over time and also for the interaction between change over time and therapist experience. The reason for the post hoc power analysis was to understand the power for finding significance in the repeated measures ANOVAs given the pattern observed of increasing use of explanatory statements over time and a difference in use of explanatory statements between experienced therapists and those with less experience (which is arguably clinically significant). A post hoc power analysis was carried out (alpha=.05) based on a pre-post analysis, without considering the second trimester value. The effect size considered to be a clinically

meaningful was one point in the Likert scale scores, i.e., 5% change in use of interventions. Using our data to provide SD at baseline for rating of explanatory statements (1.28) and the correlation between baseline and post 0.30, and the pattern of means, where one group stayed the same over time and the other group increased by one unit, it was estimated that a sample size of 37 would have been needed in each therapist group to achieve a power of 0.80 (alpha = .05). The power in this study with five in each of the two groups was found to be 0.15.

By way of comprehensiveness, repeated ANOVAs were conducted to explore whether there was any change in any of the other CM interventions with participants undertaking CM. The ANOVAs were also used to test whether the experience of therapist affected the use of an intervention and whether there was an interaction between therapist experiences and the stage of therapy. There were no significant changes in the use of interventions over the course of therapy nor were there any differences between therapists in their use of interventions for any of the remaining CM items. There were also no significant interactions between changes in interventions over the course of therapy and whether the therapist was more or less experienced.

Tables for Appendix to Draft Journal Article

Table 1:

Framework for sample of sessions rated

	CM clients selected N	Sessions n	DBT clients n	Sessions n	Total sessions n
6 therapists conducting CM and DBT	6	18	6	17	35
9 therapists CM only	4	12			12
9 therapists DBT only			4	12	12
Total	10	30	10	29	59

Table 2.

Psychometric properties of NASCoM items which are prohibited under CM (and acceptable under DBT)

Item number	Abbreviated title	Reliability Within modality [a]
18	Setting agenda	.52 [ns]
19	Directiveness	.75
20	Providing assurance	.89
21	Providing advice	.81
22	Psy. techniques	.90
23	Psychoeducation	.95
24	Providing information	.95
25	Setting homework	.55 [ns]

[a] Inter-rater reliability for DBT sessions alone

[ns] reliability not significant from zero

Table 3.

Mean and SDs of NASCoM items for CM sessions and DBT sessions

Item on NASCoM scale	Item Classification in CM	Mean CM sessions (N = 30)	SD CM sessions	Mean DBT sessions (N = 29)	SD DBT sessions	Difference between Means of CM & DBT sessions	t value *	Significance level
Receptive listening	essential	3.50	2.341	1.62	1.347	1.88	3.76	*p* <.0001
Use of tentative style	essential	2.90	1.47	1.21	1.013	1.70	5.13	*p* <.0001
Use of language of mutuality	essential	3.97	1.65	1.41	1.181	2.55	6.81	*p* <.0001
Therapeutic relationship	essential	1.13	1.31	.62	.862	.51	1.77	*p* = .082
Emotional Attunement	essential	5.33	1.40	1.93	1.193	3.40	10.04	*p* <.0001
Awareness of Feelings	essential	1.60	1.07	.62	.728	.98	4.08	*p* <.0001
Avoidance of Affect	essential	.13	.34	.17	.384	-.04	-.41	*p* = .683
Explanatory Statements	essential	1.27	1.28	.93	.704	.34	1.24	*p* = .221

Use of Metaphor	essential	.20	.48	.07	.26	.13	1.30	p = .202
Personal disclosure	unique	.17	.37	.48	.51	-.32	-2.71	p = .009
Exploration of Limitations	essential	.03	.18	.34	.70	-.31	-2.45	p = .017
Disjunctions	essential	.13	.35	.03	.19	.10	-5.895	p = .179
Frame Changes	essential	.13	.575	.10	.31	.03	-6.564	p = .805
Setting agenda	proscribed	.03	.18	.59	.50	-.55	-4.842	p <.000
Directiveness	proscribed	.50	.57	1.59	.82	-1.09	-10.944	p <.000
Providing assurance	proscribed	.27	.45	1.17	.60	-.90	-6.564	p <.000
Providing advice	proscribed	.30	.53	2.14	1.50	-1.84	-6.291	p <.000
Psy. techniques	proscribed	.03	.18	3.28	1.87	-3.24	-9.459	p <.000
Psychoeducation	proscribed	.13	.34	1.31	1.28	-1.17	-4.842	p <.000
Providing information	proscribed	.63	.89	4.45	1.68	-3.81	-10.944	p <.000
Setting homework	proscribed	.03	.18	1.24	.69	-1.21	-9.269	p <.000

*T test for independent sample of means

EXTENDED DISCUSSION

Research that implements treatment integrity procedures are rare (Perepletchikova, Treat & Kazdin, 2007) and even rarer for non-skill building therapies (Randall & Biggs, 2008). It is in this current research environment of low reporting of adherence testing, that the NASCoM was developed to assess adherence to CM, a psychodynamically oriented treatment for people with BPD. Several key items of the NASCoM were found to have good inter-rater reliability for sessions of CM treatment rated alone and when rated with sessions of DBT. However, a number of items had low inter-rater agreement. Discriminant analysis of the NASCoM items also showed that CM sessions can be perfectly distinguished from DBT sessions. As the NASCoM measured the extent to which an item was rated, this study carried out three additional analyses: (a) a factor analysis of the CM items used by therapists practicing CM (b) an analysis of the use of CM interventions over the course of therapy; and (c) associations between selected items and aspects of a working therapeutic alliance. Low sample size limited the power of some of these analyses.

Development of the NASCoM

The NASCoM was developed specifically for CM as adapted by Meares (2004, 2005) for clients with a diagnosis of BPD. The format and content of the NASCoM is similar to the Sheffield Psychotherapy Rating Scale (SPRS) developed by Shapiro and Startup (1990) for Exploratory Therapy which was an adaptation of Hobson's CM. Of the 16 exploratory items in the SPRS, 12 items were adapted to the NASCoM. As there was some similarity between the NASCoM and the SPRS especially in relation to the exploratory items in the SPRS, it may have been useful to have rated the sessions in this study against the SPRS as well as the NASCoM. Such an exercise may have highlighted how the interventions used in Exploratory Therapy and CM differed in this current study. The findings from such a comparison of the two instruments may have shed light on the question raised by Perepletchikova, Treat and Kazdin (2007) as to whether new adherence scales need to be created each time a new or revised therapy is tested for adherence. The

findings may also have assisted in determining to what extent the SPRS would have needed to be changed to capture the CM used in this study.

Ratings of the NASCoM

Despite good inter-rater agreement on several key items of the NASCoM, there were four items that lacked significant inter-rater agreement. The non-significant findings for two of these items, namely, identifying patterns in relationships and addressing acceptance of feelings, can largely be explained by floor effects in the ratings for those items in both CM and DBT. The two remaining non-significant items involved the two facilitative items, warmth and rapport, despite being rated frequently in each session. These two items have struggled in other studies to reach acceptable inter-rater agreement (see Godfrey, Chalder, Ridsdale, Seed, & Ogden, 2007; Hill, O'Grady, & Elkin, 1992). Greater attention will need to be given to rating the use of warmth and rapport if they are to be used effectively in future adherence studies. One strategy for improving the reliability of these two items could be the provision of criteria for rating these items. For example, criteria for rapport could include noting times when the client referred to what the therapist had said in a constructive way. Other possible behaviours could include times when the client proactively disclosed information or made attempts to explore difficult personal information with the therapist. Criteria for warmth could include use of laughter shared in session or occasions when the therapist mirrored the tone of the client.

Challenges in rating CM items

Inter-rater agreement of DBT sessions was high (above 0.8) in relation to proscribed items (see Table 2 of Appendix 1). Proscribed items largely consisted of skill-building activities. Perepletchikova, Treat and Kazdin (2007) found in a review of selected journals that while adherence testing was infrequent, it was significantly higher for skill-building therapies compared to non-skill building therapies. Two proscribed items in the CM involved collecting information by way of asking questions and being directive. These two interventions also received high inter-rater

agreement in a psychodynamic therapy called Dynamic Deconstructive Therapy (G. A. Goldman & Gregory, 2009). It is possible that it is not whether a therapy is skill building per se that facilitates inter-rater agreement; rather it is whether the therapy can be described by way of interventions which involve asking questions or being directive. For example, where therapists are expected to facilitate awareness of feelings in the client (Item 7 of the NASCoM) rather than direct the client or ask questions of the client, interventions appear more challenging to rate. Facilitating awareness of feelings involves the therapist speculating about what the client may be feeling and needs to be distinguished from attuning to the feelings expressed by the client (B. B. Goldman, Startup, Walton, & Bendit, 2011). Rating of this item requires the rater appreciating what the client has said before the intervention so that the rater can distinguish between emotional attunement and facilitating awareness. In contrast, directiveness or asking questions simply involves rating what the therapist says without any reference to the context in which the client speaks. When one takes into account that both raters in this current study had training or experience in CM but only one rater had limited experience in DBT, the results of the inter-rater agreement highlight the relative ease of rating directive skill-building therapies such as DBT in contrast with psychodynamically oriented therapies such as CM.

During the piloting phase of rating sessions, the raters found rating unreliable for some of the CM items (cf proscribed items in the NASCoM) even with the benefit of having the audio tapes transcribed. As a result, a number of changes were made to the NASCoM manual during the piloting phase to improve reliability perhaps at the expense of not capturing some of the subtlety in the delivery of interventions. The raters found the breakdown of emotional attunement into three interventions called coupling, amplification, and representation to be unworkable in the piloting phase. In summary, coupling is an intervention where the therapist reflects the client's feeling in a minimal way such as mirroring client's feelings. Amplification involves the therapist expanding the client's feeling response. Representation is a re-presentation of what the client has said in a way that extends rather than merely mirroring the client's feelings (see Bendit, 2010; Meares, 2005). Each intervention sits on a continuum of therapist's attempts to attune to the client's feelings and as such it is difficult to determine when one intervention ends and another begins.

The conflation of coupling, amplification, and representation into emotional attunement in the NASCoM still left the raters with some challenges distinguishing the intervention called ‘emotional attunement’ from the intervention called ‘facilitating awareness of feelings’. It was difficult to determine when a therapist was attuning to what the client was saying or when he or she was facilitating feelings that the client may not be aware of. Another difficulty was measuring the intervention called receptive listening which involved the therapist encouraging the client to talk. Some therapists used “uh huh” on numerous occasions in session which arguably facilitated the client to talk whereas other therapists used only silence. The raters settled on absolute length of silence for consistency and workability at the expense of other techniques such as the “uh huh”. Another concern was rating use of mutuality. Again, the raters resorted to rating the absence of the word "you" and the presence of the words, "we" and "I", even though “you” may have been implied by the therapist but simply not said. The above changes to the NASCoM in the piloting phase aimed to make the rating simpler but arguably at the expense of losing some information about adherence to interventions in the CM. It seems that there is a risk that aspects of interventions which are hard to rate may not be captured or not captured fully in a rating scale.

One limitation in rating was the not being able to capture some of the therapists’ non-adherent behaviour. While the NASCoM distinguished adherent from non-adherent behaviour for particular items, there was no provision for taking into account non-adherent behaviour when rating a particular intervention except when it was a proscribed item. For example, there was no mechanism for taking into account the use of personal disclosures which did not appear of any benefit to the therapy. It is difficult to take into account non-adherent behaviour as there are many behaviours that are potentially non-adherent. Further, any attempt to penalise non-adherent behaviour may have diminished attempts to measure the extensiveness of adherence behaviour. Some aspects of non-adherent behaviour could be taken into account if there was an additional scale measuring therapist competence.

Implications of CM items being rated infrequently in session

Table 3 of Appendix 1 shows that six of the 13 CM items with significant inter-rater reliability were used on average in very small dosages (no more than 5%) in CM sessions. Four of these items related to the therapeutic relationship. They were addressing requests by the client for personal disclosure, exploring the client's feelings about limits in therapy, addressing any changes in therapy, and addressing any sudden change in the client's mood (described as disjunctions). These interventions would seem useful when the therapeutic relationship is strained. The lack of use of these interventions suggest that the risk of rupture in the therapeutic alliance when working with people with a diagnosis of BPD is not as high as anticipated by those who have developed the CM (see (Bendit, 2010).

There are other interpretations for low ratings on the items relating to the therapeutic relationship. It is possible that the therapists failed to address such issues and therefore could not be rated. It is also possible that the raters failed to pick up an intervention especially addressing disjunctions involving sudden mood changes. The raters only had audiotapes of sessions which arguably do not provide the non-verbal information supplied in videotaped sessions. Having said that, even if the raters did not pick up the client's disjunction, it seems unlikely that the rater would miss the therapist's intervention relating to the disjunction.

The remaining two items with significant inter-rater agreement, rated at no more than 5% of sessions, were addressing avoidance of feeling and the therapists' use of the clients' metaphor. The item, 'addressing avoidance of feeling', loaded on the second factor analysis with the item called 'use of explanatory statements'. These two items were categorised as psychodynamically oriented interventions. The use of metaphor also can also be described as a psychodynamically oriented intervention (Hobson, 1985; Meares, 2005). (The use of metaphor was not included on any factor because it did not reach the threshold in the Table of Communalities for the Factor Analysis.) Meares (2005) considered the therapist's response to the client's use of metaphor as an important strategy in building the client's inner world and sense of self. It would seem then that it is possible that the clients used metaphors as their inner world and sense of self developed over the course of therapy but the therapists did not use the metaphors offered by clients. In any event, it was not expected that metaphors would take up a large part of the CM session

(Bendit, 2010; B. B. Goldman, et al., 2011). However, in 87% of CM sessions jointly rated the use of metaphor was not rated at all compared to 20% of sessions in Exploratory Therapy in a study by Shapiro & Startup (1992). While Exploratory Therapy is oriented differently to the CM used in this study, the difference in use of client metaphor between the present study and the study by Shapiro and Startup (1992) is worthy of closer examination. A further analysis of the sessions rated could identify the times when the clients used metaphors and when the therapists responded to their use.

The use of interventions described as addressing avoidance of feelings and acceptance of feelings were not rated at all in a number of sessions (see Table 2 of the Draft Journal article). In the event that the CM is found to provide positive outcomes for its clients, one interpretation of this finding is that these interventions are not required to effect positive change in the lives of clients with BPD. On the other hand, if the outcomes from the RCT do not show positive outcomes, the low use the above interventions may offer some explanation for such results.

Further, Table 3 of Appendix 1 shows that there was no significant difference in use of exploration of the therapist relationship, use of explanatory statements, exploration of avoidance of feeling, and the use of metaphor by therapists practising CM and those practising DBT. Waltz, Addis, Koerner and Jacobson (1993) warn that therapies do have interventions which are common and that is important that what is common (the overlap) is also measured. Otherwise, an illusion of distinctive therapies can be created. However, these four items are key items in CM ((Hobson, 1985; Meares, 2005) and there was some expectation that their use would be distinctive to CM. This current study did not set targets on absolute levels of adherence to CM items. These findings highlight the usefulness of developing absolute levels of adherence when testing for adherence to a particular therapy. Without such clinical agreed levels of adherence, one cannot be confident that the therapists were adherent to therapy being tested.

Implications of high ratings on CM items

In contrast, good inter-rater reliability was found for emotional attunement, use of tentativeness and use of mutuality. The use of emotional attunement was the CM item most frequently rated in therapy. The use of mutuality and tentativeness were the third and fourth most rated interventions with receptive silence being rated the second highest rated item. All these high rating items were classified by Bendit and Walton (Personal communications, 2011) as essential for CM and acceptable to DBT. Emotional attunement was also a key intervention in the Discriminant Analysis in discriminating whether a therapy was CM or DBT. These findings are consistent with Meares (2005) emphasis on the importance of emotional attunement in CM. Hobson (1985) also considered emotional attunement a critical intervention which was to be delivered in a particular way, namely, with mutuality and with tentativeness.

The high use of emotional attunement with mutuality and tentativeness raises a question whether a small selection of interventions around the delivery of emotional attunement would be sufficient to treat people with BPD? If so, the cost of delivering CM as practised in this RCT could be reduced substantially by having therapists with limited training deliver these interventions. Further, the low ratings on a range of CM interventions and the high use of emotional attunement suggests that the therapist practising CM in this study could have been rated as adherent to an adherence scale for non-directive person-centred therapy.

Ratings raise questions whether CM is a psychodynamic therapy

The low ratings on psychodynamically oriented interventions and the high ratings on emotional attunement and related interventions raises the question whether the CM is more a person centred therapy than a psychodynamically oriented therapy. CM does not look like classic psychoanalysis as described say by Bordin (1979) with the patient lying on a couch offering associations. If it did, it would be contrary to the injunctions of Hobson (1985) who advised against delivery of psychodynamic interpretations in a neutral, interrogative way. Rather, Hobson encouraged therapists to collaborate with their clients in the delivery of psychodynamic interpretations as tentative statements that explained events or

conflicts in a client's life (both external and inner). The unfolding exploration of the client's relationships and the client's feelings about their circumstances are the goal of the CM (Hobson, 1985) and are therefore consistent with the core features of psychodynamic therapy (Notman & Harrison, 2011). It would seem that with a larger set of sequential sessions, the exploration of underlying themes and conflicts in the client's relationships both past and present would point more clearly to the therapy's psychodynamic orientation.

The lack of unique items in the NASCoM

Perepletchikova, Treat and Kazdin (2007) state that adherence testing is specifically about testing for adherence of unique items to be confident that these items were the agents of change in therapy. In this current study, there was one item classified as unique by Bendit and Walton (Personal communications, 2011), namely, use of personal disclosure, and it was used on average in less than 5% of CM sessions. Bendit and Walton regard the remaining 14 CM items regarded as essential to therapy and acceptable to DBT. Table 3 of Appendix 1 shows that most of the essential interventions were used significantly more by therapists undertaking CM compared to therapists undertaking DBT even though these items were acceptable to DBT. The results of the Discriminant Analysis also show that one of the essential items, emotional attunement, was a key item that discriminated between the use of the two therapies in this controlled trial. In the event of positive outcomes from the controlled trial for CM, it is arguable from the findings in this study that adherence to essential items, and not just unique items, can provide some confidence of the role of essential items in therapeutic change. It also suggests that Perepletchikova et al. are too restrictive in limiting explanations of change in therapy to adherence to unique interventions.

Discriminant analysis

Discriminant analysis of the NASCoM items showed that CM sessions can be perfectly distinguished from DBT sessions. While this finding cannot be construed as showing that therapists using CM only used CM interventions and not DBT, it shows that their use of interventions was consistent with the therapy they were intending to deliver. Further support for therapist adhering to CM is found in Table 2 of the journal article where column 3 shows that CM therapists rarely used proscribed items. Table 3 of Appendix 1 also shows that many of the CM interventions, essential to CM but acceptable to DBT, were used significantly more by therapists practising CM than for therapists practising DBT. However, Table 3 of Appendix 1 also shows that three of the CM interventions, addressing avoidance of feeling, delivering explanatory statements, and use of metaphor (which are arguably psychodynamic interventions based on the works of Hobson (1985) and Meares (2005)) were not used significantly more by therapist practising CM than therapists practising DBT. While the discriminant analysis showed perfect discrimination between DBT and CM, the therapies are not distinctive at least in relation to the psychodynamic interventions used in CM.

It was also of note that four items (emotional attunement, information seeking, provision of psychological techniques, and homework) could distinguish therapies almost as well as the 23 items in the NASCoM. The cross validation result for all 23 items was 94.9% compared to 93.2% for the four items. The high use of emotional attunement suggests that it is the “bread and butter” of CM and not for DBT.

The raters were blind to which therapy was being administered. However, as the therapies were so distinctive, raters would generally have known what therapy was being administered. One of the characteristics of DBT is the use of diary cards. Generally, the first task in a DBT session is to examine the client’s diary card for the previous week. This intervention generally alerts the rater to the practice of DBT. While it seemed an unlikely scenario that the six therapists using both therapies albeit with different clients would mistakenly use interventions from the other modality over the course of therapy, the sessions of all six therapists using both modalities were sampled.

Factor analysis

The exploratory factor analysis provided a reasonably clear factor structure of the items used in CM as is evident in the Pattern Matrix in Table 1 of the Supplement to the draft journal article. There were high communalities of items with minimal cross loadings. The factors largely reflect the theoretical basis of CM, namely, humanist/experiential, psychodynamic, and interpersonal influences. The first factor consisted of four items: emotional attunement, delivering statements with tentativeness and with mutuality, and awareness of feelings. These items can be categorised as humanist/experiential interventions and were called client centred interventions. The second factor consisted of only two items, namely, exploration of the client's avoidance of feelings and the delivery of explanatory statements largely related to internal conflict within the client. These items can be categorised as psychodynamic interventions. The third factor involved four items which all related to the client-therapist relationship. These items were addressing issues in the therapist-client relationship, use of personal disclosure in the relationship, and addressing limitation and disjunctions in the therapeutic relationship. These items do have some level of interpersonal orientation but they are specifically oriented to the client-therapist relationship. One of the limitations in this analysis is that the item called identifying patterns in relationship, which is a key item reflecting the influence of interpersonal therapy in CM, was excluded from the factor analysis because inter-rater agreement on this item was not significant. It would be ideal that this three factor structure could be subject to confirmatory factor analysis in the future.

The reliability of exploratory factor analysis was not high. Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy yielded an index of 0.427. However, the Bartlett Test of Sphericity was significant (χ^2= 114.19, *df* = 78, *p* < .005). The factor analysis was based on a low participant to item ratio (10:11). Costello and Osborne (2005) have found there is a 10 % chance of the factor structure being incorrect when ratios are below 2:1 which is the case in this study. Another weakness in the analysis is the lack of items on any one factor. Clearly, a larger sample size would have improved the ratio of participants to items. None of the factors had five or more items as recommended by Costello and Osborne. The psychodynamic factor has

only two items which makes the factor weak and unstable (Tabachnick & Fidell, 2001). Finally, Cronbach's internal reliability was not strong for the factors when using CM sessions: 0.41 for therapeutic relationship, 0.56, for psychodynamic interventions, and 0.66 for client centred interventions.

Measuring adherence in relation to use of interventions

The results in this study showed that no intervention changed significantly over the three stages of therapy. With the exception of the use of metaphors and explanatory statements, these findings were largely consistent with the expectations of specialist CM practitioners (Bendit, 2010; Personal communications with Drs Bendit and Walton, 2010). However, it is not clear why interventions such as addressing limitations in therapy would not have varied over therapy. One would have expected that addressing limitations would take place in the early stage of therapy when the therapist needs to set boundaries and at the later stage of terminating therapy. One explanation for the lack of significant findings is the small sample of ten CM clients whose sessions were rated over three periods of therapy (i.e. three sessions out of a possible 120 sessions) and the infrequent use of a number of the interventions.

It was expected that the use of metaphor and explanatory statements would increase over the course of the CM (Bendit, 2010). There was also an expectation on the part of CM practitioners consulted that with explanatory statements, the experienced practitioners would use explanatory statements more frequently than practitioners of less than three years experience in CM (Personal communications with Drs Bendit and Walton, 2010). Findings in relation to the change in the use of explanatory statements over the course of therapy and in the use of experienced therapists were in the direction predicted. The differences in use of explanatory statements depending on the level of therapist experience was an increase of 5% in the use of explanatory statements when the therapists had experience in CM greater than four years compared to therapists with experience of three years or less. As outlined in the post hoc power analysis in Appendix 1, a larger sample would have been required to increase the likelihood of such a difference being significant.

There have been a number of benefits of rating interventions on their extensiveness in session. Firstly, rating extensiveness has allowed an analysis of the level of use of intervention which in turn has opened up questions about the low use of certain interventions and what this means for the conceptualisation of CM and possibly offering explanations for the future outcomes of the RCT. Rating the extensiveness of interventions has also allowed other tests to be considered such as whether the level of experience of therapist is associated with the frequency in which the intervention is used.

WAI data and adherence

The use of continuous variables, as recommended by Barber, Triffleman, & Marmar (2007), in the NASCoM also allowed this study to test associations with adherence and the working alliance. To date little research has been undertaken on the relationship between adherence and the working therapeutic alliance. It was hypothesised that greater therapist adherence in CM to emotional attunement and use of tentativeness and mutuality would have a significant relationship with client perception of bond in the therapeutic alliance. No significant association was found. This finding is contrary to the findings by Bachelor (1988) where it found that clients regard the effect of empathic interventions as creating a bond between client and therapist. One possible explanation for this non-significant finding is that adherence to these three client centred interventions could have resulted in their delivery being mechanical and repetitious. It is a challenge for the therapist to make empathic comments especially in the form of not using “you” and delivered in a tentative way. Piper, Joyce, McCallum, Azim, and Ogrodniczuk (2002) state that more of an intervention is not necessarily better but can be worse and that mechanical adherence to a treatment regime has long been regarded as risk to the therapeutic alliance. Some support for this view can be garnered from the significant finding in the study that adherence to client centred interventions was significantly associated with client agreement on the tasks of therapy. It seems that the clients were aware that their therapists were using empathic interventions in session but did not regard it

as linked to building a therapeutic bond. Perhaps the clients considered client centred interventions as the therapist “just doing their job”. Another possible explanation for the current findings being contrary to Bachelor’s (1998) is that the client groups are different. This current study involved clients diagnosed with BPD compared to university students in Bachelor’s study half of whom were recruited on the basis that they did not have a mental disorder. One of the criteria in the *DSM IV-TR* for BPD is instability in relationships (APA, 2001). Further, Meares (2005) regarded the aetiology of BPD as partly related to poor attachment to significant care givers. On these bases, any creation of bond between clients with BPD and their therapists was likely to be more challenging than with participants in Bachelor’s study.

Summary and other limitations

In the development of the NASCoM, a number of recommendations for treatment integrity as outlined in Barber, Triffleman, & Marmar (2007) and in Perepletchikova, Treat and Kazdin (2007) were included such as random sampling of sessions, ratings undertaken by trained and independent raters, use of joint rating to avoid drift in ratings, and use of continuous variables to measure extensiveness of adherence. The current study addressed two of the three recommended areas in treatment integrity, namely, rating adherence to treatment and testing whether the two therapies can be discriminated from each other. However, the third area of treatment integrity, measuring therapist competence, was not undertaken. Another limitation in this current study is its sample size. The exploratory factor analysis provided an explicable factor structure but the small sample increased the risk of it being incorrect (Costello & Osborne, 2005). The sample also did not provide sufficient power to identify significant changes in interventions over the course of therapy taking into account the experience of the therapist.

The development and testing of the NASCoM contributes to the limited number of adherence studies for psychodynamic therapies. The current study also highlights the usefulness of adherence testing in other domains of psychotherapy

research such as testing the links between adherence to treatment and the working alliance as well as measuring the extent interventions are being used in therapy. While Perepletchikova, Treat and Kazdin (2007) have outlined the relative difficulty of creating adherence scales for non-skill building therapies compared to skill-building therapies, the results of this study provide some encouragement and challenges for further adherence testing for non-skill building therapies.

References for Extended Discussion

Bachelor, A. (1988). How clients perceive therapist empathy: A content analysis of "received" empathy. *Psychotherapy, 25*, 227-240.

Barber, J. P., Triffleman, E., & Marmar, C. (2007). Considerations in treatment integrity: Implications and recommendations for PTSD research. *Journal of Traumatic Stress, 20*, 793-805.

Bendit, N. (2010). Training Manual for Conversational Model used at the Centre of Psychotherapy, Newcastle, Australia. Centre of Psychotherapy, Hunter New England Health Service.

Costello, A. B., & Osborne, J. W. (2005). Best practices in exploratory factor analysis: Four recommendations for getting the most from your analysis. *Practical Assessment, Research & Evaluation, 10*, 1-9.

Godfrey, E., Chalder, T., Ridsdale, L., Seed, P., & Ogden, J. (2007). Investigating the 'active ingredients' of cognitive behaviour therapy and counselling for patients with chronic fatigue in primary care: Developing a new process measure to assess treatment fidelity and predict outcome. *British Journal of Clinical Psychology, 46*(3), 253-272.

Goldman, B. B., Startup, M. J., Walton, C., & Bendit, N. (2011). Rater's manual for the Newcastle Adherence Scale for the Conversation Model. University of Newcastle.

Goldman, G. A., & Gregory, R. J. (2009). Preliminary relationship between adherence and outcome in Dynamic Deconstructive Therapy. *Psychotherapy Theory, Research Practice, Training, 46*, 480-485.

Hill, C. E., O'Grady, K. E., & Elkin, I. (1992). Applying the Collaborative Study Psychotherapy Rating to rate therapist adherence in Cognitive Behaviour Therapy, Interpersonal Therapy, and Clinical Management. *Journal of Consulting & Clinical Psychology, 60*, 73-79.

Hobson, R. F. (1985). *Forms of feeling: The heart of psychotherapy*. London: Tavistock Publications.

Meares, R. (2005). *The metaphor of play: Origin and breakdown of personal being* (3rd ed ed.). East Sussex: Routledge.

Notman, M. T., & Harrison, A. M. (2011). Psychdynamic therapy: Adults and children. *The Journal of Nervous and Mental Disease, 199*, 527-531.

Perepletchikova, F., Treat, T. A., & Kazdin, A. E. (2007). Treatment integrity in psychotherapy research: Analysis of the studies and examination of the associated factors. *Journal of Consulting and Clinical Pyschology, 75*, 829-841.

Piper, W. E., Joyce, A. S., McCallum, M., Azim, H. F., & Ogrodniczuk, J. S. (2002). *Interpretive and supportive psychotherapies: Matching therapy and patient personality*. Washington, DC: American Psychological Association.

Randall, C. J., & Biggs, B. K. (2008). Enhancing therapeutic gains: Examination of fidelity to the model of the internsive mental health program. *Journal of Child and Family Studies, 17*, 191-205.

Shapiro, D. A., & Startup, M. J. (1990). *Raters' manual for the Sheffield Psychotherapy Rating Scale (Memo no. 1154)*. Sheffield: University of Sheffield.

Shapiro, D. A., & Startup, M. J. (1992). Measuring Therapist Adherence in Exploratory Psychotherapy. *Psychotherapy Research, 2*(3), 193 - 203.

Tabachnick, B. G., & Fidell, L. S. (2001). *Using multivariate statistics*. Boston: Allyn and Bacon.

Waltz, J., Addis, M. E., Koerner, K., & Jacobson, N. S. (1993). Testing the integrity of a psychotherapy protocol: Assessment of adherence and competence. *Journal of Consulting & Clinical Psychology, 61*(4), 620.

APPENDIX 2: NEWCASTLE ADHERENCE SCALE AND MANUAL

RATERS' MANUAL

For

The Newcastle Adherence Scale for the Conversational Model (2010)

(NASCoM)

An adaptation of the

Sheffield Psychotherapy Rating Scale

(SPRS)

Bernard Goldman, Mike Startup, Nick Bendit & Carla Walton

Contents

I. Introduction

This Raters' Manual is intended to accompany the Newcastle Adherence Scale for the Conversational Model (NASCoM) which is an adaptation of the Sheffield Psychotherapy Rating Scale (SPRS) (Shapiro & Startup, 1990). The NASCoM adapts 17 items from the SPRS (12 exploratory items, two facilitative items, and three other items used as proscribed items in the NASCoM). The remaining 41 items from the SPRS were not included in the NASCoM. A detailed list of those items included, adapted, or excluded from the SPRS is found at Appendix A. By way of further background, the SPRS was in turn an adaptation of the Collaborative Study Psychotherapy Rating Scale, Form 6 (CSPRS-6) for use in the Second Sheffield Psychotherapy Project (see Shapiro, Barkham, Hardy, Morrison, 1990).

The Manual attempts to explain comprehensively the basis for rating the items in the NASCoM which is found Appendix II. Thus the Manual contains information on every item in the scale. It is essential that the rater be familiar with the material in this Manual before making ratings on the NASCoM.

The Manual begins with General Comments and Instructions to raters which are important in rating the NASCoM. The remainder of the Manual is organised according to Scale item number. Each item contains (where applicable):

(1) The exact wording and format of the item as it appears in the Scale.

(2) A restatement of or elaboration on the item's purpose.

(3) Definitions of terms used in the item.

(4) General guidelines for rating the item.

(5) Examples of therapist behaviour which should and should not be considered in rating the item.

(6) Specific rules for rating the item.

(7) Important distinctions to be made between items.

II. General comments about rating

1. Rating therapist behaviours.

The NASCoM is designed to rate therapist behaviour. In rating the scale items it is important to distinguish the therapist behaviour (as much as possible) from the client behaviour in response to the therapist. This is not possible when rating items 16 and 17, *Warmth* and *Rapport* respectively, in which the client behaviour must be taken into account. For the remaining items, however, the rater should attempt to rate the therapist behaviour, not the client response to that behaviour.

In rating therapist behaviour, the rater should consider what the therapist attempted to do, not whether these attempts met with success or failure. For example, in rating, Item 7, *Facilitating awareness of feelings*, the rater must determine how frequently the therapist facilitated the client's awareness of feelings regardless of whether the client rejected the therapist's attempts to name those feelings.

2. Rating therapist facilitation.

One difficulty that arises in attempting to rate therapist behaviour (which is the goal of the NASCoM) is that sometimes the client initiates a behaviour which is measured in an item. Similarly, in other cases the client may actually engage in a behaviour being measured in an item with limited therapist involvement. An item should not necessarily be excluded in either of these circumstances. In these cases, ratings should reflect the degree to which the therapist facilitates the behaviour being measured. Here, facilitation refers to more than a passive acceptance on the part of the therapist of the client's behaviour. The therapist must actively engage with the client's contribution. For example, in rating the facilitation of metaphor in therapy (Item 11), it is not for the therapist to create the metaphor for the client. The therapist is rated for what he or she does when the client offers symbolic content such as the metaphor.

3. Prerequisite knowledge to rate the NASCoM.

Raters are not required to have special knowledge of the behaviours being measured by the NASCoM in order to rate the items. The NASCoM was specifically designed so that raters with no previous exposure to the Conversational Model could reliably and validly rate therapist behaviours which occur in CM. The *Raters' Manual* has been designed to provide all the background needed in order to rate the items.

Nevertheless, it is important to note that the Conversational Model, unlike other models of therapy such as Cognitive Behaviour Therapy, provides no opportunities for didactic interventions. In fact, it proscribes such interventions. The Conversational Model promotes short therapeutic responses. The reason for parsimony is that one of the therapist's goals include creating a space for the client to explore their inner life such as their feelings and imaginings. It follows that the raters need to be sensitive to any interventions as they are likely to be neither frequent nor wordy.

It also follows that when using the NASCoM, the rater must be careful and conscientious in listening to and rating therapy sessions. It is ideal that each session is transcribed so that the interventions are categorised and substantiated. A transcription of the session should facilitate greater confidence in rating how much of the session involved a particular item. Rating is a complex task and requires the rater to be thoughtful and to exercise good judgment.

4. Rating Extensiveness, not Quality.

The NASCoM is designed to measure the extent to which therapists engages in the behaviours being measured rather than the quality with which those behaviours are performed. Although extensiveness is not totally independent of the quality of therapist behaviour, the rater should not consider the quality of the therapist behaviour per se.

The following scoring system has been developed to assist in assigning ratings to signify the extensiveness of the interventions carried out in session.

Score of 0 occurs when the therapist does not engage in any intervention in relation to a particular item. The score reflects the situation where the intervention is “not at all” present in session.

Score of 1 is for interventions that amount to 5% of the therapist’s interventions in a session. Such a score is likely to be allocated in situations where the therapist occasionally uses an intervention, say one to three times in a session.

Score of 2 reflects some use of interventions that take place more than 5% but less than 10% of the interventions used in the session.

Score of 3 reflects some use of interventions that take place more than 10% but less than 20% of the interventions used in the session.

Score of 4 reflects use of interventions that take place more than 20% but less than 25% of the interventions used in the session.

Score of 5 reflects use of interventions that take place more than 25% but less than 30% of the interventions used in the session.

A score of 6 reflects use of interventions that take place more than 30% of the interventions used in the session.

To summarise

Specific intervention occurred % of all interventions	Rating
Did not occur	0
1-5%	1
6-10%	2
11-20%	3
21-25%	4
26-30%	5
31 or more	6

5. Treatment of interventions that overlap other interventions.

There are a number of interventions that clearly overlap. As mentioned above, process interventions (the “how to”) will take place in conjunction with other interventions. For example, it would be expected that the use of tentative language (item 2) will take place when an explanatory statement (item 10) is offered. In such cases, both items need to be rated. There are also a number of interventions that can be construed in different ways so as to trigger use of a number of items. For example, handling personal disclosure (item12) while addressing the therapeutic client relationship (item 5). In such cases, unless specified otherwise in the particular items, both items can be rated.

6. Avoiding Haloed Ratings.

The NASCoM was designed for the purpose of describing the therapist's behaviour in the session. In order to use it correctly, it is essential that the rater rates what is heard, not what she/he thinks ought to have occurred.

The rater must be sure to apply the same standards for rating an item regardless of:

what types of therapy the rater thinks she/he is rating.

what other behaviours the therapist engaged in during the session.

what ratings were given to other items.

how skilled the rater believes the therapist to be in a particular modality.

how much the rater likes the therapist.

whether the rater thinks the behaviour being rated is a good or a bad thing to do.

Example of rater halo resulting from rater's judgement of therapy modality (‘a’ above):

The rater assumes that the item being rated is meant to measure an aspect of Modality A. This item might be rated higher than it should be as a result of the rater also assuming that the therapist was practising Modality A. Conversely, this item might be rated lower than it should be as a result of the rater assuming that the therapist was not practising Modality A.

Example of rater halo resulting from consideration of other behaviours the therapist engaged in during the session (‘b’ above):

In deciding what rating to assign to an item, the rater might erroneously base her/his ratings on behaviours which are similar to, or which are likely to covary with, the behaviours which are supposed to be considered in rating the item.

Example of rater halo resulting from ratings given to other items (‘c’ above):
In deciding what rating to assign to an item, the rater might erroneously base her/his ratings on ratings given to other items. This is likely to occur when the rater believes that the rating given to another item affects the rating given to the item currently being rated. For example,

Example of rater halo resulting from rater's judgement of the therapist's level of skill (‘d’ above):
The rater assumes the therapist is practising in Modality A. Furthermore, the rater assumes that the item being rated is meant to measure an aspect of Modality A. Based on these assumptions, the item might be rated lower than it should be if the rater judges that the therapist is not skilled in practising Modality A, and higher than it should be if the rater judges the therapist to be skilled in practising Modality A.

Example of rater halo resulting from how much the rater likes the therapist (‘e’ above):

The two facilitative conditions, warmth and rapport, have limited criteria for determining rating. As it seems possible that with such items, positive regard for the therapist could contaminate the ratings, it is important to be mindful of avoiding the halo effect when rating these items.

Example of rater halo resulting from rater's judgment of whether the behaviour is a good or bad thing to do (‘f’ above):

The rater might assign a lower rating to an item than is warranted because he/she thinks the therapist is a good therapist and the behaviour being measured is undesirable. Similarly, the rater might assign a higher rating than is warranted because the rater believes the therapist is a good therapist and the behaviour being rated is desirable.

7. Use of Examples.

For many of the items in this manual, we have given examples of therapeutic exchanges which provide guidelines for how to rate the therapist behaviour as adherent or non-adherent. Examples have been given when, in our experience with training raters, they have proven to be helpful. The examples in this manual are nevertheless only guidelines for how to categorise an item.

Examples in the manual can occur in three different forms:

A list of relevant aspects of the behaviour which should be considered in rating an item.

A synopsis of a therapy exchange which should (or should not) result in a rating.

A dialogue between the therapist and client which should (or should not) result in a rating.

When a dialogue is given in an example, it is italicised and the letter "T" is used to indicate what the therapist said, and "C" is used to indicate what the client said. All

names that appear in these examples are fictitious, as are most of the situations that are depicted.

8. Making Distinctions:

Because the items vary in breadth of coverage, the same therapist behaviours which are rated under one item may also be rated appropriately under another item. Conversely, the rater is sometimes required to make fine distinctions between therapist behaviours which are similar yet should be rated distinctly. For example, in Item 12, *Personal Disclosure*, the rater rates the extent to which the therapist made appropriate use of self-disclosure, while in Item 13, *Limitations*, the rater rates, among other things, the extent to which the therapist addressed limitations such as making it clear to the client the limits to therapy around personal disclosures. Thus in rating these two items the rater must judge whether a disclosure is appropriate or inappropriate. Appropriate disclosures increase the rating on *Disclosure* because they further the shared exploration of what is happening between client and therapist. Refusals to make disclosures could also be rated against *Limitations*. When possible, similar items have been placed near one another to help the rater make such distinctions. The rater should bear in mind the subtle differences between some items, and not use the same exact behaviour to substantiate ratings given to different items unless it is appropriate to do so.

This Manual also contains an "Distinctions" section within the entry for some items. This section contains information regarding how the "target" item is similar and/or

different from other "comparison" items. The "comparison" items contain a cross-reference to refer the rater to a discussion of how that item is similar to or different from the "target" item.

The rater should not infer that the existence of these "Important Distinctions" means they are the only important distinctions that need to be made. All of the items are similar to or different from other items in important ways. Thus the rater should not rely on "Important Distinctions" to point out all of the important similarities or differences which exist.

9. Specific Instances Required for Rating.

In order to rate an item greater than 0, the rater must hear a specific example of the therapist behaviour being rated. The rater should be careful not to rate behaviour as having occurred if she/he thinks it probably occurred but cannot think of a specific example. The starting point for rating each item in the scale is 0. With the exceptions of items relating to warmth and rapport, the rater should assign a rating of greater than 0 only if she/he hears examples of the behaviour specified in the items. In relation to warmth and rapport, it seems more appropriate to have a default around ‘4”. Depending on the level of warmth and rapport shown in session, the rating can be raised or lowered. While there is a default rating, the rater should still be able to justify their rating of these two items.

10. Overlap Between Current Versus Prior Sessions.

Sometimes an issue that was discussed in an earlier session is implicitly or explicitly referred to in the session being rated. Discussions which took place in an earlier session should not be considered in determining a rating given to the current session.

III. Specific comments about items in the NASCoM

1. Receptive listening: Did the therapist appear to allow silence to continue as a means of encouraging the client to talk?

The purpose of this item is to measure the extent to which the therapist uses silence as a means of encouraging the client to talk (or continue talking). This item should be rated greater than '0' only if the rater judges that the therapist used silence for the purpose of encouraging the client to continue talking. Distinct periods of silence on the therapist's part can be counted as interventions and then rated as a percentage based on the total number of interventions rated in the session. Do not rate the therapist's amount of silence relative to the client. Both can be silent much of the time or silent rarely.

Scoring also under warmth or rapport may be appropriate where the therapist appears to be deliberately withholding responses, or providing minimal encouragement, even when the client is clearly uncomfortable with the silence.

2. Tentative style: Did the therapist express his/her views concerning the patient's experiences and circumstances as tentative statements, open to correction, and inviting elaboration and feedback?

This item assesses the 'how' of the therapist's talk. It is concerned with how the therapist conveys his or her response to what the client is saying. A tentative style has the purpose of conveying to the client that the therapist is not an expert on how the client feels, thinks, or acts; rather the therapist offers tentatively a possible understanding of what may be happening for the client. For example, the therapist may preface a statement with the following words, 'This is the way I see it now...but maybe I am wrong.'

Tentative statements may well be definite (i.e. clearly 'owned' by the therapist) and often specific (i.e. referring to particular experiences and making quite detailed comments or observations concerning these). These qualities of definiteness and specificity follow from the therapist doing his or her best to be accurate. However, the therapist rating highly on this item acknowledges that he or she does not know which answers are right for the client. The therapist conveys his or her wish to be corrected, expressing a hope for communication which will lead on to dialogue, with an adjustment of misunderstanding. This wish is expressed in words, constructions and turns of phrase, as well as in the way they are spoken.

The rater should watch for such indicators of tentativeness prefacing a therapist comment such as the following:

'maybe',

'it's almost as if',

'I'm not sure about this, but...',

'I wonder if...',

‘kind of’

’like’.

EXAMPLES

While keeping in mind that the rater needs to take into account the extent that the therapist uses tentative style, the following examples illustrates a response typical of a therapist scoring '0' for a particular therapist statement.

C: I think I've been spending more money lately because I just need to cheer myself up.

T: That shows that you're obviously just going back to being a little girl who needs treats to prove someone loves her.

Questioning of an interrogatory style (such as questions beginning 'why’ would clearly not be considered to be using a tentative style. Such questioning would not score any points under this item. -- See the following two interventions which would not be given a rating under this item.

(a)

T: Why did you do that?

(b)

T: Wasn't that just another way of getting attention?

The following statements are examples of therapist using tentative styles.

(a)

C: I think I've been spending more money lately because I just need to cheer myself up.

T: I'm not sure about this, but maybe, in a way, when you feel miserable and alone, buying things is comforting. It's almost as if you're feeling again like that little girl who needs treats, as if having things for yourself helps you feel comforted, and maybe loved.

(b)

C: That's just it, you see, you don't seem to want me to get over it.

T: You feel that I don't want you to get over it. That feels pretty important to me. Let me try and put into words what may be happening here. It feels to me as if you're disappointed and so maybe a bit angry with me, as if you feel I'm not really with you, not really on your side. Maybe, that when I try to help us look at what's happening when you make such an effort to cheer yourself up, for you it's almost an attack.

3. Language of mutuality: Did the therapist use the language of shared endeavour (avoid the use of “you” and “I” and instead, used impersonal language or “we”)?

This item measures how the therapist conveys his or her participation in the therapeutic conversation. The Conversational Model encourages the therapist to use language in a way that promotes an atmosphere where the therapist and client are looking at the issues together in contrast to a therapeutic atmosphere of the therapist interviewing the client. The use of the impersonal tense or the use of “we” are considered the most important means of creating a language of mutuality as the words “you” and “I” are not used in such circumstances. However, it is important to appreciate that there will be times when it will be preferable to use “you” especially in summary or explanatory statements; otherwise the language of the therapist may sound clumsy. It follows that when the therapist uses “you” this does not occasion a form of discounting of the overall rating.

There are times when the therapist may appear to be simply excising the word “you” from a statement but where the word “you” is fully implied. The rater should treat these situations the same as if “you” were not used.

EXAMPLES

The following example would not contribute to a positive rating under this item. In this example, the therapist has located the problem only within the client:

T: This is a big part of what happens when you try to get close to someone, you both want it and yet, in a way, you fear it too.

The following intervention is an example of using impersonal language.

C: It's always hard for me to get started each time I come. I don't know why, but I just feel awkward talking to you about the kind of thing that came up last week.

T: Yes, it is difficult to discuss those sort of issues.

---

4. Patterns in relationships: Did the therapist draw parallels or point out patterns in two or more of the client's relationships?

The theoretical underpinnings of CM include the understanding that we learn in relationships. We are social beings who cannot learn without another human being. One of the most important types of learning we do is to socialise with other humans. For the person with BPD, there is some appreciation that early social environments provided a person with BPD with learning which is often dysfunctional in adulthood.

If the patterns relate to the client-therapeutic relationship, they need to be scored under item 5. However, if the therapist makes connections with not only the client-therapist relationship but another client relationship, the rater can consider the intervention under this item as well as item five.

EXAMPLES

The following are examples in which the therapist pointed out a pattern in the client's successive relationships (example a) and a parallel between two of the client's current relationships (examples b and c).

Example (a)

T: It seems easy for you, both in this present relationship and in past significant other relationships, to bend to meet the other person's needs and to neglect yourself.

Example (b)

C: I really get angry when my friend starts telling me what to do. Whenever we get together she has advice for me on how I ought to do this or how I ought to do that.

T: That sounds similar to the reaction you have when your boyfriend gives you advice. It might be helpful for us to find out what that's about.

Example (c)

C: I stormed out of the flat after my argument with Joe and did not come back for a long time.

T: This sounds similar to an incident with your mother that we spoke about a few sessions ago.

5. Focus on Client-Therapeutic relationship: Did the therapist address the client's present feelings around the therapeutic relationship or make links with the client's present feelings about the therapeutic relationship with feelings in other contexts and at other times?

This item measures the therapist's exploration of the client's feelings about the therapeutic relationship by making links (a) between events within therapy at different times: perhaps during one interview, perhaps relating what is happening in the present session to what happened in previous sessions; or (b) between patterns in the present therapeutic conversation and those in other areas of life (especially ways in which relationships are defective and distorted). Through use of observed recurrent patterns in the client's experiences and making links with the client-therapist relationship, the therapist helps the client to make sense of experiences by helping the client create greater 'wholes' and thus to counter fragmentation and loss of integration.

Any attempts by the therapist to address what is happening in the client-therapist relationship are also scored under this item as it is implicit that they point to other relationships or the therapeutic relationship in the past or previous sessions respectively.

Examples

The following example is considered an intervention under this item because the therapist made a link between events within therapy in different sessions.

C: So you are going away again.

T: Yes, I recall that it was hard for you when I was away last time.

The next two examples show how the therapist made links between patterns in the therapeutic relationship and those in other areas of life.

C: I stormed out of the flat after my argument with Joe and did not come back for a long time.

T: I am wondering whether there is some concern that this might happen here.

_____

C I really find it difficult when he asks me about my movements over the next few days. He seems to want to tie me down, and that annoys me. I just wish he wouldn't hassle me so much, and just let me decide for myself how to allocate my time.

T: I wonder if you feel I'm trying to tie you down too, when I want to know how you're feeling about things.

The next example is directly concerned with the resolution of misunderstanding in the therapeutic relationship.

C: You're probably right, I shouldn't be so bad tempered with Joe, because he doesn't realise what he's doing.

T: Mhm....It sounds as if you feel I'm finding fault with you for feeling angry with Joe, so you feel criticized or maybe even attacked by me as well as by Joe. That must feel very painful.

C: Yes, well, it did seem that you were telling me off for getting worked up about something minor, somehow.

6. Emotional Attunement: Did the therapist attune to the emotional cues or other words offered by the client by using any of the following three micro-skills: coupling, amplification, and representation?

This item is intended to measure the extent to which the therapist conveys to the client that she/he has an intimate understanding of the client's experiences and feelings and their meaning to the client by using coupling amplification. and/or representation. Each micro skill with examples are set out below.

Coupling

Coupling is a way of attuning to the emotional life of the client by acknowledging the emotional tone used by the client or implicit in the client's story. Coupling is at the heart of this model, and should be frequently used in every session. There are three ways that the therapist can respond to the emotional cues of the client in this item. Firstly, the therapist can respond to the emotional tone of the client's voice, either by using a simple empathic statement/question ("*you sound upset*?"). Secondly, the therapist can make a more complex response to the content of what the patient is saying, but including some attempt to understand the feeling (For example, the therapist may observe a feeling of confusion in the following response, "*It seems like when your mother said that, you just didn't know what to do next*."). Thirdly, the therapist can "couple" by way of picking up affect-laden words or images, and asking for elaboration.

EXAMPLES OF COUPLING

C: I get really fed up with Joe every time he brings up the subject of money. He has no idea how much this annoys me.

T: That must be frustrating. Joe does not have a clue. It is annoying that he does not know you better.

The following is an example of picking up affect-laden words:

C: I just don't know what was happening that day, the whole thing was a horror, and yet nothing was out of the ordinary

T: Horror?

Amplification: Did the therapist offer statements that enlarge or add to the feelings that the client is talking about or experiencing?

Amplification is another micro skill that allows the therapist to tune into what the client may be feeling. It is more than coupling or mirroring the client's feelings. Rather, it offers a space or invitation for the client to more fully experience and talk about their feelings. Amplification enlarges or adds to the feelings that client is talking about or is experiencing.

EXAMPLE OF AMPLIFICATION

C: I get really fed up with Joe every time he brings up the subject of money. He has no idea how much this annoys me.

T: It is infuriating.

Representation

Representation aims to achieve a dialogue between therapist and client with increasing mutual understanding, in which the desire to understand is communicated. This involves more than simple repetition or reflection of the client's message. Representation requires that something more comes from the therapist's own perspective on the experiences reported by the client. Representation is acknowledging feelings, often conflicting feelings, and representing a larger internal picture. It is more than amplification of feelings but a re-presenting of what has been said in a way that extends rather than merely mirroring the client’s feelings.

EXAMPLES OF REPRESENTATION

Example (a)

C: I get really fed up with Joe every time he brings up the subject of money. He has no idea how much this annoys me.

T: You feel really mad with Joe, and maybe it's not just for bringing up the subject of money, but also for not understanding how much he upsets you by doing it.

C: Yes, he's so clueless about how I feel, I suppose I reckon he couldn't care less....

Example (b)

C: I just don't know what was happening that day, the whole thing was a horror, and yet nothing was out of the ordinary

T: Horror?

C: Yet, everyone was going off like firecrackers, my whole family, but it was all strangely familiar.

T: So the weird thing seems to be that there was chaos, but it was normal too?

DISTINCTION

Note that explanatory statements are treated under item 10. The rater will be able to distinguish a representation from explanatory and summary statements on the basis that the purpose of representation is to empathically attune with the client. Explanatory statements are more oriented to providing an explanation about behaviours or feelings. Finally, summary statements often involve a few sentences

which have the purpose of summarising therapy rather than offering empathic understanding or explanation. Summary statements are not rated

7. Facilitate Awareness of Feelings: Did the therapist encourage the client to consider unspoken feelings of which the client may be unaware.

For a therapist to receive a rating against this item there must not be a direct clue as to what the client is feeling. The therapist is rated under this item for their capacity to speculate about the client's feelings. Therapist's speculation may be informed by the emotional tone of the client, non-verbal cues, and feelings engendered in the therapist.

The therapist can facilitate such awareness by identifying verbal and non-verbal cues supplied by the client such as posture, gestures, facial expression, and tone of voice. No doubt there are degrees of explicitness with which a therapist might base his/her facilitation of awareness. Another means of facilitating awareness of feelings is wondering aloud about possible feelings and in so doing help the client to recognise and label emotions that the client is unaware of or the client is aware of but is not expressing.

EXAMPLES

The following two examples of interventions are explicitly cue-based

Example (a)

T: As you tell me about what's been happening at home this week, you're looking like you're ready to cry. It sounds like things are pretty desperate and it is bringing up a lot of sadness.

Example (b)

T: As we talk about this, I've noticed you clenching your fists and blinking your eyes a lot. I wonder whether there is some anger about this.

C: Well, let's see....I suppose I'm feeling angry that she'd do this to me.

T: Your eyes were filling up, with feelings of anger, or maybe...

C: Well, no....I reckon I feel pretty sad, too...I'm angry she'd do this, but sad that it is happening. I suppose I have lots of feelings.

_____

The following three examples show how awareness can be facilitated by wondering aloud about the client's feelings

Example (a)

T: It seems like the story is not important to you. You sound matter of fact when you relate that story to me. But I can't help wondering about your feelings towards your boss about her doing that to you.

C: Now that you mention it, I suppose I am pretty miffed about it. But I was more focussed at the moment on the fact that I didn't get a promotion rather than how I felt about my boss as a result.

Example (b)

C: John said I was wrong to react like I did, but I just couldn't help it, somehow. I just had to tell them that I wasn't in a position to help out yet again, that they'd been taking it for granted that I would, but that it just wasn't possible. It happened again on Tuesday. Bill said that his section were short-staffed, and could I let them have an extra person for the day, despite their already having had extra help the previous day, which is much more than any section would normally ever have in a week.

T: But I wonder what you're feeling, inside, as you tell me about all these demands people are making of you at work.

Example (c)

The therapist may be feeling something which is not obvious to the client. The therapist may tentatively say to the client who is talking about sadness

T. I know you’re pretty upset about this but I wonder whether there is also anger?

Distinctions

Items of coupling, amplification and representation increase the awareness of the client's feelings. However, the primary goal of these items is to convey to the client that the therapist is interested in understanding and/or understands the client's feeling life. Unlike emotional attunement, when the therapist facilitates awareness of feelings, the therapist is more speculative than empathetic. The therapist's interventions in this item are more tentative than coupling, amplification, or representation. It should not be a surprise to the rater that the client may reject the therapist's efforts to bring about awareness. The client's rejection of the therapist's comment about the client's possible rejection does not limit the ratings for this item, rather, such rejections are often a sign that the therapist is attempting to facilitate awareness of feelings rather than intervene with emotional attunement.

When rating this item, the rater needs to distinguish the client's avoidance of affect (see item 8). Addressing avoidance relates to the therapist directly referring to perceived avoidances by the client.

8. Avoidance of Affect: Did the therapist assist the client to address any avoidances experienced by the client?

This item is concerned with the therapist's description to the client of his/her tendencies to avoid painful or problematic thoughts and feelings. Any direct confrontation is not promoted under the CM. Rather, the therapist intervention should merely describe the avoidance for the client so as to facilitate the client to then proceed and process the avoided material. Typically, the therapist's message is not 'No, it isn't as you say but, instead, it is like this and it's time you stopped avoiding facing up to it', but rather, 'Yes, I hear what you say, but there may be more to it as well, and I'd like you to look at that possibility too.'

Note that, as in the second example below, the therapist's efforts to facilitate the client to acknowledge his or her avoidance need not be successful. On the other hand, the client might begin to explore without the therapist needing to direct him/her to do so. This could also be rated under this item providing the therapist can be seen to have facilitated this exploration by the client.

EXAMPLES

Example (a)

C: There's nothing difficult about this situation at all, really, I just don't like being with him, so I keep out of his way. That's all there is to it as far as I'm concerned.

T: Yes, sure, you don't like being with him. But I can't help feeling there's something important here in this not liking being with him.

C: Well, yes, his behaviour is so unreasonable, I just have to keep my distance from him as far as possible.

T: Maybe that makes you comfortable because it protects you from something inside.

C: There's just so much tension, so much pressure when I'm with him, I don't know why.

T: Sort of feeling tense and pressurised, tense inside

Example (b)

T: Your boyfriend moved out for good this week without you expecting it.

C: Yes, I mean I knew we were having some problems but I didn't expect him to just leave and say he wasn't coming back.

T: So I suppose that's affected what you've been doing since he left.

C: Yes, I've been working a lot, putting in extra time to stop me thinking about it because when I do, I start to feel so sad.

T: So, you've been trying to avoid having time to think about it and feel sad about it.

C: Yes, that's what I've been doing. I feel like a nervous wreck, too.

9. Acceptance of affect: Did the therapist encourage the client to accept feelings of which the client is aware but which are painful or uncomfortable?

The purpose of this item is to measure the extent to which the therapist discusses the client's acceptance of feelings which she/he acknowledges experiencing but has difficulty accepting.

EXAMPLES

The following are examples of ways in which the therapist might help the client to accept feelings which are painful or uncomfortable:

The therapist helped the client to understand and feel comfortable about feeling anger toward a loved one who was engaging in behaviours which the client thought were self-defeating. It is important to distinguish acknowledgment of affect from providing reassurance. Providing reassurance is not part of CM.

T: No wonder you feel anger. [It would not be adherent to the CM if the said “It is OK to feel angry.” Such an intervention would be rated on the proscribed item relating to providing reassurance (see item 20)]

The therapist helped the client understand why she/he was experiencing feelings of relief and happiness about the death of a parent who had been a burden to her/him.

T: It makes sense you feel relieved that your father died.

The therapist attempted to help the client to be comfortable with feeling happy in the face of the client's concern that she will be setting herself up for a big "let down" if she does feel happy.

T: It is not surprising you feel confused.

DISTINCTIONS

This item differs from Awareness of Feelings and **AVOIDANCE OF AFFECT** as this item deals with feelings that the client is aware of but does not want to experience, or wishes to reject.

10. Explanatory Statements: Did the therapist introduce explanatory statements which offer possible reasons (which may or may not be 'causes') for the client's behaviour and experiences, particularly in respect of disturbances in relationships within and outside therapy?

It is not expected that explanatory statements will be used frequently in the Conversational Model especially in the early phase of therapy (first 16 weeks). It is desirable that the client should contribute some or all of the explanation themselves, so that client contributions to this are 'credited' to the therapist in making the rating, provided that there is evidence that the therapist has contributed to the client's arrival at the explanation. The rater should include interventions under this item where the therapist summarises what the client has said for the purposes of making explanatory links. Where a summary of the client's issues is provided without making explanatory links, then the rater is not to include them under this item (or any other item for that matter).

EXAMPLES

To aid rating, examples four ways in which therapists may attempt to explain the client's current difficulties are set out below:

(a) Conflicts between various personality tendencies:

T: So although you would really like the security of a relationship and feel compelled by that, you're scared and find yourself running from the possibility of an intimate relationship

_____

(b) Events or motives rooted in the client's past:

T: It seems to me that your indecisiveness regarding the possibility of separating from your wife points at that deeper conflict we've talked about -- the trouble you had earlier in your life around leaving your home and your mother.

T: It seems that an intimate relationship is attractive but bearing in mind your childhood experiences a close relationship seems frightening.

_____

(c) Basic personality tendencies which influence the client's reactions to the therapist (transference):

T: I wonder if you also feel powerless to resist the demands you perceive me making, just as you felt powerless to resist your father’s demands.

_____

(d) Motives or personality tendencies which serve to reduce anxiety or avoid discomfort:

T: It looks like there's a pattern here. Whenever you're in a situation that could potentially result in your being asked out, you either get too sick to stay or you see yourself become very loud and abrasive. It seems like you are terrified of being involved with women.

DISTINCTIONS

It can be difficult to distinguish explanatory statements from representations which form part of emotional attunement. Use of representation is for the purposes of empathic attunement. Explanatory statements are not oriented to empathic attunement. Rather, the use of explanatory statement is for the purpose of providing insight to the client about connections amongst the client's behaviours, feelings, or relationships. A statement should not be construed as an explanatory statement unless it is clear that causal relationships are being made by the therapist or by the client with the help of the therapist.

It is possible that explanatory statements could include a representation. When a statement can be broken down in sentences where one sentence can be attributed to representation and another to an explanatory statement, then each item can be rated separately.

11. Metaphor: Did the therapist encourage and elaborate the client's use of metaphor?

The therapist is rated on occasions when he or she encourages the client to use metaphoric communication, elaborates or builds upon metaphors introduced by the client. The purpose of this intervention is for the therapist to make greater 'wholes' of the client's experience, and to heighten or intensify the client's experiencing and expression of feelings. There is some expectation that the client will not offer metaphors in the early part of therapy. The client's use of metaphor in some way reflects developments in therapy where the client's symbolic content and language develops as therapy unfolds.

The rater should be alert to the possible use of metaphor by the client as an adornment rather than as direct and vivid communication. It may therefore sometimes be appropriate for the therapist not to respond to excessively ornate or elaborate metaphoric communication that possibly is serving a defensive function on the client's part.

The rater should also be alert not to rate use of metaphors simply because metaphors are used. Many metaphors are conventional figures of speech, such as words like "journey or road". Rather, the rater needs to focus on how the therapist works with the client's use of symbolic language.

EXAMPLES

The following examples show the therapist promoting the client's use of metaphor, teasing out and elaborating metaphoric content of which the client may be scarcely aware:

Example (a)

C It seems such a heavy burden of responsibility when I have to chair the meeting on a Friday. It's too much for me to cope with.

T: The weight of that burden feels really overwhelming, maybe to the point where it was crushing.

C: I find it very difficult to carry out the responsibilities of my job. There is very little guidance laid down. I'm all at sea with the work, especially at this time of year.

T: No guidance, all at sea. It seems like you're at the mercy of the waves.

Example (b)

C: There's really not much going on in my life at the moment. It feels like an empty, quiet time.

T: Empty, quiet, a void of stillness, that's a powerful image.

C: I do feel that, a chasm, I suppose, opening up between me and everything or everyone around me.

T: The vastness of the distance between you....

12. Personal disclosure: Did the therapist disclose or respond to client's personal questions about the therapist in way that advanced a shared understanding of events and processes in the therapy?

Appropriate disclosures to clients' questions are those that advance a shared understanding of the client's interpersonal behaviour and experiences. Disclosures that serve the therapist's personal needs rather than those of the client, or disclosures that respond unreflectively to the client's demands or other communications, are not rated at all. An important therapeutic goal when making a personal disclosure is to accept the validity of the client's question yet respond in a way that re-orients the client to what the client is experiencing in the therapeutic relationship.

If the response also addresses limitations in therapy, the response can also be rated under Item 13 (Limitations in therapy). If the response addresses the client-therapist relationship, it can also be rated under item 5 (Linking patterns in the client-therapist relationship).

EXAMPLES

The following disclosure would not be rated under this item because it is an inappropriate response as it responds without reflecting on the client's demands:

C: There's something I've been wanting to ask you. I mean, do you like me?

T But of course I do. You're a very attractive person.

_____

The following example would also not be considered an appropriate disclosure because the therapist refuses to acknowledge his experience in relation to the client:

C: There's something I've been wanting to ask you. I mean, do you like me?

T: I don't think I should answer a question like that.

_____

The following example would be rated under this item.

C: There's something I've been wanting to ask you. I mean, do you like me?

T: You've been wondering about this for some time now, whether or not I really like you. Maybe that tells us something important about what's been happening between us. [Notice no disclosure at this point of the exchange.]

C: Well, it's quite simple really, I just wondered, that's all. I mean, sometimes I think you're just doing your job, and don't seem that interested in me as an individual.

T: So there's something about how I come across to you that makes you feel, in a way, that I don't care for you as a person. [Again, note that there is no personal disclosure.]

C: Mhmm, it seems kind of businesslike and a bit routine.

T: Yes, perhaps my concern, which I do feel, to do things right and not let you down in terms of doing my job as I should, maybe that does come across as distant, or uncaring. [The therapist has to acknowledge his or her feelings when confronted yet use such acknowledgements to stay in tune with what the client may be feeling.]

_____

Sometimes personal disclosure is useful to reduce client anxiety and keep the focus on the therapy. It may be appropriate to answer the client's question directly so that the focus returns to therapy.

C: Do you believe in Jesus?

T: Can you tell me what is worrying you to ask this question?

One way of returning the focus to the client is asking the client how they feel about the answer.

An alternative response:

C: Do you believe in Jesus?

T: answers question and then asks "how do you feel about my answer to your question?"

Distinctions

A number of these examples could also be rated under linking patterns in the therapeutic relationship in situations where the therapist uses the client's requests for personal information to encourage reflection on the therapist-client relationship.

13. Limitations: Did the therapist promote the client's exploration of feelings concerning the limits to therapy, and boundary, loss and internalisation issues related to termination?

This item assesses the extent to which the therapist works to enable the client to deal with issues arising from the necessary limitations of therapy. These include the fixed limits to the number and length of treatment sessions, restrictions on the behaviour of both participants arising from their roles as therapist and client, and imperfections in or limitations to the therapist's ability to understand and help the client. Issues arising from these limits may include difficulties in maintaining boundaries or adhering to 'rules' governing relationships, painful feelings of loss or abandonment, or angry resentment at the therapist's withholding of the 'gifts' of time, personal disclosures, *&c*. Internalisation issues concern the ability or otherwise of the client to retain a positive sense of the therapy or therapist whilst yet acknowledging the limitations to what therapy or the therapist has offered.

EXAMPLES

The following intervention would not receive a score under this item as the therapist mentions to the client he is going on holidays (an example of a limit to therapy) without drawing out the client's reactions to these:

T As you know, this is our last meeting before I'm away on holiday for three weeks.

_____

The following intervention would be rated against this item as the therapist identifies a therapeutic boundary but also validates the client.

C: And another thing I wanted to tell you about today is that my wife and I had a bit of an argument over the children on Tuesday, because she wanted to let them stay out later because it was school holiday time, but I thought it wasn't a good idea.

T: That certainly sounds like something we should talk about in a future session, but I'm afraid there isn't time to do that today as we must finish in a minute or so.

_____

The following example would also be rated under this item as it reminds the client of a boundary (namely, the therapist having holidays) and invites the client to explore how he or she feels about the therapist going on holidays.

T: As you know, this is our last meeting before I'm away on holiday for three weeks. I was wondering what this is like for you, I was wondering whether it may be harder for you to talk about difficult things today.

_____

The following example shows the therapist encouraging far-reaching exploration of a range of feelings in relation to limits, boundaries or termination. Very often, such an exploration addresses ambivalence or mixed feelings.

C I have been wondering, lately, how far I can take this process of standing up for myself at work, and not just going along with other people's expectations of me.

T: Yes, and maybe that's particularly important just now, as we're coming to the end of our meetings.

C: And most of the time I don't like to dwell on the fact that we've nearly finished. OK I do feel different, but there're still lots of situations that I find hard.

T: It sounds like you have mixed feelings about coming to the end of therapy.

_____

In the next example, the therapist makes a worthwhile attempt to establish the boundary between irrelevant or unhelpful disclosures and appropriate sharing of feelings aroused in the therapeutic relationship itself. The rater could also rate under item 12 (*Personal Disclosures*) as the therapist addresses both limitations and personal disclosure.

C: You know, I don't find it easy to keep on telling you all these things about myself, when I know so little about you. It seems so one-sided, and I do wonder how

much it is safe to trust you, when you don't seem to want me to know you at all in any way.

T: It sounds frustrating. You share so much of yourself yet you know so little about me.

C: Yes, you expect me to tell you about very painful and private things, but there's no reciprocation.

T: It may feel safer if I spoke about myself but it would be getting away from you.

_____

There may be occasions to respond to the client and provide some self-disclosure so as to settle the client's anxiety so that the therapeutic work can continue. For example, the therapist could say:

T: Sure, there are lots of things I don't tell you, because I don't think it'd really be helpful to you if I did. But let's look back over what happened earlier today, when you told me about the rows you've been having at home and how pent up and angry you felt. I certainly felt the force of your anger, and tried to put into words how powerful it felt to me, and how I could really feel how frightening that could be for you.

In the above example, the therapist dealt with boundary issues and so should be rated under this item. Depending on the context of this intervention, it may be

appropriate for the rater to rate under item 12 (*Personal disclosure*). The main reason for rating under both items would be when the therapist has spent time both discussing boundaries and responding to client's questions about the therapist. The rater could also have rated under item five as it dealt with the therapeutic relationship.

In the next example, the therapist deals with the client's request for flexibility in the length of treatment sessions.

T: Sure, it's very frustrating when we can't deal with something that's so important to you. I'm wondering if we can talk about it next time.

C: So why can't you let me stay and tell you about it now?

T: I know this is important to you and it would be good to talk about it in next session.

_____

The final example illustrates a failure to acknowledge limitations to the therapeutic relationship, by responding to the client's demands with an inappropriate disclosure that violates the boundary rules. This intervention would not be rated under this item.

C: I know it's half past, but it's really important to me to tell you about this now, while it's fresh in my mind, rather than have to wait until next week. It's not much good if I can't tell you about things when they're happening, is it?

T I wish I could stay to hear about this, but I must leave on time today as I have to take my wife to her hospital appointment, and she'll worry if I'm late.

The therapist would have been rated if he had said:

T: I know that it is really important but we can’t deal with it in a couple of minutes. It is too important. We will need to deal with it next time.

14. *Disjunctions*: Did the therapist address any disjunctions in therapy?

Generally, disjunctions become apparent in the following circumstances:
when the client's response seems muted or the client becomes silent.,
when the client's mood changes quickly,
when the client says something intellectual, or
when the client appears to dissociate.

Disjunctions may be triggered by therapist behaviour such as incorrectly names the client's feelings, or overlooking important information provided by the client, such as the death of a parent. Sometimes disjunctions are only tangentially related to the therapist. Whatever the cause of the disjunction, the therapist needs to address it in a timely manner. It follows that one of the skills in CM is to identify when a disjunction occurs.

EXAMPLES

(a)

C: [Client suddenly becomes silent.]

T: I am wondering what has happened in therapy in the last minute or so. Something has changed. I wonder what is happening.

(b)

T: What went wrong?

C: Kylie, my daughter.

T: Of course, I have forgotten Kylie [who was the client's still born child.]

C: It felt like you punched me.

T: It must have felt hard. I am sorry.

In the next example, the client complains of the therapist's failure to understand what she has been saying, and the therapist makes a constructive effort to deal with it in terms of limitations:

(c)

C: But you don't seem to understand how hard it is for me to work this out with her. You seem to think it's a simple matter of telling her my position. But that's just not possible. I sometimes despair of getting much real sympathy or understanding from you.

T: I am sorry. I can hear that I am not understanding. I have not appreciated the real difficulty of dealing with her.

_____

In the next example, the therapist explores with the client why he has not attended therapy for an extended period of time.

T: When we had our last session was there something I said that freaked you out?

C: Don’t remember

T: I asked you how sex was with your boyfriend. Was there something we talked about that upset you or irritated you?

15. Frame Changes: Did the therapist address frame changes?

It is important that any changes to therapy be addressed. There are many types of frame changes that can take place. Changes can be as significant as the therapist going on holidays resulting in a change in the pace of therapy or the client not attending a session or attending late. However, frame changes can be as small as the client exhibiting a new behaviour such as bringing food and drink into session or asking the therapist to open or close the window. With such changes, the therapist is expected to explore what these changes mean for the client.

One of the main reasons for addressing frame changes is that clients with BPD frequently address difficult issues through actions. By addressing frame changes the therapist is addressing issues that may be taking place between the therapist and client.

A frame change can also be a sign of a disjunction, such as the client failing to attend therapy because of something said by the therapist in the previous session. When the therapist attempts to repair such a disjunction, such an intervention needs to be rated under Disjunctions. If the therapist does not address a potential disjunction, the rater may rate under frame changes. It is also possible for the rater to rate under this item and 'disjunctions' in the event that the therapist firstly checks with the client about a frame change and then mentions a possibility of a disjunction.

EXAMPLE

T: I tried to call you. I left a message when you did not come.

C: I was sick.

T: I rang your home number over a period of time.

C: I was hiding in my room. I was not talking to anyone.

T: So it was not about the therapy.

C: No, I felt frozen. I could not talk to anyone.

16. Warmth: Did the therapist convey warmth?

Warmth, which has been equated with unconditional positive regard, has been defined by Rogers and Truax (1967) as "the therapist communicating to his [sic] client a deep and genuine caring for him [sic]as a person with human potentialities, a caring uncontaminated by evaluations of his [sic] thoughts, feelings, or behaviors". This communication need not be explicit but the therapist's caring should be made evident by her/his behaviour. Raters who have developed their own operational definition of warmth are encouraged to use it only if it is consistent with how warmth is defined above.

The rater must be careful not to assume that the therapist conveys warmth merely because she/he is a therapist. The rater must also remember that she/he is not rating how warm the therapist is in general, but rather how much warmth the therapist conveyed in the session being rated.

The rater should begin at a default of 4 and rate upwards or downwards depending on how much warmth the therapist conveys to the client.

Distinction

The rater should rate Item 16 and Item 17 independently. It is possible for the therapist to be warm and caring and yet not get along with the client. Conversely, it is possible for the therapist to not demonstrate warmth or caring for the client and yet develop strong rapport.

17. Rapport: How much rapport was there between therapist and client (i.e., how well did the therapist and client get along)?

This item is intended to measure the extent to which the relationship between the therapist and client is marked by harmony and accord (i.e., how well the therapist and client got along in the session). Raters who have developed their own operational definition of rapport are encouraged to use it only if it is consistent with how Rapport is defined above.

Among the items in this scale, this item is clearly the most dependent on client behaviour as well as therapist behaviour. Although the rater should assign a low rating to this item if she/he believes that the therapist made efforts to get along with the client without success, this item should not be given a high rating unless rapport clearly existed between the therapist and client.

18. Agenda Setting: To what extent to the therapist set out an agenda for the session?

Agenda setting involves the therapist negotiating with the client on how the session will be organised e.g. negotiating what time will be spent on various topics or interventions. While agenda setting can be a collaborative exercise, it is usually initiated by the therapist. Agenda setting is proscribed in the Conversational Model. Rather, the model aims to encourage the client to find a space in therapy where they can experience and reflect on their life events without being influenced by an agenda.

However, it is appropriate for the therapist practising the CM to undertake agenda setting under three scenarios and therefore should not be rated. Firstly, in the event of a risk of deliberate harm to self or others is raised before or in session it is incumbent on the therapist to address these issues by the end of the session. Secondly, in a situation where there has been a major frame change, such as non-attendance in therapy over a period of time, the therapist will need to devote a part of the session to explore what this means for the client. Thirdly, if the therapist perceives that there is a serious threat to therapy such a disjunction, it is expected that the therapist will address such threats.

EXAMPLES

(a)

T: It seems like it would be important for us to spend some time talking about your family. What do you think about doing some of that today?

(b)

T: What would you like to cover today in session?

Distinction

If the therapist sets out an agenda without any negotiation with the client, then the therapist's behaviour should be rated under item 19 (*Directiveness*).

19. Directiveness: How much did the therapist direct or guide the session in an explicit way?

The purpose of this item is to rate occasions when the therapist explicitly directed the session. The therapist might accomplish this by initiating a significant change in content or shift the focus of the session or by maintaining the focus on topics which she/he wants to discuss.

However, it is appropriate in the Conversational Model for the therapist to be directive under three scenarios and therefore should not be rated under this item. Firstly, in the event that a risk of deliberate harm to self or others is raised before or in session, it is incumbent on the therapist to address these issues by the end of the session. Secondly, in a situation where there has been a major frame change such as non-attendance in therapy over a period of time, the therapist will need to devote a part of the session to explore what this means for the client. Thirdly, if the therapist perceives that there is a serious threat to therapy such as a serious disjunction, it is expected that the therapist will address such threats. In the event of any of the above three scenarios, a therapist should not be allocated any points in relation to interventions in the above three scenarios.

EXAMPLES

The following are examples of explicit guidance by the therapist:

(a)

T: All right. Let’s shift gears now and talk about what has been happening in the past week.

(b)

T: (After discussing how the client was getting along at home and on the job): *What symptoms have you experienced since I last saw you?*

C: In general I have been irritable with my husband and the kids this week.

T: It sounds as if we should discuss what has been going on at home but before we do that, how did the job interview go?

(c)

C: (In the midst of a discussion about a situation at the client's workplace that involved the foreman): Even my buddy at work, Jim, says that the foreman is hard to get along with. But that might be because Jim is missing a lot of work lately. He always wants me to cover for him. I am getting sick of being used by Jim.

T: It sounds like you have some issues about Jim that you might want to talk about. However, before we do that, can we discuss your interactions with the foreman.

Distinctions

Scoring under this item requires identifying when the therapist clearly changes the direction in the session. Generally, asking questions should be rated under item 24 involving gathering information. However, asking questions when it also involves a shift in the direction of therapy are rated under this item as well. It is also possible that some interventions can be rated under agenda setting (item 18) and under this item when the agenda setting appears to be an attempt to change the direction of the session.

20. Providing reassurance: Did the therapist provide reassurance to the client?

This item is not part of the Conversational Model. A high score on this item would suggest that the therapist was not practising the CM. The reason for not using reassurance in the model is that it tends to move the client away from the experiences in session or experiences being described in session. Providing reassurance can close down exploration of feelings.

Examples:

The following would be rated high and therefore poorly against CM adherence.

(a)

C: My parents were furious about me dropping out of University.

T: It was wrong of your parents to get mad with you.

b)

C: I am really a bad person.

T: No, you're not.

(c)

C: I'm really in trouble.

T: No, you’re not actually.

21. Advice giving: Did the therapist provide any advice (including non-psychological and psychological advice) and undertake problem solving?

This item rates the extent to which the therapist provided advice such as recommending the client undertake certain tasks or involve in problem solving. However, therapist interventions relating to suicidal or self-harming behaviour are not rated under this item.

22. Providing psychological techniques: Did the therapist offer psychological techniques to assist the client or suggest various types of practice of techniques between session?

Examples of techniques are use of relaxation exercises, sensitisation and exposure interventions, pleasure scheduling, and thought monitoring.

23. Psychoeducation: Did the therapist provide psychoeducation around various issues affecting the client?

Psychoeducation involves the therapist specifically referring to research or evidence about a psychological phenomenon. For example, the therapist could provide psychoeducation around giving up smoking and say to the client that “research has shown that quitting cigarettes is the hardest of all drugs to give up.” This item involves the therapist providing information about how people in general feel, behave, or respond regardless of whether the information applies specifically to the client.

24. Information gathering: Did the therapist gather information by way of questioning which was not for the purposes of clarification.

Regular questioning of the client is not part of the Conversational Model. However, it is appropriate to ask the occasional question especially if it is to seek clarification from the client (such as a question relating to a gap in the client's story) or relates to emotional aspects of the client's story (such asking the client how he or she is affected by something that the client is describing such as an illness). It is important that appropriate questions relate to the content of what the client is saying especially the emotional content. Any other type of questions about the client's life should be construed as information gathering.

Distinctions

Asking questions around the use of a psychological technique would be rated under providing psychological techniques. For example, asking questions about the content of a diary card or a homework task would be rated under delivery of a psychological technique or homework assignment respectively.

Examples

The following is an example of information gathering.

C: I had a big exam today.

T: What was the exam?

C: It was an English exam.

T: How do you think you went?

The following are two examples of an appropriate question that would not be construed as information gathering followed by an information gathering example.

C: I have been sick with asthma off and on for a long time.

T: How does the asthma affect you?

An information gathering respond could have been:

T: What medication do you take?

25. Homework Assigned or reviewed: Did the therapist or client develop one or more specific assignments for the client to engage in between sessions? Did the therapist review any homework assigned to the client?

The purpose of this item is to measure the extent to which the therapist develops homework or assists the client in developing homework. Homework can be an assignment which the client is to engage in (but not necessarily complete) before the next session. This item also measures the therapist's efforts to review any homework negotiated with the client.

References

Sharpiro, D.A. & Startup, M.J. (1990). *Rater's manual for the Sheffield Psychotherapy Rating Scale*. Memo 1154, MRC/ESRC, Social & Applied Psychology Unit, Department of Psychology, The University of Sheffield S102RN.

Sharpiro, D.A., Barkham, M., Hardy, G.E., & Morrison, L.A. (1990). The second Sheffield psychotherapy project: Rationale, design and preliminary outcome data. *British Journal of Medical Psychology*, *63*, 97-108.

Appendix A: Sheffield Psychotherapy Rating Scale

Table 1: Items (17) which have been included in or adapted to the NASCoM

(The items numbers are references to the SPRS item numbers)

1. Setting and following agenda: Did the therapist work collaboratively with the client to formulate and follow a specific agenda for the session? (Adapted)

2. Homework reviewed: Did the therapist review previously assigned homework with the client? (Adapted)

11. Warmth: Did the therapist convey warmth?

12. Rapport: How much rapport was there between therapist and client (i.e., how well did the therapist and client get along)?

13. Empathy: Was the therapist empathic toward the client (i.e. did she/he convey an intimate understanding of and sensitivity to the client's experiences and feelings)? (adapted)

18. Language of mutuality: Did the therapist use the language of shared endeavour ('I' and 'we')?

29. Patterns in Relationships: Did the therapist draw parallels or point out patterns in two or more of the client's relationships for the purpose of helping the client understand how she/he functions in interpersonal relationships?

30. Cue Basis: Did the therapist explicitly base his/her interventions on cues (verbal and non-verbal) supplied by the client? (Adapted)

31. Metaphor: Did the therapist encourage and elaborate the client's use of metaphor?

32. Focussing: Did the therapist focus on the here and now experience of the client in the session, encouraging the client to stay with feelings before any attempt to 'explain' them? (Adapted)

34. Disclosure: Did the therapist make appropriate use of self-disclosure to advance a shared understanding of events and processes in the therapy? (Adapted)

35. Limitations: Did the therapist promote the client's exploration of feelings concerning the limits to therapy, and boundary, loss and internalisation issues related to termination?

38. Explanatory Hypotheses: Did the therapist introduce possible reasons (which may or may not be 'causes') for the client's behaviour and experiences, particularly in respect of disturbances in relationships within and outside therapy?

51. Exploration Of Feelings: Did the therapist help the client to explore her/his feelings related to an interpersonal relationship? (Adapted)

52. Acknowledgment Of Affect: Did the therapist attempt to help the client to acknowledge affect that she/he was not expressing or of which she/he was unaware? (Adapted)

53. Acceptance Of Affect: Did the therapist encourage the client to accept feelings of which the client is aware but which are painful or uncomfortable?

72. Homework Assigned (Adapted)

Table 2: Items (41) in the SPRS not included in the NASCoM

7. Supportive Encouragement

8. Convey Expertise

9. Therapist's Communication Style

10. Involvement

14. Formality

16. Encourages Independence

17 Negotiating Style: Did the therapist express his/her views concerning the patient's experiences and circumstances as tentative statements, open to correction, and inviting elaboration and feedback?

21. Specific Examples

26. Exploratory Therapy Rationale

27. Relating Interpersonal Change To Therapy

33. Confrontation: Did the therapist confront the client with his/her avoidances by describing them and either directing the client to cease avoiding or facilitating the client's ceasing to avoid?

36. Understanding Hypotheses: Did the therapist offer statements of empathic understanding that brought her/his own perspective to bear in the mutual understanding of the client's experience?

37. Linking Hypotheses: Did the therapist link the client's present feelings with feelings in other contexts and at other times, with the central link being between each of these and the 'here and now' of the therapeutic relationship?

39. Sequencing of interventions

40. Structuring the session

54. Relationship of thoughts and feelings

55. Rationale for cognitive procedures

56. Relate improvement to cognitive change

57. Reporting cognitions

58. Exploring personal meaning

59. Recognizing cognitive excluded

60. Exploring underlying assumptions

61. Distancing of beliefs

62. Examine available evidence

63. Testing beliefs prospectively

64. Searching for alternative explanations

65. Realistic consequences

66. Adaptive/functional value of beliefs

67. Maintaining gains

68. Rationale for behavioural procedures

69. Practicing "rational responses"

70. Planning/practicing alternative behaviors

71. Skills training: did the therapist attempt to teach the client skills (e.g. Assertiveness, social skills, task relevant skills) in the session?

73. Increasing pleasure and mastery excluded

74. Scheduling/structuring activities excluded

75. Self-monitoring excluded

76. Recording thoughts excluded

77. Manipulating behavior via cues or consequences

78. Negotiating therapy content

79. Explanation for therapist's direction

80. Summarizing

Appendix A: The Newcastle Adherence Scale for Conversational Model (NASCoM)

1. Receptive listening: Did the therapist appear to allow silence to continue (or use minimal encouragement such as "okay or ""uh-huh, ") as a means of encouraging the client to talk

0	1	2	3	4	5	6		
not at all		0-5%	6-10%		10-20%	21-25%	26-30%	30%-

2. Tentative style: Did the therapist express his/her views concerning the patient's experiences and circumstances as tentative statements, open to correction, and inviting elaboration and feedback?

0	1	2	3	4	5	6		
not at all		0-5%	6-10%		10-20%	21-25%	26-30%	30%-

3. Language of mutuality

Did the therapist use the language of shared endeavour ('I' and 'we' and the passive tense)?

0	1	2	3	4	5	6

4. Identifying Patterns in relationships: Did the therapist draw parallels or point out patterns in two or more of the client's relationships for the purpose of helping the client understand how she/he functions in interpersonal relationships?

0 1 2 3 4 5 6

5. Focus on Client-Therapeutic relationship: Did the therapist address the client's present feelings around the therapeutic relationship or make links with the client's present feelings about the therapeutic relationship with feelings in other contexts and at other times?

0 1 2 3 4 5 6

6. Emotional Attunement: Did the therapist attune to the emotional cues or other words offered by the client by using either of the following micro-skills: coupling, and amplification?

0 1 2 3 4 5 6

7. Awareness of Feelings: Did the therapist encourage client to consider unspoken feelings of which the client may be unaware or avoiding.

0 1 2 3 4 5 6

not at all 0-5% 6-10% 10-20% 21-25% 26-30% 30%-

8. Avoidance of Affect: Did the therapist assist the client address any avoidances experienced by the client?

0 1 2 3 4 5 6

9. Acceptance of affect: Did the therapist encourage the client to accept feelings of which the client is aware but which are painful or uncomfortable?

0 1 2 3 4 5 6

10. Explanatory Statements: Did the therapist introduce explanatory statements which offer possible reasons for the client's behaviour and experiences

0 1 2 3 4 5 6

11. Metaphor: Did the therapist encourage and elaborate the client's use of metaphor?

0 1 2 3 4 5 6

12. Personal disclosure: Did the therapist disclose or respond to client's personal questions about the therapist in way that advanced a shared understanding of events and processes in the therapy?

0 1 2 3 4 5 6

13. Limitations: Did the therapist promote the client's exploration of feelings concerning the limits to therapy, and boundary, loss and internalisation issues related to termination?

0 1 2 3 4 5 6

14. Disjunctions: Did the therapist address any disjunctions in therapy?

0 1 2 3 4 5 6

not at all 0-5% 6-10% 10-20% 21-25% 26-30% 30%-

15. Frame Changes: Did the therapist address frame changes?

0 1 2 3 4 5 6

16. Warmth: Did the therapist convey warmth?

0 1 2 3 4 5 6

17. Rapport: How much rapport was there between therapist and client (i.e., how well did the therapist and client get along)?

0 1 2 3 4 5 6

18. Agenda Setting: To what extent to the therapist set out an agenda for the session?

0 1 2 3 4 5 6

19. Directiveness: How much did the therapist direct or guide the session in an explicit way?

0 1 2 3 4 5 6

20. Providing reassurance: Did the therapist provide reassurance to the client?

0 1 2 3 4 5 6

21. Advice giving: Did the therapist provide non-psychological advice and undertake problem solving?

0 1 2 3 4 5 6

not at all 0-5% 6-10% 10-20% 21-25% 26-30% 30%-

22. Providing psychological techniques: Did the therapist offer psychological techniques to assist the client or suggest various types of practice of techniques between sessions?

0 1 2 3 4 5 6

not at all 0-5% 6-10% 10-20% 21-25% 26-30% 30%-

23. Psychoeducation: Did the therapist provide psychoeducation around various issues affecting the client?

0 1 2 3 4 5 6

24. Information gathering: Did the therapist gather information by way of questioning which was not for the purposes of clarification.

0 1 2 3 4 5 6

25. Homework assigned: Did the therapist or client develop one or more specific assignments for the client to engage in between sessions?

0 1 2 3 4 5 6