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.

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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.

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CONTENTS

Table of Tables .......................................................................................................... 7

Critical Review ........................................................................................................... 8

Abstract .................................................................................................................. 9

Overview ............................................................................................................... 12

Definition of BPD ............................................................................................... 12

Prevalence rates for BPD .................................................................................. 13

Treatment for BPD ............................................................................................ 13

Treatment Integrity ................................................................................................ 14

Comparative treatments used in this study ........................................................... 17

Overview of treatments ..................................................................................... 17

Dialectical Behaviour Therapy .......................................................................... 17

Conversational Model ....................................................................................... 20

Comparison of DBT and CM ............................................................................. 23

Development of the Newcastle Adherence Scale of the Conversation Model
(NASCoM) ............................................................................................................ 23

Sheffield Psychotherapy Rating Scale .............................................................. 24

Adaptation of the Sheffield Psychotherapy Rating Scale ................................... 24

Factor analysis .................................................................................................. 25

Measuring changes in interventions over the course of therapy ....................... 26

Adherence to CM and the Working alliance ...................................................... 28

Postscript to the critical review .......................................................................... 29
Adherence to CM

Conclusion ........................................................................................................ 50

References for the Draft Journal Article............................................................ 51

Tables for Draft Journal Article ......................................................................... 53

Newcastle Adherence Scale for the Conversational Model (NASCoM) ............ 54

Supplement to draft journal article ..................................................................... 59

Factor analysis .................................................................................................. 59

Reliability .......................................................................................................... 60

Table for Supplement to the Draft Journal Article .......................................... 61

Factor loadings from the structure matrix ....................................................... 62

Appendix 1: Additional Methods and Results section ...................................... 63

Method .............................................................................................................. 63

Participants ...................................................................................................... 63

Process measures ............................................................................................ 63

Statistical analysis ........................................................................................... 65

Results .............................................................................................................. 66

Inter-rater agreement ........................................................................................ 66

Discriminant analysis ......................................................................................... 67

Extensiveness of interventions over the course of therapy and their interaction
with therapist experience ................................................................................... 67

Tables for Appendix to Draft Journal Article ............................................... 70

Framework for sample of sessions rated ......................................................... 71
Psychometric properties of NASCoM items which are prohibited under CM (and acceptable under DBT) ................................................................. 72
Mean and SDs of NASCoM items for CM sessions and DBT sessions .......... 73
Extended Discussion ..................................................................................... 75
Development of the NASCoM .................................................................... 75
Ratings of the NASCoM .............................................................................. 76
Challenges in rating CM items ................................................................. 76
Implications of high ratings on CM items ................................................. 80
Ratings raise questions whether CM is a psychodynamic therapy .......... 81
The lack of unique items in the NASCoM .................................................. 82
Discriminant analysis .................................................................................. 82
Factor analysis ........................................................................................... 84
Measuring adherence in relation to use of interventions ......................... 85
WAI data and adherence .......................................................................... 86
Summary and other limitations ................................................................. 87
References for Extended Discussion ......................................................... 89
Appendix 2: Newcastle Adherence Scale and Manual ................................ 91
TABLE OF TABLES

The following Tables are found in this thesis:

Table 1 of the draft journal article: Newcastle Adherence Scale for the Conversational Model (NASCoM)

Table 2 of the draft journal article: Psychometric properties of items in the NASCoM

Table 1 of supplement to the draft journal article: Factor loadings from the structure matrix

Table 1 of Appendix 1: Framework for sample of sessions rated

Table 2 of Appendix 1: Psychometric properties of NASCoM items which are prohibited under CM (and acceptable under DBT)

Table 3 of Appendix 1: Mean and SDs of NASCoM items for CM sessions and DBT sessions
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
Adherence to 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.