Training
Series
No. 7

Yale Adherence and Competence Scale (YACSII) Guidelines

Second Edition

Yale University Psychotherapy Development Center

Training Series No. 7

Sponsored by NIDA P5O DA 09241

Yale Adherence and Competence Scale (YACSII) Guidelines

Second Edition

Kathryn F. Nuro, Ph.D., Lisa Maccarelli, Ph.D.,
Steve Martino, Ph.D., Samuel A Ball Ph.D
Stuart M. Baker, M.A., C.A.D.C.,
Bruce J. Rounsaville, M.D.
and Kathleen M. Carroll, Ph.D.

Yale University Psychotherapy Development Center Substance Abuse Center
Department of Psychiatry VA CT Healthcare Center (151D) 950 Campbell Avenue
West Haven, CT 06516

Adapted from the following sources:
1) Yale Adherence and Competence Scale (YACS) Guidelines (Joanne Corvino, Kathleen Carroll, Kathryn Nuro, Charla Nich, Rachel Sifry, Tami Frankforter, Sam Ball, Lisa Fenton, and Bruce Rounsaville, unpublished manuscript, 2000); 2) A General System for Evaluating Therapist Adherence and Competence in Psychotherapy Research in the Addictions (Carroll et al., 2000); 3) Independent Tape Rater Guide: Manual for Rating Therapist Adherence and Competence for the NIDA Clinical Trials Network Protocols 4 and 5 (Samuel Ball, Steve Martino, Joanne Corvino, Jon Morgenstern, Kathleen Carroll, unpublished manuscript, 2002); 4) Raters Manual for Matching and Maintenance Treatment Study (L. Fenton, unpublished manuscript 1999); 5) Raters Manual for Cocaine Alcohol Psychotherapy Treatment Study (R.L Sifry, K.M. Carroll, L. Gordon, S. Ball, J. Corvino, R. Bisighini, unpublished manuscript 1995); 6) Rater's Manual for Project Match Tape Rating Scale (H.M. Behr, R.M. Bisighini, K.M. Carroll, R. MacLean, & K.F. Nuro, unpublished manuscript, 1994); and 7) Rater's Manual for the Collaborative Study Psychotherapy Rating Scale (M.D. Evans, J.M. Piasecki, M.R. Kriss, & S.D. Hollon, 1982).

Editor: Joanne Corvino, M.P.H.
Yale University Psychotherapy Development Center

Graphic Designer: Mark Saba, M.A.
Manager, Graphics & Photography
MedMedia Group, Yale University School of Medicine

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Introduction

The Yale University Division of Substance Use Psychotherapy Development Center (funded by NIDA P50 DA 09241) seeks to develop, evaluate and disseminate a range of effective psychotherapies for drug use disorders. The Yale Adherence and Competence Scale (YACS) (Carroll et al., 2000) is a general system for rating therapist adherence and competence in delivering behavioral treatments for substance use disorders. The YACS Guidelines (Corvino et al., 2000) was developed to be utilized in a wide range of studies and to assist in the systematic evaluation of treatment development, delivery and fidelity. The first edition of the YACS included three scales measuring 'general' aspects of drug abuse treatment (Assessment, General Support, Goals of Treatment), as well as three scales measuring critical elements of empirically supported therapies that are frequently evaluated in clinical research in the addictions (Clinical Management, Twelve Step Facilitation, and Cognitive- Behavioral Treatment). All the scales in the YACS were validated using data from randomized clinical trials. Our psychometric analyses suggested that the scales had excellent interrater reliability, factor structure, as well as concurrent and discriminant validity. Correlations between adherence and competence scores within scales were in the moderate range, indicating relative independence (and thus nonredundancy) of these dimensions. For more detailed information describing the background, development and validation of the YACS, please refer to Appendix A.

The Yale Adherence and Competence Scale, second edition (YACSII) encompasses a number of improvements in the items and rating guidelines since the first edition was published in 2000. In addition to more detailed rating guidelines, the second edition also includes new scales for two additional treatments that have been shown to be efficacious in the treatment of drug abuse: Interpersonal Therapy (IPT), and Motivational Interviewing (MI). This edition also includes a group of Supplemental Items. These are items that have been used in various Center studies and have been shown to have adequate interrater reliability and validity. However, psychometric analyses have not suggested they "load" on any particular scale. This may not be the case for other investigators evaluating different treatments or populations, so they are included here in case other investigators find them useful.

In addition, the second edition covers a number of improvements we have made in the training and supervision of independent process raters, technical aspects of conducting ratings of adherence and competence, and some general guidelines for item/scale development. The second edition also has an accompanying videotape that compliments and extends information provided in the manual. The video provides the viewer the opportunity to watch vignettes of two therapy sessions, to determine adherence and competence ratings for those vignettes, and to compare their ratings with those based on a demonstration of a group of 'expert' raters doing a consensus rating of the same two vignettes.

The video is intended to be an aid in the training independent raters in how to use the YACS system. It contains portions of Motivational Interviewing and

Cognitive Behavioral Treatment sessions. It also includes consensus ratings for these treatment vignettes made by expert raters. Thus, when a rater in training finds his/her ratings are different from the consensus on the videotape, s/he can watch the vignettes again for clarification. When used as component of a larger didactic training session with multiple trainees, the trainer can pause or interrupt the video at critical points to facilitate further discussion of an item. The tape rating guidelines, rating scale, and tape rating worksheet for the video are available in Appendices B, C, and D respectively.

The goals of the second edition are to provide:

- Updated and refined items and rating guidelines for 5 comparison treatments and 'general' aspects of drug abuse treatment
- advances made in the training of independent raters of psychotherapy
- basics for developing items/scales for unique treatments and
- videotaped demonstration of the consensual rating process

Note: The taping rating guidelines, tape rating scale, and tape rating worksheet in the Appendix were developed specifically for rating the videotape accompanying this manual. For any study, these forms must be developed to meet the needs of the particular study.

The Basics: Getting Started

Item Generation

Items for the YACS were generated directly from review of session videotapes and from the treatment manuals and are geared to the types of questions that are addressed in many process and treatment fidelity studies, such as "Did the therapists adequately adhere to the treatment manual in this study? Were treatment A and treatment B discriminable? Were interventions associated with the theoretical mechanisms of action in this treatment apparent?" The particular items or scales selected for any process study depend, of course, on the research questions to be addressed. That is, for studies evaluating the discriminabilities, or differences, between two different treatments, it would be important to include items that cover the defining characteristics of the treatments to be compared, as well as items capturing elements the two treatments might be expected to share. In a study assessing treatment fidelity, investigators would select those items that capture adequate delivery of the treatment, as well as items that might capture inappropriate delivery of the treatment or common mistakes.

In general, when generating items to define a given therapy, we follow the recommendations of Waltz and colleagues (1993), by developing items of the following types: 1. Interventions, behaviors, or processes that are unique and essential to each treatment evaluated (an example would be encouragement to find a sponsor in TSF treatment, which is essential in TSF but would not be expected to be found in other approaches). 2. Interventions, behaviors, or processes that are essential to the treatments evaluated but not unique to them (an example would be discussing the patients goals for treatment, which is essential in most treatments but not unique to any of them). 3. Interventions, behaviors, or processes that are acceptable but neither essential nor unique (an example might be the use of therapist self-disclosure within TSF treatment, as this behavior is not prescribed in the treatment manual but often occurs within this treatment approach). 4. Interventions, behaviors, or processes that are proscribed. Examples of proscribed interventions would be those that should not occur in any therapy (e.g., discussion of clearly irrelevant topics), as well as interventions that should be unique to a comparison approach (e.g., providing TSF interventions in a CBT treatment).

Because the YACS is intended to assess therapist adherence and competence in the delivery of the treatment, items are written so as to focus exclusively on therapist, not patient, behavior. Thus, each item is phrased as, "To what extent did the therapist encourage or facilitate....". To increase reliability, items were worded so as to be as specific and concrete as possible and to focus on observable therapist behaviors. For example, "To what extent did the therapist assess the patient's general functioning since the last session" would be preferable to the more general and subjective, "To what extent did the therapist seem concerned about the patient".

Format of the Ratings

All YACS items use a common Likert-type format. For each item, two dimensions are rated: The first dimension, 'Frequency and Extensiveness', is a 'quantity' or 'adherence' rating that taps the degree to which the intervention was present in that session (e.g., whether it occurred and with what intensity). The second dimension, Skill Level, is a 'quality' or 'competence' rating that indicates skill with which the therapist delivered the intervention (and is rated only if the intervention occurred within the session rated).

This quantity/quality rating system has several advantages: First, it recognizes that therapist adherence and competence are not necessarily highly related. That is, a therapist can deliver an intervention exactly as described in the treatment manual but do so ineffectively (e.g., in a wooden manner or at an inappropriate time). Second, older process rating systems like those developed for the NIMH Collaborative Study on the Treatment of Depression (DeRubeis et al., 1982), often required each session to be rated by two types of raters if both adherence and competence evaluations were needed. That is, because is was necessary for the evaluation of discriminability that independent raters who were 'blind' to treatment assignment evaluated therapist adherence, the 'blind' raters would then be unable to assess therapist competence (because global ratings of competence require knowledge of the treatment condition. Therefore, additional ratings by treatment 'experts' who were familiar with the treatment manual were needed to provide ratings of therapist competence. The YACS saves time and the expense of a second set of ratings by having each item scored for both adherence (how much it occurred in a session) and competence (how skillfully the therapist delivered it). Thus, the need for global ratings of therapist competence is eliminated. This approach has been used successfully by other investigators (Barber, Mercer, Krakauer, & Calvo, 1996; Barber, Krakauer, Calvo, Badgio, & Faude, 1997); however, evaluations of those scales have indicated that correlations between adherence and competence ratings have been quite high, calling into question the need for the two types of ratings for those scales.

Rater Selection and Training

Because of the complexity of the rating task, it is important that raters be experienced clinicians themselves (Moras & Hill, 1991). Process raters for the YACSII were predominantly masters-level clinicians who have experience in treating substance users and who often have experience in one or more of the study treatments evaluated in the YACSII (e.g., CBT, TSF, CM, IPT, or MI). Procedures for rater training largely parallel those used to train therapists for psychotherapy outcome studies (Carroll, Kadden et al., 1994; Carroll & Nuro, 1997). First, rater trainees attend a didactic seminar which includes detailed review of the rating manual as well as several group practice ratings using taped examples. To see an example of an Agenda for this type of seminar see Appendix E. Second, rater trainees rate at least 10 practice tapes, which are evaluated with respect to 'expert' consensus ratings of those tapes. Raters are 'certified' only after their ratings achieve acceptable reliability with respect to the consensus ratings. Rater recalibration sessions are held regularly to monitor and prevent rater drift. Reliability is formally evaluated several times while the rating task is ongoing. This is done using a small set of session tapes that are each rated by each of the raters, and where the raters are unaware of which tapes are used to calculate interrater reliability.

YACSII
General Guidelines for Rating Videotaped Therapy Sessions

The following general guidelines are designed to foster a consistent and reliable approach to performing independent ratings of the psychotherapy process. Following these general guidelines are the 2 general item scales, the 5 treatment scales, and the group of supplemental items. For each item there are detailed descriptions, examples of the item, and guidelines for making lower versus higher ratings for Frequency and Extensiveness and Skill Level.

1. Rate Observable Therapist Behaviors

Items refer to therapist's behaviors, not the patient's behavior or the patient's responses. In rating therapist behaviors, the rater should consider what the therapist actually attempted to do, not whether those attempts were met with success or failure. Raters should only rate an item if the occurrence of it was **explicit**, not merely implied. Raters should have specific examples in mind to substantiate their ratings and consider the entire session when rating an item. Because raters must make fine distinctions among therapist behaviors, it is essential that the rater listen to the session carefully and without distraction.

2. Rate Therapist Facilitation

Ratings should reflect the degree to which the therapist facilitated the behavior being measured, even if the therapist had only limited involvement. Facilitation means **any** therapist effort to verbally encourage or prompt the patient in a specific activity, rather than merely acting as a passive recipient of the patient's initiated behavior. Raters should rate all of the therapist's efforts to facilitate the session. Instances of therapist facilitation that do not fit into any of the rating item categories should be rare.

3. Avoid Haloed Ratings

An adherence/competence rating scale is designed for the purpose of describing the therapist's behavior in the session. In order to use such a scale correctly, the rater must rate **what actually occurred**, and not what ought to have occurred from the rater's perspective. Therefore, the rater must be sure to apply the same standards for rating an item regardless of:

(1) the type of therapy the rater thinks he/she is rating
(2) other behaviors the therapist engaged in during the session
(3) ratings given to other items
(4) how skilled the rater believes the therapist to be
(5) how much the rater likes/dislikes the therapist
(6) ratings given to the same therapist on other tapes

4. Rate Each Therapist Behavior on All Applicable Item

A therapist's statement or question may be relevant to several items. Because items may overlap in terms of breadth of coverage, the same therapist behavior that is appropriately rated on one item may also apply to another item. Raters should carefully consider what they have observed and code their observation on **all items that apply.** For example, a therapist may ask a patient at the beginning of a session, "What are the substance abuse issues that caused you to come here?" This question is open-ended (MI item), and is related to the problems for which the patient entered treatment (Assessment item). Raters should rate this one occurrence on both items.

5. Use the Rater's Guide During Each Rating

To prevent rater drift, it is strongly recommended that all raters regularly review the Rater's Guide when rating a session. A Rater's Guide provides definitions, guidelines, and specific examples to promote accurate rating. Because of the complexity of the scale items, it is essential that the raters are completely familiar with the item definitions before rating them. The raters should be careful to rate each item distinctly (i.e., consider the extent to which the behavior specified in that item occurred without simultaneous consideration of other similar items). If raters are uncertain about how to rate what the therapist has said, the raters should stop the tape and reference the Rater's Guide to isolate the best-matched item descriptors. Throughout this process raters must exercise their judgment to clarify subtle differences between items and to make conclusions about final ratings.

6. Review the Entire Session, Tally Therapist Behaviors (system reviewed pages 7–9), and Take Notes Before Making A Rating

Raters must listen to the entire session before making final ratings. As they listen to the session, raters should make hash marks to indicate when an item has occurred. In addition, it is recommended that raters take notes while listening to the session. Raters should record all of this information on the Tape Rating Worksheet. There is an example of a Tape Rating Worksheet in Appendix C. The worksheet also includes page numbers that coincide with the manual for each item, which makes it more efficient for the rater to refer to the manual during the rating process. Tallying and note taking enhance the accuracy of the ratings because they keep the raters focused on what actually occurred in the session and provide raters with information critical for making final ratings on all the items. In particular, narrative note taking greatly helps raters make Skill Level ratings.

7. Rate Every Item by Circling Whole Numbers

This scale is designed so that every item is rated for every therapy session. Do not leave any item blank. Although raters may be tempted to give a score between whole numbers (e.g. 4.5) only whole numbers are acceptable scores. Thus, please CIRCLE only whole numbers for each variable.

8. Protect Confidentiality

All tapes and rating scores are confidential material. Raters must listen to tapes and rate sessions in a place where colleagues, family members and friends cannot hear the sessions. Raters should handle tapes like private medical records and not leave tapes or rating material unattended. Raters should not discuss the content of sessions with anyone other than project staff. There should never be any identifying information labeled on the tape itself can destroy this tape when it is returned.

9. RATING FREQUENCY AND EXTENSIVENESS VS RATING SKILL LEVEL

For all items, raters must distinguish between (1) Frequency and Extensiveness, and (2) Skill Level of therapists' behaviors. Frequency and Extensiveness is defined as the amount of time and attention devoted by the therapist to a particular technical or stylistic intervention. This rating blends together both the Frequency (i.e., the number of discrete times the therapist engages in the intervention) and Extensiveness (i.e., the depth or detail with which the therapist covers any given intervention). These separate but related constructs inform each rating interactively. In other words, the highest ratings involve therapist behaviors that are both high on frequency and extensiveness, whereas middle range scores may reflect behaviors that were done less frequently or with less depth. The specific system for coding the tape for Frequency and Extensiveness is described below.

Note: The number of levels or alternatives for each item in a scale has an important bearing on reliability where the optimum number appears to be seven (Finn, 1972).

Frequency and Extensiveness:

All raters must use the following definitions to make their final Frequency and Extensiveness ratings for each item.

Rating of:

1 = Not at all	The variable never explicitly occurred.
2 = A little	The variable occurred once and was not addressed in any depth.
3 = Infrequently	The variable occurred twice, but was not addressed in depth or detail.
4 = Somewhat	The variable occurred one time and in some detail OR the variable occurred 3-4 times, but all interventions were very brief.
5 = Quite a bit	The variable occurred more than once in the session, and at least once in some detail or depth OR the variable occurred 5-6 times, but all interventions were very brief.
6 = Considerably	The variable occurred several times during the session and almost always with relative depth and detail OR the variable occurred more than 6 times, but all interventions were very brief.
7 = Extensively	The variable occurred many times almost to the point of dominating the session and was addressed in elaborate depth and detail OR the variable occurred briefly at such a high frequency that it became difficult to count.

For the Frequency and Extensiveness ratings, the starting point for rating each item in the scale is "1". The rater should assign a rating of greater than "1" only if he/she hears examples of the behavior specified in the items. The rater must be able to substantiate with examples the rating assigned to every item. This guide provides many examples of therapist behaviors that would "count" or endorse each item.

To acquire accurate counts, all raters should use a hash or tally mark system while reviewing the tape. Using the Tape Rating Worksheet (Appendix D), raters should make a hash mark next to the item when it occurs. If the item occurs more than once then there should be corresponding hash marks (i.e., item mentioned 3 times would look like this: (/ / /). If an item occurs in detail, the hash mark(s) can be circled to help raters make a final rating determination (i.e., at the end of listening to the entire session) that includes consideration of the depth or extensiveness of therapeutic interventions.

***Note*:** The raters should rate all instances of an item's occurrence. In some cases, an item will have a very large number of un-circled hash marks that indicate a high frequency of brief interventions. Sometimes, no or very few instances may have occurred. In other cases, interventions may have been delivered in detail (Appendix D) or an extensive fashion. In the end, the rater must convert his/her tallies from the Tape Rating Worksheet into final ratings on the Tape Rating Scale (Appendix C). The hash mark system should capture the rater's overall best judgment of the therapist's style and technique used during the session.

For example, corresponding rating notations might look like this:

1 ***(Not at all)*** = **(no hash marks)**
The variable never explicitly occurred

2 (*A little)* = one hash mark, uncircled **(/)**
The variable occurred once and was not addressed in any depth.

3 (*Infrequently)* = two hash marks, uncircled **(//)**
The variable occurred more than once, but was not addressed in in depth or detail

4 (*Somewhat)* = one circled hash mark, or 3-4 uncircled hash marks (Ø)
The variable occurred one time and in some detail OR the variable occurred 3-4 times, but all interventions were very brief. **(/ / /)**

5 (*Quite a bit)* = two or three hash marks, at least one circled, or 5-6 hash marks (Ø / /)
The variable occurred more than once in the session, and at least once in some detail or depth OR the variable occurred 5-6 times, but all interventions were very brief **(/ / / / /)**

6 (*Considerably*) = more than three hash marks, several circled, (Ø/ /Ø/Ø)
or, 6 or more hash marks uncircled. **(/ / / / / /)**
The variable occurred several times during the session and almost always with relative depth and detail OR the variable occurred more than 6 times, once in some detail or depth OR the variable occurred 5-6 times, but all interventions were very brief.

7 (*Extensively*) = more than five hash marks, almost all circled,
or, numerous uncircled hash marks. **(Ø Ø Ø Ø / Ø Ø)**
The variable dominated the session, occurred many times, and was addressed in elaborate depth and detail OR the variable occurred briefly at such a high frequency that it became difficult to count. **(/ / / / / / / / / / / / / / / / / /)**

Skill Level:

Skill Level refers to the therapist's demonstration of:

- expertise, competence and commitment
- appropriate timing of intervention
- clarity of language
- responding to where the patient appears to be

All raters must use the following definitions to make their final Skill Level ratings for each item:

Rating of:

9 = Not at all	The variable was not observed (i.e., rated "1" for Frequency and Extensiveness).
1 = Very poor	The therapist handled this in an unacceptable, even 'toxic' manner.
2 = Poor	The therapist handled this poorly (e.g., showing clear lack of expertise, understanding, competence, or commitment, inappropriate timing, unclear language).
3 = Acceptable	The therapist handled this in an acceptable, but less than 'average' manner.
4 = Adequate	The therapist handled this in a manner characteristic of an 'average', 'good enough' therapist.
5 = Good	The therapist handled this in a manner slightly better than 'average.'
6 = Very good	The therapist demonstrated skill and expertise in handling this issue.
7 = Excellent	The therapist demonstrated a high level of excellence and mastery in this area.

When rating Skill Level, the starting point for rating each item should be "4." That is, raters should begin by assuming that a therapist will behave adequately or at an average level. Raters assigning scale scores above or below a "4," should have examples or notations in mind to support their scores. To help raters with this task, the Guide provides Skill Level Rating Guidelines that describe how a specific strategy is of higher or lower quality than an "adequate" rating of 4.

A useful method for recording Skill Level ratings while listening to a session is to combine them with the hash mark system. When a strategy occurs with adequate skill, the rater records a simple hash mark without a notation about quality (/). The absence of a notation always connotes adequate skill level. If a strategy occurs with more or less than adequate skill, the rater records a hash mark with a superscripted number that corresponds to the specific Skill Level rating. For example, a strategy implemented with poor skill would look like $/^{2}$. A strategy implemented with very good skill would look like $/^{6}$. The raters also may include a few narrative examples of higher or lower quality strategies on the worksheet. In this manner, the raters can organize the data efficiently and more easily cull and average the varying Skill Level ratings to determine and justify the final competency ratings for each item.

***Note*:** Although there may be significant overlap between the Skill Level and its effectiveness (implied by the patient's verbal response), Skill Level is not the same as effectiveness in that it does not require the patient's positive response. A therapist may score highly on Skill Level for a particular item regardless of the patient's response. Of equal importance, Skill Level must be distinguished from Frequency and Extensiveness. For example, a therapist's score of "6" on Frequency and Extensiveness for a particular item does not necessarily mean the Skill Level was high. Raters should rate Skill Level independent of Frequency and Extensiveness. Thus, it is perfectly appropriate for a rater to give a rating of "3" on Skill Level even if the Frequency and Extensiveness rating is a "6."

Assessment Items Guidelines (5 Items)

NOTE: The phrase *"drug of choice"* or *"drug"* appearing in italics is study specific. These items can be changed to reflect the relevant substance in any particular study.

Example: In Use of Other Substances, the substance relevant to the study population (e.g., cocaine, heroin, marijuana, etc.) can be substituted for drug of choice.

ASSESSMENT OF TARGETED/PRIMARY DRUG USE (cocaine/heroin/marijuana, etc.): To what extent did the therapist assess the patient's use of primary drug since the last session, including the pattern of substance use (if any)?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent which the therapist evaluated the patient's pattern of primary drug use since the last session.

A higher rating would be achieved if the therapist spends most of the session exploring the patient's use of 'primary drug' on a day by day basis since the last session, including specific amounts and patterns of use. A lower rating would be achieved if the therapist simply asked if the patient used primary substance since the last session.

Examples:

T: "Have you used any 'primary drug' since we last met?" I would like to hear about what led to the use and how you reacted."

T: "Let's go through each day and look at when you used, how much you used, and what kinds of events, thoughts and feelings may have contributed to your using."

Skill Level Rating Guidelines:

Higher: A therapist conducts a higher quality assessment of the use of primary substances by asking about day to day consumption, method of use, and carefully identifies what caused the patient to use. In addition, the therapist assesses the extent of the use, encouraging his/her full disclosure. In cases where the patient denied use, the therapist follows up adequately so that there is reasonable certainty that use did not occur. The therapist's stance is supportive and non-judgemental, which encourages the patient to feel comfortable and speak freely.

Lower: Lower skill level ratings occur when the therapist asks about 'primary drug' in a non-specific manner and does not follow-up the initial inquiry with more detailed questions. Low skill scores should be given in cases where the clinician does not use a supportive, non-judgemental approach, cuts off discussion, or is critical of the patient.

USE OF OTHER SUBSTANCES: To what extent did the therapist assess the patient's use of substances other than *drug of choice* (e.g., drugs, cigarettes, caffeine) since the last session, and relate the use of these substances to *drug of choice* use?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist explored the patient's attitudes or beliefs regarding the use of other substances in the context of his/her attempt to become abstinent from *drug of choice*. This may be scored only if the therapist explicitly asks about drugs other than *drug of choice* or if the therapist asks about the use of "anything else" only after having inquired about *drug of choice* usage.

This item would receive a lower rating if the therapist asks about other drug use without relating it to *drug of choice* use. It would receive a higher rating if the therapist makes the connection between *drug of choice* use and other drug use, especially when the patient increases the use of other drugs once he/she is abstinent from *drug of choice*, and nearly the entire session is devoted to the assessment of the use of other substances.

Examples:

T: "Since you have been abstinent from *drug of choice* this week, how is it going with the marijuana? Have you used any more/less than usual since our last session?

T: (After having asked about *drug of choice* use) "Have you used anything else?"

Skill Level Rating Guidelines:

Higher: A higher quality assessment includes the therapist asking a thorough series of questions about the use of drugs other that the patient's drug of choice. This includes relating other substance use to abstinence from *drug of choice* and/or non-use of other substances to abstinence from the drug of choice.

Lower: Less skilled assessment would involve merely asking about other drug use, without connecting this to the use of the patient's drug of choice, or without exploring the individualized patterns of use for the individual, his or her reactions to the episode of use, antecedents or consequences of substance use, etc.

ASSESSMENT OF ALCOHOL USE: To what extent did the therapist assess the patient's drinking since the last session, including the pattern of alcohol use (if any)?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent which the therapist evaluated the patient's pattern of alcohol consumption since the last session.

This item would receive a '0' rating if the therapist asks the patient how they are doing with no specific mention of alcohol. A higher rating would be achieved if the therapist explores the patient's consumption of alcohol on a day by day basis since the last session, with thoroughness comparable to assessment of the patient's drug of choice. In studies where drug abuse is being targeted, this item refers specifically to alcohol use as distinguished from illicit drug use. Some studies may find it useful to include other behaviors of interest as well (eg., smoking).

Examples:

T: "Have you had anything to drink since we last met?"

T: "Let's go through each day and look at when you drank, how much you drank, and what kinds of events, thoughts, and feelings contributed to your drinking.

Skill Level Guidelines:

Higher: A therapist conducts a higher quality assessment of alcohol use by asking about day to day consumption, as well as carefully analyzing and identifying what caused the patient to drink. In addition, the therapist assesses the extent of the patient's drinking, encouraging his/her full disclosure.

Lower: Lower level ratings occur when the therapist asks about alcohol in a non-specific manner and does not follow-up the initial inquiry with more detailed questions.

PSYCHOPATHOLOGY: To what extent did the therapist explicitly focus on the patient's psychopathology (e.g., symptoms of depressive, anxiety, psychotic disorders)?

Frequency and Extensiveness Rating Guidelines:

This item is intended to tap the extent to which the therapist focused specifically on psychiatric symptoms or problems of the patient or his/her past and current treatment for a psychiatric disorder. This discussion would typically include symptoms of mood, anxiety, personality, eating, or psychotic disorders. The discussion of emotional, cognitive, interpersonal, perceptual, behavioral, self-image, or somatic symptoms must be tied to a potentially separate psychiatric condition to be rated on this item. This distinction may be subtle for those disorders that are common in substance abusers. For example, discussion of anhedonia and negative mood during cocaine abstinence, sleep disturbance following opiate withdrawal, weight loss during methamphetamine use, or a suicide gesture during an alcohol blackout would be rated on one of the substance use items rather than on this item as a discussion of the symptoms of depression. If in the context of this discussion, however, the therapist explicitly points out that these substance-related symptoms resemble depression and inquiries into possible depressive episodes, then this item would be rated.

The easiest items to rate will be when the therapist either reviews a psychiatric symptom measure, inquiries into prior mental health treatments, effects or side effects of psychiatric medications, or specifically asks for an update on the status of a psychiatric disorder ("How has your depression been since we last met? Did you decide whether you wanted me to schedule an evaluation with the doctor for an antidepressant?").

Higher ratings would be given for a thorough discussion of a psychiatric disorder in which the therapist queries or discusses most or many of the patient's symptoms. Similarly, a detailed careful query into whether a disorder is secondary to a substance abuse disorder or a primary, independently co-occurring disorder should be given a high rating. A *moderate rating* might include a more general question about a disorder or its prior treatment. A *lower score* might involve a more cursory status inquiry without any further follow-up questions or facilitated discussion ("Have you had any panic attacks in the prior 30 days?" "So it sounds like the voices have started bothering you again since we last met." "Did your parents ever try to get you into treatment for your eating disorder?").

Examples:

T: "I want to become clearer on the symptoms of depression you have been experiencing. I am going to mention common problems associated with depression. Tell me if any of these symptoms have been a problem for you. Difficulty falling asleep? Decreased energy? …..

T: "You say you have been having intense feelings of anxiety for several years. When did your problems of anxiety begin? Were they present before you started to use cocaine?"

Skill Level Rating Guidelines:

Higher: Initial therapist efforts to assess psychopathology typically are straightforward and "adequate" in quality (e.g., "Have you ever experienced psychiatric difficulties? How depressed have you been feeling?"). Higher Skill Level ratings for psychopathology occur when the therapist asks a series of logically related, clear and concise questions to assess in depth primary psychiatric symptoms and potential disorders. Use of specific psychiatric measures and review of them with the patient also may increase Skill Level ratings. Likewise, the therapist's formal efforts to assess a patient's mental status may improve the quality of the intervention. Additionally, careful efforts to address issues of comorbidity with substance use disorders receive higher ratings. Finally, higher ratings are given when the therapist carefully examines the patient's psychiatric treatment history and the treatments' effectiveness in reducing psychiatric symptoms and improving the patient's functioning.

Lower: Lower Skill Level ratings occur when the therapist approaches the assessment of a patient's psychopathology in a haphazard manner without sufficiently delving into symptom pictures common to particular psychiatric disorders or behavioral problem areas. Therapists also may ask questions about psychopathology in overly complex ways (e.g., compound questions about symptoms) or use jargon or technical terminology that is unfamiliar to the patient.

Note: *If the therapist is following a structured questionnaire assessing symptoms or problems, and therefore, reviews a large quantity of potential symptoms, the rating could go up to a 5. For a rating above 5, the therapist discusses potential symptoms in an expanded and in depth manner.*

ASSESSMENT OF GENERAL FUNCTIONING: To what extent did the therapist assess the patient's general level of functioning in major life spheres (e.g., work, intimate relationships, family life, social life everyday stress, etc.)?

Frequency and Extensiveness Rating Guidelines:

This item measures the extent that the therapist assessed the patient's functioning in each of the major aspects of the patient's life (e.g., intimate relationships, family matters, friendships, other social relationships, and vocational pursuits).

Rating of:

1 Therapist makes no mention or inquiry of areas of major life spheres.

2 Therapist may mention major life sphere(s) but only inquires very superficially.

3 Therapist inquires about one major life sphere in a somewhat superficial manner.

4 Therapist inquires about one major life sphere in a very in depth manner (i.e. with a lot of exploration).

5 Therapist inquires about two or more life spheres in a somewhat in depth manner (i.e. with some exploration).

6 Therapist inquires about two or more life spheres in an in depth manner.

7 Therapist inquires about more than two major life sphere in an expanded and in depth manner.

This enhances accuracy of the ratings because raters will be reminded of information that is relevant to rating the items, and keeps the rater focused on what actually occurred in the session. Because raters are asked to make fine distinctions, it is essential that the rater watch the session carefully and without distraction.

Examples:

T: "Tell me about your job. How long have you been in your current position and what would be your next step in the company?

T: "You mentioned that you work the night shift on your job. What is working all night like since your wife and children are on a completely different schedule? Sometimes that can be stressful."

Skill Level Rating Guidelines:

Higher: A skilled therapist would fully explore the sphere(s) of the patient's life and connecting them to sum up the quality of the patient's life based on what is disclosed by the patient. This can facilitate the patient's recognizing in what aspects of his/her life there are problems and where things are going all right. When there is a particular area of compromised functioning (e.g., relationship with significant other), the therapist would examine that thoroughly and relate it back to the patient's overall level of functioning.

Lower: A less skilled therapist might inquire about different life sphere(s) without asking any follow-up questions, and without relating the different sphere(s) to the patient's overall functioning.

Assessment Items

(5 Items)

NOTE: The phrase "*drug of choice*" or "*drug*" appearing in italics is study specific. These items can be changed to reflect the relevant substance in any particular study.

Example: In Use of Other Substances, the substance relevant to the study population (e.g., cocaine, heroin, marijuana, etc.) can be substituted for *drug of choice.*

ASSESSMENT OF TARGETED/PRIMARY DRUG USE
(cocaine/heroin/marijuana, etc.): To what extent did the therapist assess the patient's use of 'primary drug' since the last session, including the pattern of substance use (if any)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

USE OF OTHER SUBSTANCES: To what extent did the therapist assess the patient's use of substances other than *drug of choice* (e.g., drugs, cigarettes, caffeine) since the last session and relate the use of these substances to *drug of choice* use?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

ASSESSMENT OF ALCOHOL USE: To what extent did the therapist assess the patient's drinking since the last session, including the pattern of alcohol use (if any)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

PSYCHOPATHOLOGY: To what extent did the therapist explicitly focus on the patient's psychopathology (i.e. symptoms of depressive, anxiety, psychotic disorders)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

ASSESSMENT OF GENERAL FUNCTIONING: To what extent did the therapist assess the patient's general level of functioning in major life spheres (e.g., work, intimate relationships, family life, social life, everyday stress, etc.)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

General Support Items Guidelines (4 Items)

NOTE: The phrase "*drug of choice*" or "*drug*" appearing in italics is study specific. These items can be changed to reflect the relevant substance in any particular study.

Example: In Exploration of Feelings, the substance relevant to the particular study population (e.g., cocaine, heroin, marijuana, etc.) can be substituted for *drug*.

GENERAL PRAISE FOR PATIENT'S PAST EFFORTS THAT DO NOT INCLUDE ROLE OF MEDICATION: To what extent did the therapist compliment and/or praise a past patient effort that did not include the role of *medication*?

Frequency and Extensiveness Rating Guidelines:

By complimenting and cheering the patient on, the therapist fosters the belief that patient efforts that do not include medication have enhanced their recovery. A higher rating would be achieved when the therapist consistently, throughout the session, praises the patient for his/her efforts in treatment. A lower rating would be achieved when the therapist uses praise sparingly and inconsistently.

Examples:

T: "Your decision/choice/level of motivation... has helped you stay clean and sober."

P: "I tried to stay away from people, places, and things that could lead me to get high."

T: "Great!"

Skill Level Rating Guidelines:

Higher: A skilled therapist will consistently take opportunities to praise the patient for their efforts in areas of their life that contribute to their recovery. In addition, the therapist's genuine appreciation for the patient's commitment to making changes in their lives to enhance their recovery, helps the patient see that there are changes they can make in an active way that compliment, yet are different from the possible benefits of medication.

Lower: A less skilled therapist will be less enthusiastic about the patient's efforts in various areas of their lives, beyond medication compliance, that enhance recovery.

EXPLORATION OF FEELINGS: To what extent did the therapist help the patient to explore his/her feelings related to current symptoms OR clarify affect states as related to *drug* use or other target problems?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist facilitated discussion that clarified the patients feeling state (e.g., attempting to help the patient put his feelings into words or discriminate affects associated with drug effects from other affect states). This may include clarification or exploration of feelings in an interpersonal situation.

This item would receive a lower rating if the therapist helps the patient label his/her feelings, but does not explore them any further. To be rated higher, the therapist needs to thoroughly explore the relationship between feelings, behavior and drug use and distinguish between feelings that are drug effects versus other affect states.

Examples:

T: "It sounds like the situation at work made you angry and after work you went out and had a few beers. I wonder what the connection is between anger and alcohol for you."

T: "You mentioned that you got mad at your wife for something that wouldn't have bothered you at all if you hadn't been drinking. So, alcohol seems to make you react to situations with more intensity with a shorter fuse.

Skill Level Rating Guidelines:

Higher: A skilled therapist will help the patient identify his/her feelings as they relate to current symptoms, target problems and distinguish them from affect states that are related to drug use. The therapist will ask a series of questions that tease out the patient's affect states and connect them to appropriate issues in the interest of helping the patient be able to label his/her feelings and know when they are related to symptoms, target problems, or feelings that are drug effects.

Lower: A less skilled therapist may help the patient to label his/her feelings without exploring further to make the distinction between affect states related to symptoms or target problems and those that are drug effects.

SUPPORT BY FAMILY MEMBERS/SIGNIFICANT OTHERS: To what extent did the therapist inquire about or discuss the availability and nature of support from family members and/or significant others for the patient's involvement in treatment or efforts to become abstinent?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist attempted to ascertain whether the patient's family and/or significant others could be used as a resource in treatment OR could attend sessions to explain the patient's treatment to the family OR how drug use in a family member could adversely affect the patient. This item can also be addressed if there is a clear lack of family support.

Significant others are defined as people with whom the patient has a familial relationship (i.e. parent of patients' child) or as people living with the patient (i.e. a lover). This item does not include significant friends, neighbors, or coworkers who do not live with the patient. For this item to receive a rating greater than "1", this relationship should be evident to the rater.

This item would be rated higher in collateral (spouse) sessions, which thoroughly explored the spouse's real or perceived level of support for the patient, means of providing support or barriers to support. A lower rating would be achieved if the therapist merely asked if the patient has any support from family members or significant others, without pursuing their availability or specific nature of their support.

Examples:

T: "You mentioned that you are close to your older sister and feel she is supportive and pleased you want to become abstinent. Is she willing to take you to meetings since you don't have a car?

T: "Your brother Bob seems to be someone you really confide in and trust. Since you need a place to stay for a while, is he someone you could ask?

T: "From the sound of it, you really have alienated your family and your wife is still using. I wonder how your lack of support might interfere will your becoming abstinent."

Skill Level Rating Guidelines:

Higher: A skilled therapist would help the patient identify specific family members/significant others who could be supportive of the patient's wanting to stop using drugs. Further, the therapist helps the patient identify the specific ways different people would available to the patient. For example, who might attend sessions with the patient, and who is someone the patient can go to with problems or when he/she feels like using? If it is determined that there is a total lack of support in the patient's life, the therapist would also facilitate a discussion with the patient around how to develop a supportive social network that will support his abstinence, (eg., self-help groups like AA/NA).

Lower: A less skilled therapist might help the patient identify whether or not there are any supportive people in his/her life, without exploring the specifics of how different people could be available.

OPTIMISTIC REASSURANCE FOR FUTURE PATIENT EFFORTS (NON-MEDICATION):

To what extent did the therapist communicate confidence that patient efforts THAT DO NOT INCLUDE MEDICATION will yield success in the future?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist conveyed the idea that patient efforts/treatment will be helpful. For this item to be scored as having occurred, the patient effort/treatment MUST NOT include medication. This item focuses on the therapist's demonstration of his/her belief that non-medication effects will play an important role in the patient's recovery. For this item to be rated higher, the therapist's primary focus during the session is on non-medication efforts that contribute to abstinence. In addition, specific efforts that are made, such as going to meetings, developing interests, relationships, etc., are emphasized as essential to recovery. A lower rating would be achieved if the therapist makes reference to patient's efforts in treatment that are not related to medication compliance without expressing the belief that these efforts play a key role in the recovery process.

Examples:

Pt: "If I keep going to AA meetings and call my sponsor when I get a drug urge, I'll be able to stay sober."

T: "That's right! If you do those things, you'll be well on your way to 90 days of sobriety!"

T: "Keep on doing what you're doing!"

T: "Your decision/choice/level of motivation…helps you stay clean and sober."

Skill Level Rating Guidelines:

Higher: A skilled therapist facilitates the patient's identification of specific non-medication treatment efforts that contribute to his/her recovery. The therapist will acknowledge, with great enthusiasm and confidence, the belief that these efforts are essential to the recovery process.

Lower: A less skilled therapist might ask the patient what other efforts he/she is making as part of the recovery process without explicitly expressing the belief that efforts in addition to medication are important to recovery.

General Support Items

(4 Items)

NOTE: The phrase "*drug of choice*" or "*drug*" appearing in italics is study specific. These items can be changed to reflect the relevant substance in any particular study.

Example: In Exploration of Feelings), the substance relevant to the study population (e.g., cocaine, heroin, marijuana, etc.) can be substituted for *drug*.

GENERAL PRAISE FOR PATIENT'S PAST EFFORTS THAT DO NOT INCLUDE ROLE OF MEDICATION: To what extent did the therapist compliment and/or praise a past patient effort that did not include the role of *medication*?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

EXPLORATION OF FEELINGS: To what extent did the therapist help the patient to explore his/her feelings related to current symptoms or clarify affect states as related to *drug* use or other target problems?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

SUPPORT BY FAMILY MEMBERS/SIGNIFICANT OTHERS: To what extent did the therapist inquire about or discuss the availability and nature of support from family members and/or significant others for the patient's involvement in treatment or efforts to become abstinent?

FREQUENCY & EXTENSIVENESS:

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

OPTIMISTIC REASSURANCE DUE TO FUTURE PATIENT EFFORTS (NONMEDICATION): To what extent did the therapist communicate confidence that patient efforts that DO NOT INCLUDE MEDICATION will yield success in the future?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

Clinical Management Items Guidelines (11 Items)

One of the 'treatment-specific' scales, CM is a psychotherapy control condition that has been frequently used in clinical trials that involve a medication component (e.g., Carroll et al., 1994; Carroll et al., 1998; O'Malley et al., 1992). Also called Compliance Enhancement, this approach has been adapted for use with drug dependent individuals (Carroll & O'Malley, 1996) from the guidelines developed by Fawcett et al., (1987) for the NIMH Collaborative Study on the Treatment of Depression (Elkin et al., 1985). The goals of Clinical Management are: (1) to provide nonspecific, common factors of a psychotherapeutic relationship, including a supportive doctor-patient relationship, education, empathy, and the instillation of hope, without providing active ingredients specific to other 'active' psychotherapies, (2) to provide medication management as well as opportunity to monitor patients' clinical status and treatment response, and (3) to provide a convincing therapeutic rationale and so foster greater retention in treatment protocols and compliance with medication.

Note: The phrase "*drug of choice*" or "*drug*" appearing in italics is study specific. These items can be changed to reflect the relevant substance in any particular study.

Example: In Biochemical Rationale for Addiction, the substance relevant to the study population (e.g., cocaine, heroin, marijuana, etc.) can be substituted for *drug*.

BIOCHEMICAL RATIONALE FOR ADDICTION: To what extent did the therapist present a biochemical rationale for addiction (i.e. suggesting that chronic *drug* use or craving may be related to changes in neurotransmitter levels or post-synaptic adaptation associated with chronic *drug* abuse)?

Frequency and Extensiveness Rating Guidelines:

The purpose of this item is to measure the therapist's attempts to provide a basic biological rationale for the etiology or maintenance of addiction. This may entail a discussion of brain functioning with particular attention to neurotransmitter processes, the likelihood that disruption of this system could be caused by chronic *drug* use, and such disruption could account for *drug* craving. This may occur during a discussion of the causes for tolerance or withdrawal. The complexity of this explanation is likely to vary according to what the therapist thinks the patient is likely to understand. A higher rating is achieved when the therapist thoroughly explains the biochemical rationale for addiction and connects brain functioning, the effects of drug use on the brain and its relationship to drug craving. A lower rating would be achieved when the therapist presents only a rudimentary biochemical rationale.

Examples:

T: "It is believed that *drug* alters neurotransmitters in your body which could account for your cravings such that the more you use *drug*, the more you crave."

T: "When you use *drug,* over time it affects the chemicals in your brain and makes you feel like you need more to get the same effect. The effects on your brain create the addiction."

Skill Level Rating Guidelines:

Higher: A skilled therapist would not only explain the biochemical rationale for addiction in great detail, making connections to issues of craving, tolerance and withdrawal, but would also check in with the patient making sure the discussion is conducted at a level the patient understands. By making sure the patient understands the biochemical rationale for addiction, the therapist attempts to enhance medication compliance, abstinence and treatment retention.

Lower: A less skilled therapist might thoroughly present the biochemical rationale but not attend to whether or not the patient understands, making the discussion less meaningful to the patient and less likely the patient will benefit from treatment.

ADDRESSING PATIENT'S CONCERNS ABOUT *STUDY MEDICATION*: To what extent did the therapist assess the patient's concerns about taking *study medication* AND address those concerns?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist detects what concerns the patient has about taking *study medication* AND discusses those concerns with the patient in an attempt to resolve them. To achieve a higher rating, the therapist must elicit and discuss the patients concerns, so as to promote understanding and enhance medication compliance. A lower rating is achieved when the therapist asks about the patient's concerns but doesn't address them.

Examples:

T: "Do you have any concerns or questions about taking *study medication*?"

T: "If you have any concerns, please let me know about them as soon as possible.

T: "Now that we have discussed your concerns about *study medication,* do you have any more questions? Are you feeling more comfortable about taking the medication now?

Skill Level Rating Guidelines:

Higher: A skilled therapist would be open to the patient's concerns about taking medication and attempt to address the issues with thoughtful consideration, making sure the patient's concerns are clearly considered and appreciated. In being receptive to the patient's concerns and clarifying any misconceptions about the medication, the therapist helps promote medication compliance.

Lower: A lower rating would be achieved here when the therapist addresses concerns the patient raises about the *study medication* in a cursory or dismissive way and does not initiate any helpful discussion about the medication.

RELATING (PAST) ACTUAL BEHAVIORAL OCCURRENCES TO COMPLIANCE/ NONCOMPLIANCE WITH *STUDY MEDICATION:* To what extent did the therapist relate actual positive/negative changes in behavior to *study medication* compliance/noncompliance?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist makes a causal link between the patient's compliance or noncompliance with the *study medication* and positive and/or negative changes in behaviors. In rating this item, the rater should consider discussions of change in *drug* use and/or discussions of change in other areas of the patient's life. A higher rating is achieved when the therapist clearly connects the patient's compliance with medication to positive and negative changes in the patient's behavior in several life spheres. (e.g., work, relationships, drug use…). A lower rating is achieved when the therapist raises the issue of medication compliance without connecting it to the patient's changes in behavior.

Examples:

T: "Do you notice things are improving since you started taking *study medication*?"

T: " I've noticed since you have been compliant with *study medication,* you have been abstinent from *study medication* and you haven't been late for work. Do you think there's a connection?"

Skill Level Rating Guidelines:

HIgher: A skilled therapist would make connections between compliance with *study medication* and positive and negative changes in the patient's behavior and how that affects various life spheres. In addition, the therapist would pay attention to whether or not, and in what particular areas, these connections resonate for the patient. In doing so, this allows the therapist to explore further and to facilitate the patient's compliance with *study medication.*

Lower: A less skilled therapist might determine if the patient has been compliant with the *study medication* but make vague or no connections to the patient's behavior as a result. In addition, a less skilled therapist would not assess whether or not the patient makes any important connections between his/her medication compliance and behavior.

EMPHASIS ON CRUCIAL ROLE OF *STUDY MEDICATION* TO FUTURE RECOVERY: To what extent did the therapist communicate confidence that if the patient takes the *study medication*, areas of his/her life will improve or if the patient doesn't take *study medication*, areas of his/her life will worsen?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist urges the patient to adhere to the *study medication* regimen because of its future desired effects. To achieve a higher rating the therapist must consistently express confidence that the patient's life will be significantly affected by his/her compliance/noncompliance to the *study medication.* The connection must be made between medication compliance/noncompliance and positive/negative improvements in the patient's life.

Examples:

T: "I think *study medication* will help you achieve yours goals of getting your life back on track by helping you stay abstinent."

T: "If you continue taking your *study medication* and doing so well, other opportunities may seem more likely."

T: "You haven't taken your *study medication* since our last session and you now report that your craving has been worse and that you actually used two days ago. It seemed to me things were going better for you when you were taking the *study medication.*"

Skill Level Rating Guidelines:

Higher: A skilled therapist is careful to connect compliance with medication to improvements or possible setbacks in the patient's life. It is important that the therapist believes in the role of the *study medication* in the patient's treatment goals and communicates this belief with confidence.

Lower: A less skilled therapist may stress the importance of taking the *study medication* without connecting compliance with improvements or setbacks, and/or does not convey with confidence that the medication plays a crucial role in improvement.

MEDICATION DOSAGE: To what extent did the therapist discuss the *study medication* dosage that was prescribed?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist discusses the specific *study medication* dosage with the patient. In order for this item to be rated highly, the therapist must give the patient some specific reason for the specific dosage that has been prescribed (e.g., to increase response, reduce side effects) OR why the dose is being changed. A lower rating would be achieved if the therapist raises the issue of the medication dosage without offering any explanation for it, or for a change in the dosage.

Examples:

T: "How much *study medication* are you taking?"

T: "The dosage of *study medication* is given because we have found that this dosage provides the best response with the fewest side effects."

Skill Level Rating Guidelines:

Higher: A skilled therapist would thoroughly discuss the specifics of why the particular *study medication* was prescribed, making sure the patient understands possible benefits and side effects of the medication. In addition, the therapist is open to the patient's questions and concerns about the *study medication* and addresses their issues with compassion and respect.

Lower: A less skilled therapist might simply tell the patient the dosage of the *study medication* without being open or sympathetic to the patient's questions or concerns.

This item is distinguished from MEDICATION SCHEDULE, which refers specifically to the therapist providing specific directions on when the *study medication* should be taken. It is also to be distinguished from MEDICATION COMPLIANCE, which refers to the extent to which the therapist attempted to ascertain whether the *study medication* was taken as prescribed.

MEDICATION SCHEDULE: To what extent did the therapist inquire about or discuss the patient's schedule for taking the *study medication*:

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist discusses with the patient the schedule he/she asked the patient to follow in taking the *study medication*. In order for this item to be rated highly, the therapist must give the patient some specific reason for the specific schedule that has been suggested (e.g., to ensure the desired effects of *study medication*) and/or review the patient's *study medication* schedule day by day. A lower rating would be achieved if the therapist states what the medication schedule is without giving a rationale for it.

Examples:

T: "What time of day do you take your *study medication*?"

T: "It is important to take the *study medication* in the morning each day. Taking it at the same time each day ensures that you will receive the best effects of the medication."

Skill Level Rating Guidelines:

Higher: A skilled therapist will provide a rationale for the medication schedule and connect compliance with the medication schedule to medication compliance and maintaining abstinence. In addition, the therapist will remind the patient that keeping to the schedule will offer the patient the best effects of the *study medication*. A skilled therapist will also elicit the patient's concerns or questions about the medication schedule and address the issues thoughtfully, thereby enhancing the patient's motivation to be compliant with the medication schedule.

Lower: A less skilled therapist might provide specific reasons for the medication schedule without making important connections to medication compliance and abstinence. In addition, the therapist might be more directive with the patient, as opposed to actively eliciting the patient's concerns or questions about the medication schedule and addressing the issues.

This item is distinguished from MEDICATION DOSAGE, which refers specifically to the therapist providing specific directions on what amount of the *study medication* should be taken. It is also to be distinguished from MEDICATION COMPLIANCE, which refers to the extent to which the therapist attempted to ascertain whether the *study medication* was taken as prescribed.

MEDICATION COMPLIANCE/NONCOMPLIANCE: To what extent did the therapist inquire about or discuss the patient's compliance/noncompliance with the prescribed *study medication* regimen SINCE THE LAST SESSION?

This item refers to the extent to which the therapist discusses the patient's compliance/noncompliance with the prescribed *study medication* regimen. Noncompliance refers to any deviation from the prescribed dosage or schedule. In order to be rated highly, the therapist must conduct an extended inquiry (i.e., on a day by day basis including questions about dosage and schedule) as to the patient's compliance since the last session OR the therapist must respond to or attempt to resolve the patient's noncompliance. Lower ratings would be given for asking about compliance without further inquiry.

Examples:

T: "Did you take the *study medication* last week?" (no further inquiry made)

T: " You said you took your *study medication* every day since we last met. Did you take it at the same time every day? Did you take the same dosage every day?

T: " In reviewing how you have taken your medication since last session, it looks like you tend to take it every other day and not at a specific time, but when you remember it, sometimes in the morning and sometimes in the evening. Are you skipping days because you are experiencing side effects from the medication? If the issue is that you aren't remembering to take it, let's develop a plan to help you take it as prescribed, on a daily basis, and at the same time every morning.

Skill Level Rating Guidelines:

Higher: A skilled therapist will make extended inquiries about medication compliance, making sure to emphasize that the patient will receive the greatest benefits from the medication by taking it as prescribed, which includes dosage, schedule and taking it every day. In addition, the therapist will facilitate a discussion that helps the patient identify and reveal the questions or concerns he/she may have about the medication that affect medication compliance. Once identified, the patient's concerns are addressed by the therapist in a reassuring and thoughtful way, in the interest of helping the patient feel understood and supported by the therapist. Ultimately, this approach serves to improve medication compliance.

Lower: A less skilled therapist might stress the importance of compliance with the *study medication* without making inquiries about the patient's concerns or questions about the medication, when to take it, etc. As a result, the patient's concerns do not get addressed and the patient is less likely to become more compliant.

This item is distinguished from MEDICATION DOSAGE, which refers specifically to the therapist providing specific directions on what amount of the *study medication* should be taken. It is also to be distinguished from MEDICATION SCHEDULE, which refers specifically to the therapist providing specific directions on when the *study medication* should be taken.

EDUCATION OF THE INTERACTION BETWEEN *STUDY MEDICATION* AND *DRUG USE*: To what extent did the therapist assess the patient's understanding of or educate the patient about how *study medication* works, its effects when taken with *drug*, and/or how to handle a potential interaction.

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist educates the patient on the bodily reaction they should experience when taking the study medication (how the medication works), as well as what bodily reaction they would experience should they mix *study medication* with *drug*. This may also include a discussion of products they should avoid while taking *study medication.* A higher rating is achieved when the therapist explicitly covers the bodily effects of the medication and the interaction effects and specific products or product types to avoid when on the *study medication.* The discussion should cover in depth the possible bodily effects, both positive and negative, that the combination of the *study medication* and *drug* could produce.

Examples:

T: "If you ingest products with *drug* in them while taking *study medication*, you will become very ill. You will feel nauseated and dizzy and might feel weak and unsteady on your feet."

T: " *Study medication* may help with *drug* cravings."

T: "Due to the negative interaction effects, while you are taking *study medication* should not take any products containing X, like A, B, or C.

Skill Level Rating Guidelines:

Higher: A skilled therapist will carefully inform the patient of the possible negative effects of taking the *study medication* and *drug*, and/or other products, so that he/she understands and can avoid problems. Educating the patient about interaction effects is informative and allows the therapist to demonstrate respect and concern for the patient. A skilled therapist will also fully describe how the *study medication* works and that in order to get the benefits the patient wants from taking the medication, it is important to stay away from *drug* and/or other products that could interfere with the benefits of the *study medication.*

Lower: A less skilled therapist might describe how the medication works, without educating the patient as to the specific bodily effects that might be experienced. In addition, the interaction effects of the *study medication* and *drug* might be mentioned without explicitly stating what they could be and how they might affect the patient.

This item is to be distinguished from ACTUAL OCCURRENCE 0F A *MEDICATION* INTERACTION OR ANY SIDE EFFECTS, which refers to the therapist's exploration of an actual interaction that already occurred.

EDUCATION OF OTHER POSSIBLE SIDE EFFECTS OF *STUDY MEDICATION*: To what extent did the therapist discuss the possibility of other side effects from *study medication* other than the interaction of *study medication* with *drug*; (e.g. fatigue, aftertaste, symptoms such as nausea, flushing of the face, lethargy, hyperactivity, acne, etc.).

Frequency and Extensiveness Rating Guidelines:

This item refers to the therapist's discussion of the possibility of various side effects. For a higher rating to be achieved, the therapist should go into great detail as to possible side effects and how often different side effects actually occur. For a lower rating, the therapist just mentions them as a possibility.

Example:

T: "You may notice side effects from *study medication* such as acne..."

T: "Sometimes people experience various side effects from this medication, like fatigue, flushing of the face and lethargy. While it is common to feel tired from the medication, once you on the medication for a few days, that effect will lessen.

Skill Level Rating Guidelines:

Higher: A skilled therapist will thoroughly cover the possible side effects of the *study medication* and how frequently they tend to occur. In the process of explaining the possible side effects, the therapist will help the patient weigh the possible benefits of taking the medication versus the possible side effects. The therapist will be careful to elicit and address the patient's concerns about side effects as well. By educating the patient empathizing with his/her concerns, the therapist may enhance the patient's motivation to take the medication and to benefit from its effects.

Lower: A less skilled therapist will cover the possible side effects of the medication without being explicit about what they are or how frequently they are experienced. Little attention will be paid to eliciting the patient's questions or concerns about side effects and/or the concerns that are raised by the patient are not addressed in a satisfying or empathic way. This lack of support and understanding from the therapist can undermine the patient's compliance with mediciation, especially when side effects are experienced.

This item is distinguished from ACTUAL OCCURRENCE 0F A *STUDY MEDICATION* INTERACTION OR ANY SIDE EFFECTS, that refers to side effects that actually occurred.

ACTUAL OCCURRENCE OF A *STUDY MEDICATION* INTERACTION OR ANY SIDE EFFECTS: To what extent did the therapist inquire about the actual occurrence or possible occurrence of the *study medication* interaction or any side effects?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist inquired about the ACTUAL occurrence of an interaction or side effects due to taking *study medication.* To be rated highly, the therapist should have attempted to discern whether any reported symptom was likely to be the result of the *study medication* or another etiology. In addition, the therapist might conduct a thorough review of a side effect checklist. A lower rating would be achieved if the therapist inquires about the patient's symptoms without determining whether they are, in fact, side effects of the *study medication* or attributable to another etiology.

Note: *If the therapist is following a form and therefore reviews a large quantity of potential symptoms, the rating would go up to a 3. For a rating above 3, the therapist discusses potential symptoms in an expanded and in depth manner.*

Examples:

T: "Have you noticed any interactions or side effects since taking the *study medication*?"

T: "Have you been careful about the potential effects of doing such things as using perfume or cooking with sherry while taking *study medication*?"

Skill Level Rating Guidelines:

Higher: A skilled therapist will conduct a detailed inquiry regarding any symptoms the patient may be experiencing and discern whether any symptoms are possible side effects of the medication. The therapist will elicit patient concerns about side effects and clarify what symptoms may, in fact, be side effects of the medication, or caused by something other than the medication, or as an interaction effect. In a supportive way, the therapist will educate the patient, offering information that helps the patient understand the benefits and the side effects of the medication, thereby fostering medication compliance.

Lower: A less skilled therapist may determine if the patient is experiencing side effects of the *study medication* or of an interaction effect without explicitly identifying these symptoms for the patient as side effects of the medication. And, if the symptoms that the patient is experiencing are NOT side effects of the *study medication*, the therapist may not make that clear. This leaves the patient unclear about what symptoms being experienced are actually side effects of the medication and will likely make the patient less tolerant of the side effects and less likely to remain compliant with the *study medication.*

MANAGEMENT OF AN ACTUAL *STUDY MEDICATION* INTERACTION OR SIDE EFFECTS: To what extent did the therapist explore how or why an interaction may have occurred and articulate a plan for side effects to be monitored or reduced or for interactions to be prevented?

Frequency and Extensiveness Rating Guidelines:

This item refers to whether or not the therapist assesses how or why a patient may have experienced an interaction effect or side effects, and if so, whether a plan is made to monitor and/or reduce side effects and to prevent interactions in the future. For a higher rating, the therapist should explore in great detail how the event was handled and articulate a plan for managing the problem in the future. A lower rating would be achieved if the therapist determines that the patient experienced an interaction or side effects but does not articulate a plan for side effects to be monitored and/or reduced.

Examples:

T: "You told me you're getting acne. That could be related to taking *study medication*. If it continues or worsens then we'll lower the dose."

T: "Because you drank and didn't have a reaction, we'll raise the dose."

Skill Level Rating Guidelines:

Higher: A skilled therapist makes a detailed inquiry to determine how and why an interaction/side effects from the *study medication* may have occurred, being careful to acknowledge any discomfort or distress these may have caused the patient. The therapist will explicitly express interest in wanting the patient feel better, and develop a plan for the patient's side effects to be monitored by both the patient and the therapist, and to prevent any further interactions. By doing so, the therapist reassures the patient that there are potential benefits of the *study medication*, and with careful monitoring and management of the patient's symptoms, maximum benefit can be achieved from compliance with the *study medication.*

Lower: A less skilled therapist may recognize the interaction or side effects, but minimize the patient's distress, saying basically that all medications have side effects and/or you shouldn't use if you are on the medication. The therapist may not articulate a plan to help the patient prevent interactions and/or manage side effects, and will not emphasize the potential benefits of the medication when the problems are addressed.

Clinical Management Items

(11 Items)

NOTE: The phrase "*drug of choice*" or "*drug*" appearing in italics is study specific. These items can be changed to reflect the relevant substance in any particular study.

Example: In Biochemical Rationale for Addiction, the substance relevant to the study population (e.g., cocaine, heroin, marijuana, etc.) can be substituted for *drug*.

BIOCHEMICAL RATIONALE FOR ADDICTION: To what extent did the therapist present a biochemical rationale for addiction (i.e. suggesting that chronic *drug* use or craving may be related to changes in neurotransmitter levels or post-synaptic adaptation associated with chronic *drug* abuse)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

ADDRESSING PATIENT'S CONCERNS ABOUT *STUDY MEDICATION*: To what extent did the therapist assess the patient's concerns about taking *study medication* and address those concerns?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

RELATING (PAST) ACTUAL BEHAVIORAL OCCURRENCES TO COMPLIANCE/NONCOMPLIANCE WITH *STUDY MEDICATION*: To what extent did the therapist relate actual positive/negative changes in behavior to *study medication* compliance/noncompliance?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

EMPHASIS ON CRUCIAL ROLE OF *STUDY MEDICATION* TO FUTURE RECOVERY: To what extent did the therapist communicate confidence that if the patient takes the *study medication,* areas of his/her life will improve or if the patient doesn't take the *study medication*, areas of his/her life will worsen?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

MEDICATION DOSAGE: To what extent did the therapist discuss the *study medication* dosage that was prescribed?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

MEDICATION SCHEDULE: To what extent did the therapist inquire about or discuss the patient's schedule for taking the *study medication*?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

MEDICATION COMPLIANCE/NONCOMPLIANCE: To what extent did the therapist inquire about or discuss the patient's compliance/noncompliance with the prescribed *study medication* regime since the last session?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

EDUCATION OF THE INTERACTION BETWEEN *STUDY MEDICATION* AND *DRUG* USE: To what extent did the therapist assess the patient's understanding of or educate the patient about how *study medication* works, its effects when taken with *drug*, and/or how to handle a potential interaction?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

EDUCATION OF OTHER POSSIBLE SIDE EFFECTS OF *STUDY MEDICATION*: To what extent did the therapist discuss the possibility of other side effects from *study medication* other than the interaction of *study medication* with *drug*; (e.g., fatigue, aftertaste, symptoms such as nausea, flushing of the face, lethargy, hyperactivity, acne, etc.)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

ACTUAL OCCURRENCE OF A *STUDY MEDICATION* INTERACTION OR ANY SIDE EFFECTS: To what extent did the therapist inquire about the actual occurrence or possible occurrence of the *study medication* interaction or any side effects?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

MANAGEMENT OF AN ACTUAL *STUDY MEDICATION* INTERACTION OR SIDE EFFECT: To what extent did the therapist explore how or why an interaction may have occurred and articulate a plan for side effects to be monitored or reduced or for interactions to be prevented?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

Twelve Step Facilitation (TSF) Items Guidelines (9 Items)

Twelve Step Facilitation Therapy (TSF) is a manual-guided treatment that was developed for use in psychotherapy research protocols for the treatment of alcohol and/or drug abuse and dependence. The facilitation program in TSF is intended for use in brief, individual outpatient treatment for persons who satisfy the DSMIV criteria for drug abuse or dependence. The treatment is designed to be used as the primary treatment for patients who may or may not have had previous substance abuse treatment.

TSF is intended to be consistent with active involvement in Twelve Step recovery programs such as Narcotics Anonymous (NA), Cocaine Anonymous (CA), and Alcoholics Anonymous (AA). It assumes that addiction is a progressive disease of mind, body, and spirit, for which the only effective remedy is abstinence from mood-altering substances, 'one day at a time'. TSF adheres to the concepts set forth in the Twelve Steps and Twelve Traditions (Alcoholics Anonymous, 1981).

The overall goal of this treatment is to promote abstinence by facilitating patients' active involvement and participation in the fellowship of 12-Step recovery programs (NA, CA, AA). Active involvement in 12-Step programs is regarded as the single most important factor responsible in maintaining sustained recovery from dug dependence, and therefore, is the desired outcome of participation in this treatment..

Note: The phrase "*drug of choice*" or "*drug*" appearing in italics is study specific. These items can be changed to reflect the relevant substance in any particular study.

Example: In Exploration/Confrontation of Denial of Drug(s) Effects on Significant Aspects of Patient's Life, the substance relevant to the study population (e.g., cocaine, heroin, marijuana, etc.) can be substituted for *drug*.

***PREVIOUS ASSIGNMENT:** To what extent did the therapist review the patient's reactions to last session's assignment, (e.g., explore or address any difficulties encountered in carrying out the assignment, provide a rationale for homework, reinforce the importance of extra-session practice of skills)?

Frequency and Extensiveness Rating Guidelines:

This item measures how much attention the therapist pays to homework previously assigned to the patient. It gives the therapist the opportunity to provide a rationale for doing extra-session assignments, as well as the opportunity to reinforce the positive aspects of the patient's performance and the importance of practicing new coping skills to maintain sobriety.

To achieve a *higher rating* on this item, the assignment must be thoroughly discussed, and a rationale provided for the importance of extra-session activities, especially if the assignment was not completed. The therapist links this behavior to the patient's efforts to protect or achieve their treatment goals. A *lower rating* would be achieved if the homework is not explicitly discussed or is merely mentioned but not reviewed.

Examples:

T: For last week's assignment, you agreed to try to break your morning pattern of using drugs. You went to the gym in the mornings instead of using. That's great! What was it like for you to make these changes?

T: Last session you said that you wanted to speak with your pastor about joining the choir. You thought this would be a good way to meet new people who don't use and that this would help you stay clean. What got in the way? How might you set things up this week so you can talk to the pastor instead of using?

Skill Level Rating Guidelines:

Higher quality discussions of assignments include linking this behavior to the patent's efforts to protect or maintain their recovery and/or problem solving of roadblocks that interfere with the patient's ability to complete assigned tasks.

Lower quality discussions fail to connect completion of tasks to maintained recovery.

***Note:** This item should be used only for studies in which the comparison treatment does not involve outside-of –session tasks (i.e., Cognitive-Behavioral Treatment).

TWELVE STEP MEETING INVOLVEMENT: To what extent did the therapist encourage the patient to become active in AA/NA/CA (e.g., through 12 Step meeting attendance, getting a sponsor or plan specific AA/NA/CA-related activities for the week such as speaking or helping at a particular meeting, use of the telephone or encourage the patient to use AA/NA/CA involvement as a means of coping)?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent the therapist encouraged the patient to attend meetings, find a sponsor or become involved in special Twelve Step activities as a way of developing a support system to help maintain sobriety. The therapist reinforces the ideas that AA/NA/CA is a fellowship of people with the common problem of alcohol/cocaine addiction and that the patient should rely on AA/NA/CA as a resource for support in times of crisis. In addition, the therapist may encourage the patient to find an AA/NA/CA group that is relevant to his or her own needs (e.g., working mothers, single parents, ethnic and racial minorities, older adults, gays and lesbians, etc.).

To achieve a *higher rating* on this item, the therapist should encourage involvement several aspects of AA/NA/CA (e.g., use of sponsor, meeting attendance, social contacts with recovering friends). A *lower rating* would be achieved if the therapist limits the encouragement to one aspect of AA/NA/CA, such as meeting attendance and does not explore all Twelve Step activities, or merely praises the patient for attending meetings.

Examples:

T: Lets talk about your experience with last night's meeting. What did you hear people talk about? Did anyone share anything that that sounded like your story?

T: Sounds like you had a difficult day at work. How would you feel about calling your sponsor and sharing that with him?

Skill Level Rating Guidelines:

Higher quality discussion of 12-step program involvement occurs as the suggestions become more specific, e.g. calling particular 12-step peers at particular times during the week, taking on specific jobs at specific 12 step meetings. The therapist links this behavior to the patient's efforts to protect or maintain their recovery.

Lower quality discussions fail to connect 12-step program involvement to maintained recovery.

SELF-DISCLOSURE: To what extent did the therapist explicitly refer to the therapist's own life experiences or beliefs?

Frequency and Extensiveness Rating Guidelines:

This item measures the level of self-disclosing statements made by the therapist during the session. These statements may include references to the therapist's beliefs or experiences, such as his/her personal recovery from addiction or emotional growth. In addition, self-disclosing statements may be made in an attempt to provide the patient with emotional support, as examples of alternatives for problem solving, or as a means to establish a therapeutic alliance.

This item should be rated greater than "1" if any self-disclosing statement is made by the therapist. It should be rated higher if the therapist gives detailed accounts of their own experience, resulting in the therapist's self-disclosure dominating the session.

Examples:

T: When I was in early recovery I.…"

T: "Something I've found helpful is to..."

Skill Level Rating Guidelines:

Note: *When rating the quality of the therapist's self-disclosure, score for the appropriateness of the therapist's content and affect.*

Higher: More effective use of this technique is typically very limited and targeted at specific behaviors or feelings with the intent of providing suggestions for problem solving or emotional support. The intervention is well timed, specific, and limited.

Lower: Less effective use of this technique, would be more extensive discussions of the therapist's experiences, use of the therapist's life as "the exemplary way" to approach recovery. Lower ratings should also be given in cases where the disclosure appeared to be unnecessary or did not serve clear goals in the interest of the patient.

CONFRONTATION: To what degree did the therapist explicitly confront the patient and/or employ a confrontational style in working with the patient?

Frequency and Extensiveness Rating Guidelines:

For this item, confrontation is defined in a narrow sense as the therapist's use of a confrontational style to point out problems caused by denial or refusal to accept the patients *drug* problems. Arguing with the patient, labeling the patient, interpreting his/her behavior in terms of denial would be associated with a confrontational style. Merely raising an issue to make the patient aware of his/her *drug* addiction is not necessarily a confrontation.

Higher: Frequent feedback about the level of the patient's *drug* use or problems caused by it or value laden (negative consequences) presentation of feedback to patient around level of patient's *drug* use or problems caused by it (highly confrontational content, highly confrontational style).

Lower: Lack of feedback about the level of the patient's *drug* use or problems caused by it or neutral presentation of feedback to patient around level of patient's *drug* use or problems caused by it (highly confrontational content, low confrontational style).

Examples:

T: You say that you want to stay sober, but you keep a six-pack of beer in the refrigerator "just in case you have company." That's what AA calls keeping a reservation for the next drunk.

T: You say that you are afraid of having your probation violated and going to jail for having dirty drug screens, but you keep using and avoiding NA meetings.

Skill Level Rating Guidelines:

Higher: killed use of this intervention by a therapist separates the patient from his/her behavior. Thus the behavior becomes the focus, not the value of the individual, e.g. "When you invite your old using friends to your house for a party and expect not to use, I wonder if there is part of you that still wants to use?"

Lower: Lower skill scores should be given in cases where there is high confrontational style and the therapist does not take into account the struggles that the patient may have with the continued thoughts and urges to use, e.g., "I see your behavior as denial of your addiction". "If you keep using *drug(s)* like that, you'll kill yourself!" Arguing with, harshly criticizing, or negative valuation comments would be associated with lower skill scores.

RESISTANCE TO TWELVE STEP RECOVERY: To what extent did the therapist explore the patient's denial/resistance to Twelve Step recovery (e.g., avoiding AA/CA/NA meetings, minimizing negative consequences, discussing the patients resistance to following Twelve Step recovery in terms of his/her denial, or discussing the patients need to surrender)?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent the therapist makes the patient aware of his/her level of denial and approaches denial in the context of Twelve Step Recovery, as a consequence of the power of *drug use*. In addition, Twelve Step Recovery sees hope for recovery only through accepting the loss of control over addictive substances and surrendering to a belief in a higher power as the road to recovery. The therapist encourages participation in AA/CA/NA as the treatment of choice to help the patient maintain sobriety.

Higher ratings should be given in sessions with frequent feedback about the level of the patient's involvement with 12 step programs (AA/NA/CA) or exploration of resistance to this involvement.

Lower scores should be given in cases where lack of involvement is noted but the therapist does not actively explore resistance.

Examples:

T: You said that you would go to three meetings this week, but you didn't get to any. I'm wondering if you are using your denial to put other people's needs in front of your recovery and minimizing your need for support to stay clean?

T: By continuing to go over to your friend's house you put yourself at risk of using. I guess you haven't fully accepted that you are an addict and that you can not use safely anymore.

Skill Level Rating Guidelines:

Higher: Skilled use of this intervention by a therapist separates the patient from his/her behavior. Thus the behavior becomes the focus, not the value of the individual, e.g. "When you skip going to the NA meeting, I wonder if there is part of you that doesn't quite accept that you can't do this alone?"

Lower: The therapist addresses the behavior, but does not take into account the struggles that the patient may have with the continued resistance to accepting help, "You are just in denial of your addiction so you don't think you need help."

This item is distinguished from **DISEASE CONCEPT OF ADDICTION**, which deals with the acceptance of the concept of addiction as a disease, versus this item that assesses the patient's acceptance of Twelve Step Recovery as the treatment of choice for their addiction.

DISEASE CONCEPT OF ADDICTION: To what extent did the therapist discuss the patient's acceptance of his/her "disease," its implications, or its symptoms, or discuss the disease concept of addiction?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist discussed the disease concept of addiction, in that the patient has a chronic, progressive illness, which if not arrested may lead to death, institutions, or jail. The therapist should refer to the characteristics of the of the disease i.e., (1) it is "Chronic"- once the patient is an addict he/she is always an addict (2), it has clearly identifiable "Symptoms" marked by loss of control, specific predictable effects over the course of the illness (psychological, social, physical), and denial or resistance to accepting the reality of the loss of control or negative consequences of continued use (3) It is "Progressive"- over time the symptoms worsens (4) If left untreated it is "Fatal", (5) It is "Treatable" with abstinence and support.

This item would achieve a *lower rating* if the therapist mentions the disease concept without more presentation of information or examination of the patient's responses to the information. A *higher rating* would be achieved if the therapist thoroughly discusses points made above, including the patient's responses to the concept.

Examples:

T: Looking at what you told me about your history with drugs and alcohol, I can see a clear pattern of increase in your use over the years. This is a symptom of addiction.

T: Finally a person has to come to terms with, or accept, the fact that they can't use or drink safely anymore. The only thing that makes sense is to stop altogether, one day at a time. Once you're an addict, you're always an addict.

Skill Level Rating Guidelines:

Higher: Skilled presentation of this material involves the use of specific personal information about the patient drawn from discussion and the drug and alcohol use history. "You started out drinking two or three beers a night when you were 17, now you're drinking 18 beers a night. This is an example of an increased tolerance to alcohol which is a symptom of addiction."

Lower: Presentation of this material is more generalized and is not specific to the patient, such as stating an AA slogan without explaining it or relating it to specific issues relevant to the patient.

This item is distinguished from **TWELVE STEP RECOVERY,** which addresses the acceptance of Twelve Step Recovery specifically to treat addiction in contrast to the general acceptance of the disease concept of addiction.

TWELVE STEP RECOVERY: To what extent did the therapist explicitly refer to Twelve Step Recovery OR interpret or explain a particular Step to the patient OR invoke a particular Step concept during the session OR discuss the patient's progress through the Steps?

The Twelve Steps of AA:

1: We admitted we were powerless over alcohol - that our lives had become unmanageable.

2: Came to believe that a Power greater than ourselves could restore us to sanity.

3: Made a decision to turn our will and our lives over to the care of God *as we understood Him.*

4: Made a searching and fearless moral inventory or ourselves.

5: Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6: Were entirely ready to have God remove all these defects of character.

7: Humbly asked Him to remove our shortcomings.

8: Made a list of all persons we had harmed, and became willing to make amends to them all.

9: Made direct amends to such people wherever possible, except when to do so would injure them or others.

10: Continued to take personal inventory and when we were wrong promptly admitted it.

11: Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.

12: Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Frequency and Extensiveness Rating Guidelines:

This item would achieve a *lower rating* if the therapist mentions a particular step without more presentation of information or examination of the patient's responses to the information. A *higher rating* would be achieved if the therapist thoroughly discusses Twelve Step recovery, a particular step and/or a patient's progress through the steps.

Examples:

T: As we look at the First Step of NA, what comes to mind for you when you hear the word "powerless"? How does that make you feel?

T: So, in the 2nd step, whose job is it to make you "sane"?

Skill Level Rating Guidelines:

Higher: Skilled presentation of this material involves clear, specific explanations of particular steps in combination with specific personal information about the patient drawn from discussion and the drug and alcohol use history. "Continuing to go to your cousin's house and expecting that he won't offer you marijuana would be an example of the "insanity" in the second step; doing the same behavior and expecting different results."

Lower: Lower ratings should be given in cases where the material is discussed by the therapist in a superficial, perfunctory, or jargon-laden manner without reference to how it relates to the patient, his or her interpretation of the material, or his or her reactions to it.

SPIRITUALITY/HIGHER POWER: To what extent did the therapist explicitly invoke the concept of spirituality or a higher power as a source of strength, hope, and guidance in the patient's working a recovery program (e.g., invoking the Serenity Prayer, reference to Steps 2 or 3 of AA/NA/CA)?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist takes the initiative in facilitating a discussion of spirituality. Discussions of spirituality may include an examination of the patient's religious beliefs, use of prayer/meditation, references to God or other Higher Power concept, or discussion of broad principles or values that bring meaning and direction to a patient's life. The therapist typically frames the issues of spirituality as an important cornerstone for successful recovery. This item would not be rated highly if the patient primarily initiates and sustains the discussion. To be rated, the therapist must explicitly explore the patient's beliefs, suggest spiritual resources or practices, provide discussion materials (e.g., Step 2 or Step 3 handouts from a 12 Step workbook or a copy of the Serenity Prayer: "God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and wisdom to know the difference..."), or invoke religious or spiritual concepts to promote the patient's recovery effort.

Examples:

T: "Tell me more about what's really important to you – what matters the most to you in your life and how did drug use take you away from these things?"

"A lot of people caught up in their addiction become spiritually bankrupt. They lose sight of a power greater than themselves that can help them in their time of need. What are your spiritual beliefs?"

"When you say you pray, what do you mean by that? Sometimes when people pray, they are only asking for something from God without listening carefully for his response."

Skill Level Rating Guidelines:

Higher: A higher rating occurs when the therapist actively emphasizes the importance of spirituality in recovery with a clear command of the material and intentional encouragement of the client to explore spiritual matters. Use of materials that further promote the patient's active participation in a discourse about spiritual development may enhance quality further. In general, the discussion of spirituality is thorough, meaningful, expansive, and inspiring.

Lower: A lower rating would be given when the therapist only tacitly reinforces a patient-initiated discussion of his/her spirituality or religiosity ("Being connected to God will help you."). Lower ratings also occur when the therapist simplifies a more open-ended, complex spiritual discussion into one of the 12 steps ("The struggles you have had in understanding God's plan remind me of the third step."). The discussion is constricted and lacks depth, individualization, and enthusiasm.

EXPLORATION/CONFRONTATION OF DENIAL OF *DRUG* EFFECTS ON SIGNIFICANT ASPECTS OF PATIENT'S LIFE: To what extent did the therapist explore or confront the patient's past or current denial in relation to past, current, or future use of *drug*, or the extent of damage *the drug* has done, is doing, or will likely do to their life?

Frequency and Extensiveness Rating Guidelines:

Denial is manifested as a complete lack of concern, anxiety, or emotional reaction about an immediate, serious, pressing need, conflict, or danger in the patient's life, so that the patient calmly conveys his cognitive awareness of the situation while denying its emotional implications (Kernberg, 1984). This item stresses the extent to which the therapist identifies the role of denial (i.e. explores the contradiction between the patient's life situation and his callous, indifferent, or inappropriate reaction to it.)

This item would achieve a *lower rating* if the therapist ignores or merely mentions a patient's lack of concern for negative consequences related to his/her drug/alcohol use. This item achieves a rating of greater than "1" if the therapist mentions the negative consequence. To achieve a *higher rating*, the therapist should explore these consequences in more detail, asking specific questions about the patient's drug history and its past consequences, as well as problems drug use could cause in the future.

Examples:

T: "You've just told me you believe you can continue using *drug* without compromising your body, and yet we know you've suffered serious liver damage."

T: "Look. Your urine screen is positive for cocaine. You say you haven't used cocaine in over a week. This is an example of how you're in denial. Denial only will continue to feed your addiction and ruin your life. If you really want to change your life, then start by being honest with me and, more importantly, with yourself. I cannot help you unless we break through this denial. When did you last use cocaine?"

T: "I think the reason you are giving me is just an excuse. Think about what you were willing to do for your addiction. Think about all the time, effort, and money you put into getting high. You'd do anything to get your drugs. How come you are not willing to do anything for your recovery?"

Skill Level Rating Guidelines:

Higher: Higher skill level use of confrontational strategies occurs when the therapist is clear, concise, and firm with the patient about his/her defensiveness in talking about their substance use and related areas as problems. The therapist persists in pointing out the patient's denial and tries to use confrontation to get the patient to acknowledge their problems and deal with them in more realistic terms. In addition, the therapist should discuss the consequences of their drug use in the context of Step 1 as "powerlessness," "unmanageability," "denial," or "loss of control" in combination with specific personal information about the patient drawn from discussion of their drug and alcohol use history.

Lower: Low skill level confrontational strategies insufficiently challenge the patient's distortions about his/her substance use and related life circumstances.

Twelve Step Facilitation (TSF) Items

(9 Items)

NOTE: The phrase "*drug of choice*" or "*drug*" appearing in italics is study specific. These items can be changed to reflect the substance you are studying.

Example: In Exploration/Confrontation of Denial of Drug(s) Effects on Significant Aspects of Patient's Life (pg 93), the substance you are actually studying (e.g., cocaine, heroin, marijuana, etc.) can be substituted for *drug*.

PREVIOUS ASSIGNMENT*: To what extent did the therapist review the patient's reactions to last session's assignment (e.g. explore or address any difficulties encountered in carrying out the assignment, provide a rationale for homework, reinforce the importance of extra-session practice of skills)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

TWELVE STEP MEETING INVOLVEMENT: To what extent did the therapist encourage the patient to become active in AA/NA/CA (e.g., through Twelve Step meeting attendance, getting a sponsor or planning specific AA/NA/CA-related activities for the week such as speaking or helping at a particular meeting, use of the telephone or encourage the client to use AA/NA/CA involvement as a means of coping)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

SELF-DISCLOSURE: To what extent did the therapist explicitly refer to his/her own life experiences or beliefs?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

CONFRONTATION: To what extent did the therapist explicitly confront the patient and/or employ a confrontational style working with the patient?

FREQUENCY & EXTENSIVENESS:

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

RESISTANCE TO TWELVE STEP RECOVERY: To what extent did the therapist explore the patient's denial/resistance to Twelve Step recovery (e.g., avoiding meetings, minimizing negative consequences, discussing the patient's resistance to following Twelve Step recovery, in terms of his/her denial, or discussing the patient's need to surrender)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

DISEASE CONCEPT OF ADDICTION: To what extent did the therapist discuss the patient's acceptance of his/her disease, its implications or its symptoms or discuss the disease concept of addiction?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

TWELVE STEP RECOVERY: To what extent did the therapist explicitly refer to Twelve Step Recovery or interpret or explain a particular Step to the patient or invoke a particular Step during the session or discuss the client's progress through the Steps?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

SPIRITUALITY/HIGHER POWER: To what extent did the therapist explicitly invoke the concept of spirituality or a higher power as a source of strength, hope, and guidance in the patient's working a recovery program (e.g., invoking the Serenity Prayer, reference to Steps 2 or 3)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

EXPLORATION/CONFRONTATION OF DENIAL OF *DRUG(S)* EFFECTS ON SIGNIFICANT ASPECTS OF PATIENT'S LIFE: To what extent did the therapist explore or confront the patient's past or current denial in relation to past, current or future use of *drug*, or the extent of damage *the drug* has done, is doing or will likely do to their life?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

**Note:* *This item should be used only for studies in which the comparison treatment does not involve outside-of-session tasks (i.e., Cognitive-Behavioral Treatment).*

Cognitive Behavioral Treatment (CBT) Items Guidelines (10 Items)

CBT is one of the most frequently studied treatments for substance use disorders, and thus is often evaluated as an experimental, comparison or 'reference' condition in clinical trials evaluating novel behavioral approaches. CBT has often been used as a behavioral 'platform' in pharmacotherapy trials (e.g., to provide an adequate and consistently behavioral treatment to all trial participants). The goal of CBT is abstinence from all psychoactive substances through identification of high risk situations for substance use and the implementation of effective coping strategies. As described in the manual (Carroll, 1998), skill training is offered in a number of areas, including: (1) reducing exposure to drug cues, (2) fostering resolution to stop drug use through exploring positive and negative consequences of continued use, (3) self-monitoring to identify high risk situations, (4) recognition of conditioned craving and development of strategies for coping with craving, (5) identification of seemingly irrelevant decisions which could culminate in high risk situations, (6) preparation for emergencies and coping with a relapse to substance use, and (7) identifying and confronting thoughts about substance use.

NOTE: The phrase *"drug of choice"* or *"drug"* appearing in italics is study specific. These items can be changed to reflect the relevant substance in any particular study.

Example: In Coping Skills Training , the substance relevant to the study population studying (e.g., cocaine, heroin, valium, etc.) can be substituted for *drug*.

PREVIOUS ASSIGNMENT: To what extent did the therapist review the patient's reactions to last session's assignment (e.g., explore or address any difficulties encountered in carrying out the assignment, PROVIDE A RATIONALE for homework, reinforce the importance of extra-session practice of skills)?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist focuses on homework previously assigned to the patient. A higher rating would be achieved when the therapist engages the patient in an in-depth discussion regarding the identified homework assignment (e.g. reviewing the patient's reactions, what he/she learned). In addition to specifics of the assignment, this discussion may include a focus on the rationale for the use of extra-session assignments, as well as exploration and reinforcement of the positive aspects of the patient's performance. If the patient had difficulty doing the assignment or did not attempt it at all, the therapist will explore this with him/her to determine what issues interfered with doing the assignment, the patients' thoughts about homework, and will work with the patient regarding strategies for doing the homework next time. The therapist may also address the importance of practicing new coping skills and review the rationale for doing homework assignments. Higher ratings would also be given in cases where the therapist integrates information from the homework assignment, or uses information or examples from the current homework assignment in the session. If the patient did not do the assignment, higher ratings would also be given in cases where the therapist and patient work together in the session to complete the assignment. A lower rating would be assigned when the therapist asks about the assignment but does not actively pursue a detailed discussion of the homework or facilitate a dialogue regarding the rationale for homework and the importance of practicing the new skills in between sessions.

Examples:

T: "Let's spend some time reviewing your last week's assignment. How did it go?…. Were you able to identify any triggers that make you feel like using?…Pick one of your triggers, and we will explore what you were thinking and feeling, what you did, and what the positive and negative consequences were as a result. Then, we can look at what you might have done instead, for example, if you had called a friend instead of using."

T: "By coming up with behaviors that break the learned pattern of using substances to cope, you are learning that there are alternatives to using when you are triggered. Even though these new skills may be awkward at first, the more comfortable you become using these positive coping skills, the more likely you are to not use substances when faced with a difficult situation. By doing your assignments, you are practicing new coping skills, and the more you practice, the more natural it will be to deal with difficult situations without using. In addition, by reviewing your assignments in session, we can identify additional coping skills that you can add to your repertoire."

T: It sounds like you had a hard time finding some time to do the assignments. We can talk about how you might tackle this next time, but why don't we spend just a few minutes now doing the assignment—sometimes it's a little hard to get started, but you'll find that once you get the hang of this, it'll take just a few minutes, and I think you'll find it really helpful. So, let's go through this… You know, we can talk about making changes in here, but the homework is a really important way to help you carry those changes outside of our meetings, too."

Skill Level Rating Guidelines:

Higher: A higher quality rating on this item occurs when the therapist explicitly and consistently

maintains a focus on the patient's previously assigned homework. The therapist must engage the patient in a detailed discussion of the homework, not simply a general review, including exploration of any difficulties the patient encountered in completing the assignment. For a higher quality rating to be assigned, the therapist must also integrate discussion of the present assignment with an overall emphasis on substance abuse as a learned behavior and to appreciate the idea that he/she may then learn new coping skills to deal with urges to use that will help the patient achieve/maintain abstinence. In addition, the therapist may emphasize such ideas as, "practice makes perfect" in explaining to the patient the importance of completing homework assignments. A skilled therapist would also "check-in" with the patient to determine the patient's level of understanding throughout the session.

Lower: A lower quality rating on this item may occur for several reasons. For example, the therapist may fail to pursue a discussion regarding the previously assigned homework or may engage in a more general review instead of a detailed exploration. The therapist may also fail to connect the specific homework assignment to the underlying rationale for extra-session assignments and the role of practice in skill development. Specifically, a lower quality rating would indicate that the therapist does not explicitly demonstrate for the patient the connection between the homework assignment and the rationale that, with practice, new and healthy coping skills can be learned just as substance use was learned as a way to cope.

COPING SKILLS TRAINING: To what extent did the therapist attempt to teach, model, rehearse, review, or discuss specific coping skills (generalizable strategies; e.g., generating alternatives such as drug refusal, problem solving, coping with craving, social skills), label them as such, and link them to past/future substance use?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist explicitly teaches specific coping skills, whether or not they are related to substance abuse and related problems. A higher rating would be achieved when the therapist actively and explicitly engages the patient in an in-depth discussion regarding specific coping skills, including each of the following steps: (1) an introduction and rationale for the skill, (2) a thorough explanation of the skill, (3) providing some examples of the skills, (4) linking the skill to past patient behavior, and (5) some assessment of the patient's understanding of and learning the skill. In addition, for a higher rating to be achieved, the therapist must engage the patient in the actual practice of a new coping skill during the session, and/or significant planning for skill implementation. Higher ratings would also be given when these are linked to past/future substance use ("I think if you tried this the next time you experienced those kind of thoughts, you'd find it helpful.")

Common skills include identifying consequences and antecedents of substance use, understanding and coping with craving, teaching refusal skills and assertiveness, teaching general problem solving skills, teaching skills for planning for emergencies, identifying and challenging cognitions, training in social skills, etc..

A lower rating would be assigned when the therapist does not actively pursue a discussion regarding coping skills, does so in a rapid or cursory manner, or engages patients in discussions of behaviors they might change without making the abstract principle explicit ('what could you do differently next time?'), or makes a point about abstract behavior change without discussing specific applications relevant to the patient ("you have to stop exposing yourself to high risk situations").

Examples:

T: "Now that we've gone through the steps of problem solving and narrowed down what's going on, let's go to the next step and try to brainstorm some options for solving this problem."

T: "Instead of beating yourself up for using and increasing the chance that you might use again, let's break it down so that you can learn from the experience. Tell me about what happened. Then we can look at the triggers and what you were thinking and feeling at the time—remember how last time we talked about paying attention to the patterns of your substance use as a way to change your patterns, well, lets try it now.

T: "Let's role-play that situation. I'm your son, and I'm not helping you around the house. You come home from work, and you find that the garbage was not taken out and the kitchen was not straightened up. You are very angry with me. Let's first role-play it the way it typically happens. After we are done role-playing it that way, we will talk about what happened and come up with how you can cope with the situation without letting your anger get the best of you and without getting high. Then we will role-play the situation again so that you can practice some of these techniques."

Skill Level Rating Guidelines:

Higher: A higher quality rating for this item occurs when the therapist demonstrates a focus on coping skills training. The therapist actively engages in and maintains a detailed discussion of a specific coping skill(s). For a higher quality rating to be achieved, the therapist not only discusses and teaches the specific skill(s), but must also facilitate the patient's implementation of the skill either through actual in-session practice or a detailed discussion of how the patient will apply the skill in an upcoming situation. A higher quality rating also indicates that, in covering this topic area, the therapist has consistently and skillfully integrated information regarding learning theory and its connection to coping skills training. This may be seen in discussion regarding substance use as a learned behavior and, as such, may be unlearned. The therapist may also emphasize that more positive and healthy coping skills may now be learned and, with practice, will be critical in preventing relapse. A skilled therapist would also consistently "check-in" with the patient to determine the patient's level of understanding regarding the coping skill(s) and underlying rationale.

Lower: A lower quality rating for this item occurs when the therapist fails to identify and maintain a focus on coping skills training. The discussion may also be in more general terms where a specific skill(s) is neither identified nor taught. A lower quality rating may also be assigned when a specific skill(s) is identified and discussed, but a focus on the practice and/or implementation of the skill(s) is not present. In addition, the therapist may fail to connect the topic of coping skills training to the underlying learning theory, including the idea that, with practice, new and healthy coping skills can be learned just as the behavior of substance use was learned. The therapist may also not explicitly identify the critical role of practice in skill development.

TASK ASSIGNMENT (NON TWELVE STEP MEETING INVOLVEMENT): To what extent did the therapist develop one or more specific assignments for the patient to engage in between sessions (not including twelve step meeting involvement)?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist focuses on the explicit assignment and discussion of new extra-session tasks (homework). A higher rating would be achieved when the therapist devotes a significant amount of time and engages in a detailed and extensive discussion of the new homework assignment(s). For a higher rating, the therapist must present and explain a homework assignment, provide a rationale for it (or a general rationale for homework), explore the patient's understanding of the assignment, and explore any barriers to doing the assignment. The assignment(s) must be a specific, concrete task(s) to be done prior to the next session and should not be confused with a discussion of the patient's goals on which he/she may be working between sessions. Higher ratings would also be given in cases where the therapist initiates the assignment or provides examples within the session to assure the patient understands the assignment. Higher ratings would also be given in cases where the therapist and patient develop an assignment collaboratively.

A lower rating would be assigned when the therapist fails to engage in an explicit and detailed discussion of extra-session tasks. A lower rating may also indicate a general review of the patient's identified goals rather than a focus on specific task assignment(s).

Example:

T: "Let's talk about this week's homework assignment. Since we have been discussing cravings/urges to use, including how you experience a craving/urge and plans for dealing with cravings/urges, I think it might be very helpful for you to begin to track your cravings/urges outside of sessions. The form I have here is a "Daily Record of Cravings". Let's spend some time reviewing the form and how you would complete it over the next week. I also have an example here for us to review. How does that sound?"

Skill Level Rating Guidelines:

Higher: A higher quality rating for this item occurs when the therapist explicitly identifies and assigns the specific activity/task as homework or practice to be done in between sessions. This assignment process would include extensive discussion and clarification of what completion of the task will entail, as well as explicit identification of the benefits and rationale for the assignment. For a higher quality rating to be achieved, the therapist must also clearly convey that the completion (or lack thereof) of the assignment will be reviewed during the patient's next session ***and makes it very clear how doing the assignment will be helpful to the patient***. In addition, the skilled therapist will consistently integrate discussion of the new assignment with the underlying rationale of treatment ("to learn to do anything new, you have to practice it"). Specifically for this item, the therapist may focus on helping the patient to see his/her substance use as a learned behavior and, therefore, to appreciate the idea that he/she may then learn other behaviors, including more positive and healthy coping skills, through the use of homework assignments. In addition, the therapist may emphasize such ideas as "practice makes perfect" in explaining to the patient the importance and meaning of homework assignments. In order to increase the likelihood of the above discussion's effectiveness, a skilled therapist would also consistently "check-in" with the patient to determine the patient's level of understanding regarding the new assignment as well as the rationale being presented.

Lower: A lower quality rating for this item may occur when the therapist fails to explicitly identify and assign a homework assignment(s). In addition, a lower quality rating may be assigned if the therapist does not facilitate a detailed discussion of the specific assignment(s), including the expectations regarding completion as well as explanation of the benefits and rationale for the assignment(s). A lower quality rating may also indicate a failure to connect the homework assignment(s) to the ongoing therapy by clearly conveying that the assignment will be reviewed during the patient's next session. Finally, the therapist may also fail to connect the specific homework assignment(s) to the underlying rationale for extra-session assignments and the role of practice in skill development. Specifically, a lower quality rating would indicate that the therapist does not explicitly demonstrate for the patient the connection between the homework assignment(s) and learning theory, including the idea that, with practice, new and healthy coping skills can be learned just as substance use was learned.

COGNITIONS: To what extent did the therapist ask the patient to monitor, report, or evaluate SPECIFIC COGNITIONS associated with substance use or related problems?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent which the therapist elicited the patient's specific thoughts or cognitions associated with substance use or related problems exacerbated by negative thinking. These can be specific thoughts the patient experienced either within or outside of sessions. In contrast to the coping skills item which emphasizes more the behaviors related to substance use, this item focuses on the dysfunctional, irrational, distorted, or automatic thoughts that are often related to substance abuse and related problems.

The **techniques** most commonly used to identify these problem cognitions include Socratic questions, downward error, and functional analysis. Some cognitions most commonly associated with substance abuse are related to *catastrophizing, dichotomous thinking, jumping to conclusions, unrealistic expectations, and low frustration tolerance*. A discussion of the *abstinence violation effect* would be rated on this item. This cognition involves the catastrophizing of a single episode of substance use into full-blown relapse through dichotomous thinking. Once the nature and content of the dysfunctional or maladaptive thoughts are identified, a series of cognitive disputing techniques may be used to help point out the irrationality.

To be *rated highly*, the therapist should have made numerous attempts in the session to elicit the patient's specific thoughts underlying certain behaviors, emotional experiences, or opinions. A higher rating also will typically include one or more attempts to dispute these irrational, maladaptive, or automatic thoughts. A *low rating* is given when the therapist seldom isolates a patient's cognitions or does not make efforts to help a patient reconsider distorted patterns of thinking.

Examples:

T: "It seems like when people criticize you, you feel like you have done something very wrong. The criticism may even be very constructive or minor in the context of an overall job well done. It's as if you think you have to be perfect or should be able to figure out everything on your own."

T: "Be careful. When you hear yourself saying to yourself "Nobody cares about me", you might want to stop and think. How true is it that because your siblings don't want you to live in your mother's house doesn't mean that they're out to get you or don't give a damn about you. Is there another way to look at why they don't want you to stay with your mother right now?"

Skill Level Rating Guidelines:

Higher: Higher quality cognitive interventions occur when a therapist takes time to isolate the unique cognitive distortions or beliefs held by the patient that underpin problematic behavior and mood or interpersonal difficulties. In addition, to receive higher Skill Level ratings, the therapist must make repeated persuasive attempts to help the patient reconsider distorted cognitions and adopt more realistic or rationale viewpoints. Interventions in which the therapist clearly describes common cognitions associated with substance use as a means to further engage the patient in this cognitive restructuring process also increase ratings.

Lower: A lower rating occurs when a therapist only makes a general inquiry into the patient's thoughts or beliefs (e.g., "Do you remember what you were thinking or saying to yourself when you decided to go into the bar and have a drink?") and does not get to the underlying

cognitive distortion or attempt to dispute the belief. The therapist appears tentative or clumsy identifying or restructuring the patient's cognitions. Premature abandonment of the intervention also results in lower Skill Level ratings. Finally, lower quality ratings may occur when a therapist provides a list of common cognitive distortions without trying to obtain a detailed understanding of the patient's idiosyncratic distortions.

PAST HIGH RISK SITUATIONS: To what extent did the therapist discuss any high risk situations the patient encountered in the past, and explore any specific actions that were taken to avoid or cope with the situation(s)?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist actively encourages the patient to identify a high risk situation(s) that occurred in the past and identify the coping skills that he/she employed to manage the situation(s). A higher rating would be achieved when the therapist engages the patient in a thorough and detailed discussion regarding the meaning of a "high risk situation," specific high risk situation(s) faced by the patient in the past, and the specific actions taken by the patient to avoid or cope with the identified situation(s). A higher rating would also include the therapist's facilitation of exploration and discussion regarding alternative, more effective coping skills for use in the identified high risk situation.

A lower rating would be assigned when the therapist fails to engage the patient in an in-depth discussion regarding high risk situations. This would include a failure to discuss the definition of a high risk situation and identify a specific high risk situation(s) encountered by the patient as well as a failure to explore the coping skills used by the patient at the time. In addition, a lower rating would be assigned when the therapist fails to facilitate a discussion of more positive and effective coping skills the patient may have used in the given high risk situation.

Example:

T: "Let's begin by trying to get a sense of those situations that have been most difficult for you in the past, particularly those situations in which you have been most likely to use. This way we can get a sense of what you were thinking and feeling in those situations as well as what you ended up doing to manage the situations. We will call the situations in which you were most likely to use "high risk situations." By discussing your high risk situations, we can get a better idea of what (people, places, and/or things) triggers your substance use. Then, we can help you to identify better ways to cope with those and/or similar situations should they occur in the future.

Skill Level Rating Guidelines:

Higher: A higher quality rating for this item occurs when the therapist explicitly and consistently focuses on the topic of "high risk situations," particularly past high risk situations encountered by the patient. The therapist must convey in a clear and understandable manner the meaning of a "high risk situation." In addition to the general introduction and definition of a "high risk situation," the therapist must actively engage the patient in discussion regarding a high risk situation(s) that is specific to the patient. For a higher quality rating to be achieved, the therapist must help the patient to not only identify the high risk situation(s), but also facilitate discussion of what led to the situation(s), the coping skills used at the time, and specific alternative ways that the patient could use to cope with this high risk situation(s). The therapist may refer to such past high risk situations as "dangerous," "risky," "people, places, and things," or "conditioned cues." Overall, a higher quality rating indicates that the therapist has made a direct connection between the patient's substance use and the reasons a specific situation may be identified as "high risk." In other words, it is clear which particular aspects of a situation are problematic for the patient.

Lower: A lower quality rating for this item may occur for several reasons. For example, the therapist may fail to engage the patient in a detailed, comprehensive, and patient-specific discussion

regarding the topic of high risk situations, including the definition. The therapist may also fail to pursue a detailed discussion of a high risk situation(s) that has been described by the patient, including an in-depth description of the situation itself and the coping skills used by the patient at the time. In addition, a lower quality rating may be assigned when the therapist fails to identify specific alternative ways the patient could use to cope with the high risk situation(s) being discussed. Finally, a lower quality rating may indicate that the therapist does not explicitly connect the patient's substance use to the identified high risk situation and/or identify which aspects of the situation are actually problematic for the patient.

FUTURE HIGH RISK SITUATIONS: To what extent did the therapist encourage the patient to ANTICIPATE ANY HIGH RISK SITUATIONS that might be encountered after the session and FORMULATE APPROPRIATE COPING STRATEGIES for such situations?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist actively encourages the patient to identify future high risk situations and develop one or more specific strategies/techniques for coping with a particular high risk situation. A higher rating would be achieved when the therapist actively and explicitly engages the patient in an in-depth discussion regarding the anticipation of future high risk situations (e.g., an upcoming payday or a specific social gathering). Specifically, the therapist not only helps the patient to identify an upcoming high risk situation(s), but also encourages the patient to develop one or more ways to manage the high risk situation being discussed. This may include the therapist providing specific strategies/techniques, inquiring about strategies/techniques used in the past, or a directed inquiry of how the patient plans to handle such a situation in the future. Strategies may include avoiding the situation, asking a friend or significant other for help, altering the situation, and so on.

A lower rating would be assigned when the therapist fails to help the patient identify specific future situations that may be high risk. In other words, the discussion appears to be more general in nature without a focus on a specific high risk situation(s) that the patient may be anticipating. In addition, a lower rating would indicate a failure on the therapist's part to actively encourage the patient to focus on and develop one or more specific strategies for managing the upcoming high risk situation(s).

Examples:

T: "Since you and I began meeting, you have openly shared your difficulty coping with your father's death and how this loss has been a significant trigger for your substance use. I know this is a hard topic to discuss, but I believe it is extremely important for us to spend some time talking about it as the anniversary of his death is later this week. Have you thought about how you were going to spend the anniversary?"

P: "I have been trying not to think about it…. I guess, at some point, I will go to the cemetery."

T: "I know this is very difficult for you. I also know that to support your maintaining abstinence, we owe it to you to spend some time talking about this very important day. Why don't you and I take some time to talk about a plan and different ways that you may be able to use to manage this difficult time. For example, would it help to have someone go to the cemetery with you or to make plans to see a friend after you visit the cemetery? What kind(s) of support could you put in place to help you cope with this anniversary without using?"

Skill Level Rating Guidelines:

Higher: A higher quality rating for this item occurs when the therapist maintains a detailed focus on an upcoming high risk situation(s), including clearly conveying to the patient the importance of this topic. This includes discussion regarding substance abuse as a learned behavior and the idea that since substance abuse is learned, he/she may then learn new ways to manage specific situations. The therapist may also ask the patient to role-play the situation(s) being discussed in order to develop and rehearse the new coping strategies. In addition, to be rated highly, the therapist must facilitate the development of elaborate, realistic, detailed, and thorough plans for how to manage the upcoming high risk situation(s) that appear appropriate to the patient's situation(s) and that have a good chance of success.

Lower: A lower quality rating for this item may occur for several reasons. For example, the therapist may fail to pursue a discussion regarding specific upcoming high risk situations and may engage in a more general discussion of high risk situations. The therapist may also fail to connect the discussion of a specific high risk situation(s) to the underlying rationale of the role of practice in skill development and the maintenance of abstinence. Specifically, a lower quality rating would indicate that the therapist does not explicitly demonstrate for the patient the connection between the session topic (anticipated/future high risk situations) and the rationale that, with awareness and practice, new and healthy coping strategies can be learned just as substance use was learned. Finally, a lower quality rating would be assigned if the therapist fails to facilitate the development of a detailed plan for coping that appears appropriate and realistic for the patient, including the use of more passive comments such as "what do you think you should do about…" without specific comments or inquiry on the likely success of the plan.

SLIP VS. RELAPSE: To what extent did the therapist convey to the patient that a slip does not necessarily mean that the patient will experience a full-blown relapse?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist explicitly conveys to the patient that a single drinking or drug experience (a slip) does not have to lead to out of control usage (a relapse). A higher rating would be achieved when the therapist engages the patient in an in-depth discussion regarding the differences between a slip and a relapse. The therapist should clearly convey that he/she is in no way giving the patient permission to use drugs; however, should an episode of substance use occur, the therapist should emphasize the importance of learning from a slip (e.g., identifying personal, situational, or environmental factors that may have contributed to the patient's decision to drink alcohol or use drugs and better ways to cope with these factors), so as to prevent the occurrence of another slip, as well as strategies for keeping a single episode of use from turning into an extended relapse..

A lower rating would be assigned when the therapist does not discuss with the patient in detail and at length the meaning of a slip and a relapse as well as the difference between the two. In addition, a lower rating would indicate that the therapist fails to engage the patient in discussion regarding the importance of identifying the factors (personal, situational, environmental, etc.) that may contribute to a slip in order to prevent the occurrence of another slip.

Examples:

T: "We are all faced with difficult situations no matter how well we may plan or attempt to avoid them. Therefore, it is important for us to talk about what may happen if you are faced with a difficult/high risk situation and end up using. This one time use is referred to as a "slip." This is different than a "full-blown relapse" where you use in a way that is more similar to your previous pattern of use. You might think about it like a fire drill—one hopes there won't every be a fire, but knowing what to do just in case is really important and keep a difficult situation from turning into a disastrous one"

T: "While we hope that a slip does not happen, for some people it does, and, therefore, it is extremely important to understand what a slip is and how it can be an important learning experience. As slips can lead to extremely difficult thoughts and feelings such as shame and/or guilt, how one handles a slip can determine if it remains a slip or becomes a full-blown relapse. The more we can learn from your slip, the better prepared you will be to use new coping skills and not use the next time you are faced with a high risk situation. "

Skill Level Rating Guidelines:

Higher: A higher quality rating for this item occurs when the therapist explicitly identifies and discusses the terms "slip" and "relapse" and engages the patient in a detailed discussion regarding the differences between the two. To be rated highly, the therapist must explicitly convey to the patient that a slip can be treated as a learning experience. As such, identifying triggers that precipitated the slip and coping behaviors that could be utilized, can help the patient to prevent a full-blown relapse. The use of specific situations related to the patient's experiences may also be included regardless of whether discussing an actual slip or the notion of a slip in general.

Lower: A lower quality rating for this item occurs when the therapist fails to clearly identify and discuss the terms "slip" and "relapse," including a detailed discussion of the differences

between the two. In addition, a lower quality rating would indicate that the therapist has failed to identify and emphasize the idea that a slip can be treated as a learning experience, including using a slip to prevent a full-blown relapse. The therapist may also fail to use specific patient-related experiences in discussing an actual or hypothetical slip.

EXPLORATION OF CRAVINGS/TRIGGERS/URGES FOR DRUG(S) OF CHOICE: To what extent did the therapist assess and/or explore specific cravings, triggers, or urges for *drug(s) of choice* and identify them as such?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist focuses on the topic of cravings/triggers/urges. A higher rating would be achieved when the therapist engages the patient in an in-depth discussion regarding the concept of cravings/triggers/urges. In addition, the therapist must actively and explicitly encourage the patient to identify specific cues (e.g., being around people with whom he/she used, getting paid, certain affect states, and so on) that are associated with cravings or urges for him/her. This discussion may also include clarification and exploration of the subjective experience of craving as it is experienced by the patient.

A lower rating would be assigned when the therapist fails to engage in an explicit and detailed discussion of cravings/triggers/urges. A lower rating may also indicate a general review of this topic, but a failure on the therapist's part to discuss and identify the specific cues that are associated with cravings or urges for the patient.

Examples:

T: "Today we are going to talk about the topic of triggers. You may have heard this term before. In general, a trigger is anything that increases the chance that someone will get high……"

T: "Now, I want you to think about the last time you used, maybe sometime during the last week. If you didn't use during the past week, then think about the last time you had an urge to use. Try to remember the details of the situation so you can play it back in your mind, almost like a movie in your memory. Try to identify the specific cues, for example, where you were, who you were with, how you were feeling, etc."

Skill Level Rating Guidelines:

Higher: A higher quality rating on this item occurs when the therapist actively engages in and maintains a detailed discussion of this topic, including an explicit linking of the presence of cravings/triggers/urges to past/future substance use. The therapist explains that craving is normal and common and doesn't necessarily mean that anything is wrong. In addition, the therapist will identify common triggers (e.g., certain people, emotions, places) that often increase a person's urge to use. This facilitates the patient's ability to identity his/her subjective experience of craving, which may help the patient identify triggers and ways to cope with craving without using. A skilled therapist will convey the time-limited nature of craving and that it will peak and dissipate if the patient does not use. Ultimately, the therapist wants to help the patient identify triggers that lead to craving, identify ways to avoid triggers when possible, and to cope with urges to use when they occur.

Lower: A lower quality rating is achieved when the therapist describes the the experience of craving in a general way, without helping the patient identify what his/her triggers are, and/or what the patient's subjective experience of craving is. As a result, the patient may understand the general concept of craving, but not be able to identify their own subjective experience or craving, their triggers, and therefore, will be less prepared to avoid cues and/or be prepared to cope with craving.

AGENDA SETTING: To what extent did the therapist articulate and implement a specific agenda for the session (e.g., identify session topics, list issues to be discussed during the session)?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist explicitly identifies and follows through with a specific agenda for the session. A higher rating would be achieved when the therapist clearly articulates and implements a specific agenda, including what the topic of the session is, the elements related to the topic and the assignment related to the topic. The therapist must present the agenda at the beginning of the session as agenda setting cannot occur at the end. In addition, announcing a task immediately before doing it is not considered providing or setting an agenda.

A lower rating would be assigned when the therapist sets a vague agenda or fails to follow through with a clear agenda that was set. In addition, a lower rating may reflect that the therapist attempted to set an agenda at a time other than the beginning of the session or rather than setting an agenda would announce a task immediately before doing it.

Example:

T: "Today we are going to talk about craving for alcohol. We will identify specific triggers that increase your cravings, and we will begin to learn alternative ways of coping with the cravings without drinking. At the end of the session we will do a practice exercise that helps you identify craving triggers through self-monitoring and to develop coping behaviors to deal with cravings when they occur. The more you know about what sets you up to use and the more you practice skills that help you cope with cravings, the better prepared you will be to maintain your abstinence."

Skill Level Rating Guidelines:

Higher: A higher quality rating for this item occurs when the therapist explicitly sets a specific agenda at the beginning of the session and follows through with the given agenda in a complete and detailed manner. The agenda should not only include the overview of the session, but also link the current topic to the rationale for the treatment, stressing the importance of learning new coping skills and practicing them in-between sessions.

Lower: A less skilled therapist may fail to set an agenda at the beginning of the session. This would include both those situations where the therapist never sets an agenda as well as those where the agenda is set at a time other than the beginning of the session. A lower quality rating would also be assigned if the therapist sets an agenda at the beginning of the session, but it is vague and/or the therapist does not follow through with the agenda completely. A lower skill rating would also be achieved if the therapist sets an agenda but is not careful to connect the topic to the overall rationale for the treatment.

ROLE-PLAY: To what extent did the therapist initiate a role-play during the session (e.g., set and act out a scene and process what occurred)?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist initiates and actively engages the patient in the technique of role-play. A higher rating would be achieved when the therapist clearly initiates and introduces the role-play and includes all elements of a role-play, including setting the scene, acting out the scene (usually reversing roles), and then processing what happened in the exercise.

A lower rating would be achieved when the therapist fails to clearly initiate and/or introduce the technique of role-play or when initiated, does not follow through or include the above mentioned key elements of a role-play.

Example:

T: "We have just talked about future high-risk situations and you are anticipating one coming up this week. Let's do a role-play to prepare you for it. I will be your friend, Bill and you be yourself. We will start with meeting him after work and see what happens. Next, I will be you and you can play the part of Bill. Afterwards, we will discuss what happened and identify some strategies to deal with this upcoming situation."

Skill Level Rating Guidelines:

Higher: A higher quality rating on this item occurs when the therapist actively engages the patient in the discussion and actual implementation of the technique of role-play. For a higher quality rating to be achieved, the therapist clearly introduces and presents the technique of role-play, as well as discusses support for the use of this technique in the patient's treatment. In this way, it is clear that the patient understands the importance and potential value of this technique in the treatment of substance abuse. A skilled therapist will usually try to use an actual situation the patient has experienced or anticipates to make it more relevant to the patient's experience. To achieve a higher rating, the therapist must include all elements of a role-play, including setting the scene, acting out the scene (usually reversing roles), and then processing, in depth, what happened in the role-play. A higher quality rating also indicates that by practicing through role-play the patient is learning new ways to cope without using, and learning is the cornerstone of this treatment.

Lower: A lower quality rating on this item may occur when the therapist fails to clearly initiate and introduce the technique of role-play, including discussion of the rationale for the technique and its connection to substance abuse as a learned behavior. The therapist may also attempt a role-play, but fail to identify a situation for the role-play that is relevant and meaningful for the patient.

Cognitive Behavioral Treatment (CBT) Items

(10 Items)

NOTE: The phrase "*drug of choice*" or "*drug*" appearing in italics is study specific. These items can be changed to reflect the relevant substance in any particular study.

Example: In Coping Skills Training, the substance you are actually studying (e.g., cocaine, heroin, marijuana, etc.) can be substituted for *drug*.

PREVIOUS ASSIGNMENT: To what extent did the therapist review the patient's reactions to last session's assignment (e.g. explore or address any difficulties encountered in carrying out the assignment, provide a rationale for homework, reinforce the importance of extra-session practice of skills)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

COPING SKILLS TRAINING: To what extent did the therapist attempt to teach, model, rehearse, review, or discuss specific coping skills (generalizable strategies; e.g., generating alternatives such as drug refusal, problem solving, coping with craving, social skills), label them as such, and link them to past/future substance use?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

TASK ASSIGNMENT (NON TWELVE-STEP MEETING INVOLVEMENT): To what extent did the therapist develop one or more specific assignments for the patient to engage in between sessions (not including 12 step meeting involvement)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

COGNITIONS: To what extent did the therapist ask the patient to monitor, report or evaluate SPECIFIC COGNITIONS associated with cocaine/alcohol use or related problems?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

PAST HIGH RISK SITUATIONS: To what extent did the therapist discuss any high risk situations the patient encountered in the past, and explore specific actions that were taken to avoid or cope with the situation(s)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

FUTURE HIGH RISK SITUATIONS: To what extent did the therapist encourage the patient to ANTICIPATE ANY HIGH RISK SITUATIONS that might be encountered after the session and FORMULATE APPROPRIATE COPING STRATEGIES for such situations?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

SLIP VS. RELAPSE: To what extent did the therapist convey to the patient that a slip does not necessarily mean that the patient will experience a full-blown relapse?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

EXPLORATIONS OF CRAVINGS/TRIGGERS/URGES FOR 'DRUG OF CHOICE': To what extent did the therapist explore specific cravings, triggers, or urges for 'drug of choice' for the purpose of labeling them as a trigger or urging the patient to avoid them?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

AGENDA SETTING: To what extent did the therapist articulate and implement a specific agenda for the session (e.g., identify session topics, list issues to be discussed during the session)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

ROLE-PLAY: To what extent did the therapist initiate a role-play during the session (e.g., set and act out a scene and process what occurred)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

Interpersonal Therapy (IPT) Items Guidelines (10 Items)

Interpersonal Psychotherapy (IPT) was initially developed for the treatment of depressed outpatients in the NIMH Multi-site collaborative study on depression (Klerman, Weissman, Rounsaville & Chevron, 1984). Adapted for use with a number of different clinical populations (Klerman & Weissman, 1993) it is based on the concept that psychiatric disorders, including depression and drug abuse, are intimately related to disturbances in interpersonal functioning that may be associated with the genesis and/or perpetuation of the disorder. The major aims in treating drug abusing patients are 1) to help the patient reduce or cease drug use, and 2) to help the patient develop more productive strategies for dealing with social and interpersonal problems associated with their drug use. Strategies to help the patient stop using include techniques to support management of impulsiveness and recognition of the context of drug use. Treating the patient's difficulties in interpersonal relations proceeds by exploring the four problem areas commonly associated with the onset or exacerbation of substance abuse: grief, role disputes, role transitions, and interpersonal deficits. Therapy proceeds with an initial evaluation of interpersonal functioning, identification of one or two major problems associated with the drug use, an explicit contract to address , and the implementation of a set of proscribed techniques to work on these problems in the context of drug use.

NOTE: The phrase "*drug of choice*" or "*drug*" appearing in italics is study specific. These items can be changed to reflect the relevant substance in any particular study.

Example: In Interpersonal Meaning of Craving, the substance relevant to the study population (e.g., cocaine heroin, marijuana, etc.) can be substituted for *drug*.

FOCUS ON PAST OR CURRENT INTERPERSONAL DEFICITS: (Defined as: Social isolation resulting from a significant lack of healthy important relationships or inability to get needs met from relationships.) To what extent did the therapist focus on the patient's interpersonal deficits?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the session is devoted to focusing on the patient's interpersonal deficits. A patient is considered to have an interpersonal deficit if he/she is socially isolated or if he/she is unable to get one or more significant needs met in ANY of his/her current or recent relationships. The therapist is unlikely to tell the patient that he/she has an interpersonal deficit or that they are going to focus on it. Rather, the therapist focuses on the deficits without labeling them. A higher rating would be achieved when the therapist devotes a significant amount of time and explores at some depth what he/she perceives to be interpersonal deficits. A lower rating would be achieved when the therapist does not appear to be focusing on the area of interpersonal deficits or addresses this topic in a more general way that is not specific to the patient's interpersonal experiences.

Examples:

T: "I understand that you are currently living with your son, that you have been divorced for several years, and that you work part-time in a department store. How do you get along with your fellow employees?"

P: "OK, I guess. I leave them alone, and they leave me alone."

T: "Would you consider any of the people at work to be your friends?"

P: "No, and I wouldn't want them to be. I don't believe in mixing personal life with work."

T: "What other friends do you have outside of work?"

…..and so on, reviewing the patient's relationships with son, people outside of work, friends, significant others, etc., including what they do together, how oftenthey see each other, etc.

Skill Level Rating Guidelines:

Higher: A skilled therapist actively engages in a thorough questioning and discussion of the patient's past and present relationships, including the number and quality of identified relationships. The therapist may also focus on the patient/therapist relationship, the patient's participation in interpersonal activities, and the formation of new relationships. In addition, for a high quality rating, the discussion of the above material must be specific to the patient's history and present level of functioning. The need for patient specific discussions will be evident in such areas as the exploration of the patient's interpersonal patterns and previous interpersonal difficulties experienced by the patient. As this discussion may be difficult for the patient, a skilled therapist would be both supportive and nonjudgmental in gathering information and would be sensitive to the patient's level of comfort and/or discomfort.

Lower: A less skilled therapist discusses this issue in a more general way, failing to base interventions on the disclosure of information provided in the session by the patient. The therapist may appear to be providing generic feedback and the discussion does not seem to be guided by the specific material provided by the patient. It may also appear as if the therapist does not follow-up on information presented by the patient. In sum, a lower quality rating occurs when the therapist fails to gather individualized and comprehensive information regarding the patient's interpersonal history, and as a result, is unable to provide patient-specific feedback and direction within the session.

INTERPERSONAL MEANING OF CRAVING: To what extent did the therapist explore how drug use or craving since the last session related to specific interpersonal problems or difficulties with role transitions that were taking place at the time of the craving or slip?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist explicitly discussed the relationship between a specific episode of drug use or craving and an interpersonal conflict or problem that the patient was having at the time of use or craving. A higher rating would be achieved when the therapist actively and explicitly engages the patient in an in-depth discussion regarding recent interpersonal experiences and how they may be related to the patient's drug use or craving. A lower rating would be assigned when the therapist does not actively pursue a dialogue regarding the relationship between the patient's interpersonal life and a specific episode of drug use or craving.

Examples:

T: "You said that you went out to get some cocaine last night after you argued with your wife. Tell me more about the argument. Let's try to understand what's going on between the two of you at those times." OR

T: "You said that you used cocaine after you were paid on Friday. Let's see what may have been going on in your personal life as well that made you want to use. When did you first think about using that day?"

P: "It was in the afternoon when my girlfriend called at work and wanted me to come home right after work to give her the money. I think at that time I said to myself, screw it. I'm going out after work to buy a piece before I go home."

T: "So, instead of saying 'No, I want to go out on my own for a while' directly to her, you said 'no' by going out and getting high. Let's discuss what that may be about in your relationship and how you might get your needs met more directly."OR

T: "Maybe cocaine plays a role in dealing with some problems with your girlfriend. It sounds like you were angry about her call. Let's discuss it."

Skill Level Rating Guidelines:

Higher: A higher quality rating for this item occurs when the therapist demonstrates a focus on the patient's interpersonal problem/conflict as the trigger for drug use. The connection between the patient's interpersonal functioning and the craving or slip would be explicit. Specifically, the emphasis would remain on the role of the patient's relationships in the connection between the patient's interpersonal functioning and the craving or slip, not just the craving or slip itself. In addition, for a higher quality rating to be achieved, the therapist would be consistently active and encouraging in the facilitation of the discussion gathering enough information from the patient regarding his/her interpersonal/social life in order to determine what, if any, experiences may be related to the craving or slip.

Lower: A lower quality rating for this item may occur when the therapist fails to pursue a discussion regarding an identified interpersonal problem/conflict. The therapist may also fail to gather specific information regarding the interpersonal problem/conflict. In addition, a lower quality rating may indicate the therapist's focus/emphasis on exploration of the craving or slip itself, rather than the connection between the patient's interpersonal functioning (interpersonal problem/conflict) and the craving or slip. It may appear as if the craving or slip is being discussed in isolation from the patient's interpersonal functioning.

INTERPERSONAL FOCUS: To what extent did the therapist focus on the patient's interpersonal relationships and interpersonal impact of drug use (may also include the patient's relationship with the therapist)?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the session is devoted to focusing on the patient's interpersonal relationships or the expectations of the patient and others regarding the various roles the patient holds in his/her life. Only expectations regarding interpersonal aspects of identified roles should be considered in rating this item. A higher rating is achieved when the therapist devotes a significant amount of time and conducts a detailed exploration of the patient's interpersonal life, including role expectations and how these relationships have been changed or altered with drug use. A lower rating would be assigned with the therapist fails to conduct an extensive exploration of the patient's interpersonal life and/or does not remain focused on the interpersonal aspects of the various roles the patient holds in his/her life.

Examples:

The following are various areas that may be included in discussions regarding this item:

(a) Issues that arise between a female patient who works inside the home and her husband who has a job outside the home
(b) The patient's interactions with his/her parents.
(c) A dispute the patient is having with one of her employees.

T: "You've mentioned the frustration and disappointment you experience within your relationship with your husband. It seems as if you feel that his expectations of you are unrealistic and that nothing you do ever seems to make him happy. Have you been able to speak with him about your feelings?"

The following are various areas that would <u>not</u> be seen as having an "interpersonal focus" (unless some portion of the discussion focused on an interpersonal aspect of the situation as indicated below):

(a) Responsibilities the patient has as a housewife and what she does or does not like about them. (An example of an interpersonal focus would be the disputes between her and her husband regarding these responsibilities.)
(b) Things the patient does for his parents such as maintaining their car, managing their finances, etc. (An example of an interpersonal focus would be discussions regarding the interactions the patient has with his parents around these issues.)
(c) Performing job duties that are not interpersonal in nature such as driving a truck, doing a construction job, waiting on customers, etc. (An example of an interpersonal focus would be discussions regarding interpersonal contact engaged in while performing the above tasks.)

Skill Level Rating Guidelines:

Higher: Skill in this area requires that the therapist convey a consistent grounding in interpersonal issues within the session, in the range of topics discussed, and in their relationship to drug use, with frequent connections made between the domains. A skilled therapist consistently identifies and maintains a focus on the interpersonal relationships of the patient, the various roles the patient holds, as well as the expectations of the patient and others regarding these roles. The therapist may also focus on the therapist/patient relationship as part of this content area.

Lower: A lower quality rating on this item occurs when the therapist fails to identify and maintain an interpersonal focus. The therapist may focus on the patient's responsibilities in isolation without addressing the interpersonal context in which the identified responsibilities occur, or makes trivial connections between interpersonal focus and drug use.

RELATIONSHIP SATISFACTION: To what extent did the therapist assess the patient's level of satisfaction with his/her relationships?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist surveys the patient's past and/or present interpersonal relationships to determine which aspects the patient found pleasurable or satisfying and/or which aspects the patient disliked or found unsatisfying. A higher rating would be achieved when the therapist facilitates an in-depth discussion of BOTH the satisfying and unsatisfying aspects of the patient's relationships. This discussion must include the identification of detailed examples of both the satisfying and unsatisfying aspects of the relationships being reviewed. Although both the satisfying and unsatisfying aspects need not be discussed regarding the same relationship, the amount of time and detail of this review must be considered in the rating of this item. A lower rating would be given when the therapist facilitates a review of EITHER the satisfying or the unsatisfying aspects of the patient's relationships. A lower rating may also be representative of a more time-limited and general review where the therapist does not gather information regarding the specifics of the satisfying and/or unsatisfying aspects of the identified relationships.

Examples:

Higher: The following example would achieve a higher rating since the therapist went on to engage the patient in continued discussion regarding other important people in his life who did not trust him and what was satisfying and/or unsatisfying to him about those relationships.

T: "Is there a situation you can think of that's come up recently with someone where you had strong reactions?"

P: "Yeah. I wanted to have a serious talk with my brother last week about the family business. When I started to talk to him about it he just said, 'you don't know what you're talking about' and walked away."

T: "How did you feel?"

P: "I was really mad!"

T: "What's your relationship with your brother usually like? Are there other things that bother you?"

P: (Describes some things)

T: "Is there anything you value about that relationship?"

Lower: The following example would receive a lower rating since it represents no more than general statements by the patient regarding his relationships.

T: "Can you tell me more about your frustration with your family?"

P: "I'm really sick of being treated the way I am. They never believe anything I say, and they don't seem to take me seriously. Sometimes I feel like no one takes me seriously."

T: "What do you think you can do about that?"

P: "I don't know…"

Skill Level Rating Guidelines:

Higher: A higher quality rating on this item occurs when the therapist actively facilitates a detailed discussion of the satisfying AND unsatisfying aspects of the patient's past and/or present interpersonal relationships. Regardless of which relationship the therapist and patient are exploring, a higher quality rating would be assigned ONLY if the discussion remains focused on the satisfying and unsatisfying aspects of the interpersonal relationships. A skilled therapist would also facilitate a detailed discussion in order to identify and address in future sessions, any interpersonal patterns regarding the patient's relationships. In addition, the skilled therapist would remain nonjudgmental and supportive in allowing the patient to identify and explore both the satisfying and unsatisfying aspects of his/her relationships.

Lower: A lower quality rating on this item may occur when the therapist fails to maintain a focus on obtaining information regarding the satisfying AND unsatisfying aspects of the patient's relationships. In addition, a lower quality rating may be assigned if the therapist does not facilitate a balanced discussion of both the satisfying and unsatisfying aspects. Rather, the therapist focuses on either the satisfying OR unsatisfying elements. A lower quality rating may also indicate that the therapist did not gather enough information to be able to identify any patterns across the patient's past and/or present relationships.

UNDERSTANDING AND REVIEW SOCIAL NETWORK: To what extent did the therapist identify specifically who is in the patient's current social network *and/or* explore the nature of the patient's relationships with these people and how those relationships might be used to support recovery?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist attempts to evaluate WHO is included in the patient's current social network. This includes identifying the people with whom the patient spends his/her time (at home, out socially, at work, and even on the streets or using drugs), as well as discussing the nature of the time spent with the above identified people. A higher rating would be achieved when the therapist devotes a significant amount of time and facilitates an extensive exploration to identify the relationships that are present in the patient's life. In addition to identifying the relationships included in the patient's current social network, the therapist MUST gather information regarding the nature of the activities in which the patient engages with the people discussed, and explore how those relationships might be used to support abstinence and recovery. A lower rating would be assigned when the therapist fails to facilitate an in-depth discussion to identify the relationships within the patient's current social network, and, therefore, also fails to gather information regarding the specific nature of the patient's current relationships.

Examples:

T: "I would like to spend some time getting a sense of the people in your life…..those people who you feel are important to you….. and discussing your relationships with them."

P: "You mentioned a few co-workers with whom you spend some time outside of work. What do you typically do with them? Do you go to sporting events, movies? What activities do you enjoy?

Skill Level Rating Guidelines:

Higher: A higher quality rating on this item occurs when the therapist facilitates a thorough questioning and discussion of the patient's current interpersonal relationships/social network, i.e., an abbreviated "interpersonal inventory." For a higher quality rating to be assigned, the therapist must remain focused on obtaining a detailed picture of the patient's current social network and what relationships might support or undermine the patient's abstinence. This should include a thorough description of the patient's daily life and the activities in which he/she engages. A skilled therapist would provide a safe environment where exploration of the patient's social network included the identification of drug-related individuals/relationships and activities in the patient's life. Although focused on gathering the information indicated above, the therapist must also remain supportive and encouraging and remain aware of the possible difficulty of this topic for the patient.

Lower: A lower quality rating on this item occurs when the therapist's discussions are more general and the information gathered does not provide a detailed description of the patient's current relationships/social network or the nature of the patient's relationships. A lower quality rating may also indicate an absence of the identification and exploration of the patient's drug-related relationships and activities as part of his/her current social network, including a failure by the therapist to facilitate such a discussion.

INTERPERSONAL RATIONALE FOR DRUG USE: To what extent did the therapist relate the patient's drug use or craving to difficulties in the patient's relationships, role expectations, or personal life, and/or explore how interpersonal relationships might be precipitants of drug use? (e.g., "You became dependent on drugs as a way of solving problems in your personal life.")?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the session was devoted to focusing on the relationship of the patient's drug use to his/her interpersonal relationships and/or other problems in his/her personal life, including the role expectations held within the patient's interpersonal relationships. A higher rating would be achieved when the therapist makes a specific connection between drug use and the patient's relationships or other personal problems. Although the therapist is to remain focused on the interpersonal aspects of the discussion, a connection to the patient's drug use must explicitly be made. A lower rating would be achieved when a specific connection between drug use and the patient's interpersonal relationships or other personal problems is not made. For example, the therapist may focus on the patient's relationships/interpersonal functioning, but a connection to the patient's drug use is never explicitly identified.

Examples:

T: "From what you've told me it sounds like your relationships with your wife and with your friends are very strained right now, and I wonder whether you think these issues may be related to your drug use."

T: "It sounds like you see both your husband and your children expecting you to be super competent, tireless, and totally selfless. I get the impression that although you attempt to live up to that role you have ended up getting high, perhaps because you simply weren't able to live up to such high standards. Perhaps part of you doesn't even want to try and so your drug use may be one way of saying you're having a hard time with this."

Skill Level Rating Guidelines:

Higher: A higher quality rating on this item occurs when the therapist actively and in a supportive manner engages in making a connection between the patient's drug use and his/her interpersonal problems. For a higher rating to be achieved, the therapist must demonstrate that he or she is working under the assumption that the patient's drug use is, in some way, connected to his/her interpersonal problems, including difficulties in the patient's relationships, conflicts regarding role expectations, and/or other personal problems. A skilled therapist may also explicitly discuss with the patient how one's interpersonal difficulties can be associated with drug use (and the addiction process in general) and how one's continued drug use can then be associated with ongoing interpersonal difficulties. The relationship between the two is bi-directional.

Lower: A lower quality rating on this item occurs when the therapist does not make any explicit connection between the patient's drug use and his/her interpersonal problems. In addition, the therapist does not appear to be working under the assumption that there is a connection between drug use and interpersonal problems/disruptions. Specifically, the therapist does not identify how interpersonal difficulties may have contributed to the patient being more vulnerable to drug use and how the patient's drug use then continued to impact his/her interpersonal functioning.

INTERPERSONAL THERAPY RATIONALE: To what extent did the therapist provide a rationale which emphasized that working on understanding and changing the patient's interpersonal relationships and/or social roles would alleviate his/her substance abuse problem (e.g., "Working on these problems will reduce your need or desire to use drugs.")?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist discusses the importance of focusing on relationships and "personal issues" for the purpose of reducing drug use or the need to use drugs. A higher rating would be achieved when the therapist devotes a significant amount of time to facilitating an in-depth discussion of the importance of focusing on the patient's interpersonal functioning in order to address his/her drug use. In addition to presenting the rationale for utilizing an interpersonal approach, the therapist makes a specific connection between the patient's interpersonal functioning and his/her drug use or need to use drugs. A lower rating would be assigned when the therapist fails to present a clear and in-depth rationale for utilizing an interpersonal approach in addressing the patient's drug use or need to use drugs. A lower rating would also be received if the therapist clearly focuses on the patient's interpersonal relationships, but fails to identify that the purpose for doing so is to decrease drug use, and, therefore, does not make any connection between the patient's interpersonal functioning and his/her drug use or need to use drugs.

Examples:

T: "Since so much of what's happening with you right now has to do with your relationships with other people, I think that as you begin to understand and work out some of those things, you will have less of a need to use drugs."

T: "I think that the more you are able to express your anger directly to your mother, the less you will end up getting high as a way of telling her to 'get lost.'"

Skill Level Rating Guidelines:

Higher: A higher quality rating on this item occurs when the therapist, in a supportive manner, actively and clearly presents a rationale for focusing on the patient's interpersonal functioning in addressing his/her drug use or need to use drugs. In doing so, the therapist maintains a hopeful position and helps to identify for the patient that there are choices. The therapist explicitly identifies and explains in detail the connection between the patient's interpersonal functioning and his/her drug use. This includes discussion of the bi-directional relationship between the patient's social and interpersonal functioning and the use of drugs. Specifically, difficulties or impairment in the patient's interpersonal functioning may have made him/her more vulnerable to drug use and continued drug use has the potential to maintain interpersonal difficulties. Therefore, in focusing on the patient's interpersonal problems/difficulties, his/her drug use is also being addressed.

Lower: A lower quality rating on this item occurs when the therapist fails to clearly present a rationale for focusing on the patient's interpersonal life in addressing his/her drug use. The therapist also fails to explicitly identify and discuss the connection between the patient's interpersonal functioning and his/her drug use or need to use drugs, including a failure by the therapist to emphasize how focusing on and changing one's interpersonal functioning would also impact drug use.

RESOLVE INTERPERSONAL PROBLEMS: To what extent did the therapist explicitly focus on ways in which interpersonal problems could be resolved or needs could be fulfilled (e.g., change relationship, form new relationship, clarify role disputes, or ease role transitions)?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist actively encourages the patient to examine alternative possibilities for dealing with an interpersonal problem or issue involving the patient's expectations or role transition. Although the consideration of options will usually occur prior to the patient deciding on a course of action, this discussion may also occur after the patient has chosen or executed a course of action, as the therapist may have decided that it would be helpful for the patient to recognize that there are options other than the one he/she chose. A higher rating would be achieved when the therapist devotes a significant amount of time to facilitating a detailed discussion of multiple options available to the patient for resolving his/her interpersonal problems. A lower rating would be assigned if the therapist fails to facilitate an extensive discussion of the options available and/or only addresses one or two possible options. In addition, the therapist may identify multiple options, but fail to engage the patient in a detailed discussion of these options.

Example:

T: "From what you have said, it sounds like you feel your girlfriend does not understand you. Have you been able to speak with her about your feelings?"

P: "I've tried, but she never listens to me."

T: "How have you tried to tell her? What have you said to her?"

P: (Patient provides examples.)

T: "It sounds like you have tried to tell her on various occasions. I'm wondering if it would be helpful to try to tell her about your feelings when the two of you are not arguing? What do you think?"

Discussion of how and when to approach girlfriend continues…..

Skill Level Rating Guidelines:

Higher: For a high quality rating, the therapist must demonstrate a clear understanding of the patient's current interpersonal life. This understanding may be seen through the therapist's use of reflective statements of the patient's interpersonal problems and his/her feelings regarding these problems. In addition, the therapist must actively facilitate a detailed discussion of the options available for the resolution of patient's identified interpersonal problem(s). In this way, the therapist acts as a "coach" and advocate in helping the patient to identify the available options and in providing a sense of hope to the patient that change is possible.

Lower: A less skilled therapist does not demonstrate a clear understanding of the patient's current interpersonal relationships. This may include a failure on the part of the therapist to truly attempt to understand the patient's interpersonal problem(s). Therefore, the therapist may attempt to present and discuss the options for change in a manner that is not relevant to the patient. In addition, a lower rating may also indicate a superficial or general discussion of only a minimal number of the options available to the patient.

FEELINGS ABOUT LOSS/DECEASED: To what extent did the therapist help the patient to identify and explore feelings that the patient has about a deceased person when he/she was alive OR feelings that the patient now has about the loss OR the deceased person?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist identifies and explores the following:

1. The patient's feelings about a deceased person before that person's death;
2. The patient's feelings about the actual loss of a deceased important other;
3. The patient's feelings about the deceased person after that person's death.

Discussions of the patient's feelings about an impending death or person who is about to die should be considered in rating this item. This may include extensive discussion regarding HIV status.

A higher rating would be achieved when the therapist actively assists the patient in both identifying and exploring his/her feelings regarding one or more of the above noted topics. A lower rating would be assigned when the therapist fails to facilitate an in-depth discussion of the patient's feelings regarding at least one of the aforementioned areas. In addition, a lower rating may be assigned if the therapist helped the patient to identify his/her feelings regarding at least one of the topics noted above, but did not pursue a detailed exploration of the identified feelings.

Example:

T: "As you were talking about your sister just now, your voice got quieter and you hunched over. How are you feeling?"

P: "I really miss her."

T: "There's a lot of sadness there…"

P: "Yes."

T: "It's very normal for you to feel sad and miss her. Can you share with me how that sadness feels?"

P: "Like a big deep hole."

T: "What makes it feel that way?"

P: "It seems like I'll never get out. It's so overwhelming."

T: "Does the sadness make it feel overwhelming or do you have other feelings as well that make it feel that way?"

P: "I feel guilty and scared…"

T: "What about your sister's death has left you feeling guilty?"

Skill Level Rating Guidelines:

Higher: A higher quality rating on this item occurs when the therapist actively and gently supports and guides the patient through a detailed discussion of the patient's feelings regarding an actual or anticipated death. A skilled therapist's stance includes encouraging the patient's affective expression. In addition, a skilled therapist explicitly discusses with the patient the ways in which loss may be identified as a potential high-risk situation/trigger, including an association with increased risk and vulnerability for cravings, slips, and/or full-blown relapse. A skilled therapist also consistently conveys to the patient an awareness of the patient's level of comfort and/or discomfort in supporting the patient's participation in a potentially difficult discussion.

Lower: A lower quality rating on this item occurs when the therapist only superficially identifies and/or explores the patient's affective/emotional experiences regarding an actual or anticipated death. The therapist also does not appear to be encouraging or facilitating expression of the patient's affective experiences. In addition, a lower quality rating may indicate the failure of the therapist to identify the issue/experience of loss as a potential high-risk situation/trigger for drug use, including increased risk of cravings, slips, and/or full-blown relapse.

ROLE TRANSITION: To what extent did the therapist focus on the patient's current transition from one social role to another? This includes exploring aspects of a new role and/or evaluating losses associated with role change.

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the session is devoted to focusing on a current role transition in the patient's life. In addition to actual role transitions, this item may also include discussion regarding anticipated role transitions whether or not they, actually, occur. For example, the therapist may focus on a discussion regarding the patient's inability to move towards or failure to engage in a role transition. Common role transitions in this population include transition from a "drug user" to a person who is abstinent; transition from an adolescent living at home (using drugs, having others take care of him/her) to an adult with work and family responsibilities. Marriage and parenting are also events that require role transitions that have been difficult for those individuals with drug problems. A higher rating would be achieved if the therapist remains focused on identifying and exploring, in detail, an anticipated role transition or one that is presently occurring in the patient's life. A detailed discussion of an identified transition would include exploration of the new role as well as an evaluation of the possible losses associated with the role change. A lower rating would be assigned when the therapist fails to engage the patient in a discussion regarding an anticipated or actual transition, but rather remains focused on solely discussing details of the roles themselves. In other words, a lower rating may indicate a role-based discussion rather than a transition-based discussion.

Examples:

T: "We've talked about your unhappiness with your marriage, particularly because your husband is still using. We've also discussed your desire to leave, but you feel very anxious and frightened about being on your own."

T: "I think it is important for us to spend some time today discussing your relationship with your husband, including the things you are/were happy with and the things that make/made you unhappy."

T: "You've mentioned your fear of leaving quite a few times. What scares you the most about being on your own?"

Skill Level Rating Guidelines:

Higher: A higher quality rating for this item occurs when the therapist actively engages the patient in a detailed discussion regarding an actual or anticipated role transition. In order to receive a higher quality rating, this discussion must include the various aspects of a role transition, including discussion of the "old role," the losses associated with the transition, and exploration of the "new role." Discussion of the "new role" may focus on such areas as the social skills needed for the new role and the establishment of new interpersonal relationships and supports. In addition, a skilled therapist demonstrates an understanding that, for some patients, their social network/roles may be limited to drug-related activities and relationships with others who use "drug of choice." Therefore, a skilled therapist encourages the patient in a supportive, non-judgmental manner, to identify other social roles, including people and activities he/she might want to become involved with that do not include drug use.

Lower: A lower quality rating for this item occurs when the therapist fails to engage the patient in a detailed discussion regarding the actual or anticipated role transition. Specifically, a lower

quality rating may occur if the discussion remains focused on the identified roles of the patient rather than the transitional aspects of the situation. In addition, a lower quality rating may be assigned if the therapist fails to engage the patient in a detailed discussion regarding the transition and neither the specifics of the "old role" nor the "new role" are identified and discussed. A lower quality rating may also indicate the failure of the therapist to demonstrate an appreciation for the role of drug use in the patient's current social roles and overall interpersonal functioning.

Interpersonal Therapy (IPT) Items

(10 Items)

NOTE: The phrase "*drug of choice*" or "*drug*" appearing in italics is study specific. These items can be changed to reflect the relevant substance in any particular study.

Example: In Interpersonal Meaning of Craving, the substance relevant to the study population (e.g., cocaine heroin, marijuana, etc.) can be substituted for *drug*.

FOCUS ON PAST OR CURRENT INTERPERSONAL DEFICITS: (Defined as: Social isolation resulting from a significant lack of healthy important relationships OR due to the patient's inability to get needs met from her/his relationships.) To what extent did the therapist focus on the client's interpersonal deficits?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

INTERPERSONAL MEANING OF CRAVING: To what extent did the therapist explore how drug use or craving since the last session related to specific interpersonal problems that were taking place at the time of the craving or slip? (This requires a focus on discussing and working on the problem, in contrast to a focus on avoiding or coping with drug use or craving).

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

INTERPERSONAL FOCUS: To what extent did the therapist focus on the patient's interpersonal relationships and interpersonal impact of drug use (may also include the patient's relationship with the therapist)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

RELATIONSHIP SATISFACTION: To what extent did the therapist assess the patient's level of satisfaction with his/her relationships?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

UNDERSTANDING AND REVIEW SOCIAL NETWORK: To what extent did the therapist identify specifically who is in the patient's current social network (focus on interpersonal relationships) and/or explore the nature of the client's relationships with these people and how those relationships might be used to support recovery?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

INTERPERSONAL RATIONALE FOR DRUG USE: To what extent did the therapist relate the patient's drug use or craving to difficulties in the patient's relationships, role expectations, or personal life, and/or explore how interpersonal relationships might be precipitants of drug use? (e.g., "You became dependent on drugs as a way of solving problems in your personal life.")?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

INTERPERSONAL THERAPY RATIONALE: To what extent did the therapist provide a rationale which emphasized that understanding and/or changing the patient's relationships and/or social roles would alleviate her/his substance abuse problem (e.g., "working on these problem's will reduce your need to use drugs").

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

RESOLVE INTERPERSONAL PROBLEMS: To what extent did the therapist explicitly focus on ways in which interpersonal problems could be resolved or needs could be fulfilled (e.g., change relationship, form new relationship, clarify role disputes, or ease role transitions)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

FEELINGS ABOUT LOSS/DECEASED: To what extent did the therapist help the patient to identify and explore feelings that the client has about a deceased person when he/she was alive OR feelings that the patient now has about the loss OR the deceased person.

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

ROLE TRANSITION: To what extent did the therapist focus on the patient's current transition from one social role to another? This includes aspects of new role, and/or evaluating losses associated with role change.

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

Motivational Interviewing (MI) Items Guidelines (9 Items)

Motivational Interviewing (MI), developed by William Miller and his colleagues (Miller & Rollnick, 1991, 2002), is a brief substance abuse treatment approach designed to help clients intrinsically want to change their addictive behavior and other problem areas. Based on principles of motivational psychology and client-centered counseling, MI uses a highly empathic and collaborative approach better known as the MI style. The MI style envelops both the aims and specific techniques used in all MI sessions and is instrumental to the clinicians' ability to handle client resistance to change skillfully and to strategically develop the clients' highest level of motivation along the way. While maintaining the MI style, clinicians frequently use reflective listening skills and ask open-ended questions to explore and elaborate client motivation. Affirmations, summary reflections, heightening discrepancies, specific efforts to build motivation for change, decisional balance exercises, provision of objective feedback, and change plan development are additional techniques MI clinicians may use to move clients along motivationally. Through this manner of working with clients, MI attempts to help clients change their drug and alcohol use by: 1) becoming more aware about how their substance use causes them greater harm than good, 2) seeing the goal of reduced use or abstinence as far preferable than their status quo patterns of use, 3) developing interest and confidence in their effort to change, and 4) making a commitment to an ongoing process of change. Given that the balance of these factors may shift at any point in time, motivation is seen as something that fluctuates and that is affected by the sum total of the clients' experiences in the moment. A key factor impacting the client motivation for change is how clinicians interact with clients. To perform MI well, clinicians must demonstrate an ability to accurately understand the clients' point of view and help clients become ready, willing, and able to address their substance use problems rather than to expect clients to enter treatment already prepared to change. In short, to borrow from the title of the 2002 MI textbook, MI is a way of preparing people for change. The items described in this manual for MI attempt to capture how this process unfolds.

MOTIVATIONAL INTERVIEWING STYLE: To what extent did the therapist provide low-key feedback, roll with resistance (e.g., avoiding arguments, shifting focus), and use a supportive, warm, non-judgmental approach? To what extent did the therapist convey empathic sensitivity through words and tone of voice, demonstrate genuine concern and an awareness of the client's experiences?

Frequency and Extensiveness Rating Guidelines:

This item refers to how much the therapist maintained an empathic, client-centered approach where feedback is provided in a low-key manner and resistance is responded to using a warm, supportive approach. This therapeutic style is one of calm and caring concern and an appreciation for the experiences and opinions of the client. The therapist conveys empathic sensitivity through words and tone of voice, and demonstrates genuine concern and an awareness of the client's experiences. Arguments are avoided and a conflicted discussion may be side stepped or the focus shifted to another topic.

A higher Frequency/Extensiveness rating would be achieved if the therapist responded without defensiveness to the client's resistance behaviors such as arguing, interrupting, negating (denial), or ignoring and instead conveys accurate understanding of the client's situation of status. Some **techniques** employed may include Amplified reflection (reflecting the client's statements in an exaggerated manner); Double-sided reflection (restating what the client has said, but reminding them of the contrary things they have said previously); Shifting focus (changing the topic or focus to things the client is less resistant to exploring and changing); Reframing (acknowledging what the client has said, but offering a different perspective); or Siding with the negative (arguing against change in hopes that the client will hear the negative and realize that change is the healthy thing to do). Each of these techniques is used to reduce resistance and facilitate the beginning of the change process.

Example:

Client: "Why do you keep asking me to talk about my cocaine use? My kids are driving me crazy. You'd use cocaine too if you had my problems!"

Therapist: "You have a valid point. Maybe we should think about having your family come to a session. This problem may be bigger than you alone."

Skill Level Rating Guidelines:

Higher: A therapist demonstrates a high quality motivational interviewing style when he/she establishes an overall tone of collaboration and respect. The therapist shows he/she cares about what the client is saying and strives to accurately understand and reflect the client's statements. The therapist uses any specific therapeutic strategy in the service of promoting an overall motivational interviewing style. A therapist also demonstrates higher skill when, throughout the session, the therapist consistently is strategic and successive in attempting to build and strengthen the client's motivation for change.

Lower: A low quality motivational interviewing style occurs when the therapist controls the interview process, insufficiently facilitates the client's open exploration of his/her problem areas and motivation for change, and acts inflexibly and defensively in response to client resistance. The therapist may deliver therapeutic interventions in a technically correct manner but with little facility, warmth, or engagement of the client. A therapist who does not adjust strategies to the client's shifting motivational state or who sounds redundant in the interventions selected also may receive lower Skill Level ratings.

OPEN-ENDED QUESTIONS: To what extent did the therapist use open-ended questions (i.e., questions that elicit more than yes/no responses) to elicit the client's perception of his/her problems, motivation, change efforts, and plans?

Frequency and Extensiveness Rating Guidelines:

Open-ended questions are questions that result in more than yes/no responses and that don't pull for terse answers or very specific pieces of information. Often these questions begin with the following interrogatives: "What," "How," "In what," and "Why (somewhat less preferable)" or lead off with the request, "Tell me…" or "Describe…" The clinician uses open-ended questions to elicit an open conversation about the client's view of his/her problems and commitment to change. In brief, by using open-ended questions, the clinician gives the client a wide range for discussing his or her life circumstances and substance use patterns.

A *higher Frequency/Extensiveness rating* would be achieved if the therapist asks numerous questions that invite client conversation (see Correct Examples) as opposed to asking only yes/no response questions (see Incorrect Examples). *Lower ratings* occur when the therapist asks very few questions or almost all closed-ended ones.

Examples:

Correct:

- So, what brings you here today?
- What are some of the ways that substance use affects your life?"
- What kinds of differences have you noticed in…?

Incorrect:

- Do you use marijuana? When was the last time you used?
- Can you tell me how heroin affects you?
- Your wife thinks you are addicted to cocaine. Are you addicted to cocaine?

Skill Level Rating Guidelines:

Higher: High quality open-ended questions are relevant to the therapist-client conversation and pull for greater client exploration and recognition of problem areas and motivation for change, without appearing to be judgmental or leading to the client. They are simple and direct, thereby increasing the chance that the client clearly understands what the therapist is asking. Usually, several open-ended questions do not occur in close succession. Rather, high quality open-ended questions typically are interspersed with reflections and ample client conversation to avoid the creation of a question-answer trap between the therapist and client. The therapist pauses after each question to give the client time to respond to each query.

Lower: Low quality open-ended questions are poorly worded or timed or target an area not immediately relevant to the conversation and client concerns. They often will occur in close succession, giving the conversation a halting or mechanical tone rather than one that flows naturally between the therapist and client. Lower quality open-ended questions also may compound several questions into one query (e.g., "Tell me about how you felt before and after you got high and how that all affects your future risk for using cocaine."), making them harder to understand and respond to by the client. Further reductions in Skill Level ratings may occur if the therapist seems to be leading or steering the client or uses a judgmental or sarcastic tone when asking open-ended questions.

AFFIRMATION OF STRENGTHS AND SELF-EFFICACY: To what extent did the therapist verbally reinforce the client's strengths, abilities, or efforts to change his/her behavior? To what extent did the therapist encourage a sense of self-efficacy on the part of the client by praising small steps in the direction of change or expressing appreciation of personal qualities in the client that might facilitate successful efforts to change?

Frequency and Extensiveness Rating Guidelines:

This item refers to what extent the therapist expresses confidence in the client to achieve his/her goals. The therapist may affirm the client using many different approaches: a) using compliments or praise, b) acknowledging the client's personal qualities, competencies or abilities that might promote change, c) recognizing effort or small steps taken by the client to change. Sometimes, the therapist might use a positive reframe to affirm the client (e.g., noting how multiple treatment episodes and numerous relapses are evidence of the client's persistence in trying to deal with his or her drug use problems and not giving up). By complimenting, positively reinforcing, and validating the client, the therapist fosters the belief in the client that there is hope for successful recovery and that the client can change his/her own substance use behaviors.

***Note*:** Raters should not rate a therapist's simple statements of "Good" or "Great" as affirmations. Affirmations must include direct references to something about the client.

Examples:

Therapist: "It sounds as if you have really thought a lot about this and have some good ideas about how you might want to change your drug use. You are really on your way!"

"That must have been really hard for you. You are really trying hard to work on yourself."

Skill Level Rating Guidelines:

Higher: Higher quality affirmations occur when the therapist affirms qualities or efforts made by the client that promote productive change or that the client might harness in future change efforts rather than being general compliments. The therapist derives these affirmations directly from the conversation. As a consequence, high quality affirmations are meaningful to the client rather than being too global or trite. A key ingredient in a high quality affirmation is the appearance of genuineness rather than the therapist merely saying something generally affirming in a knee-jerk or mechanical fashion.

Lower: Low quality affirmations are not sufficiently rooted in the conversation between the client and therapist. The affirmations are not unique to the client's description of him/herself and life circumstances or history. The therapist may appear to affirm simply to buoy a client in despair or encourage a client to try to change when he/she has expressed doubt about his/her capacity to do so. In short, poor quality affirmations sound trite, hollow, insincere, or even condescending.

REFLECTIVE STATEMENTS: To what extent did the therapist repeat (exact words), rephrase (slight rewording), paraphrase (e.g., amplifying the thought or feeling, use of analogy, making inferences) or make reflective summary statements of what the client was saying?

Frequency and Extensiveness Rating Guidelines:

Reflective statements made by the therapist restate the client's comments using language that accurately clarifies and captures the meaning of the client's communications and conveys to the client the therapist's effort to understand the client's point of view. The therapist uses this technique to encourage the client to explore or elaborate on a topic. These **techniques** include repeating exactly what the client just stated, rephrasing (slight rewording), paraphrasing (e.g., amplifying thoughts or feelings, use of analogy, making inferences) or making reflective summary statements of what the client said. Reflective summary statements are a special form of reflection in which the therapist selects several pieces of client information and combines them in a summary with the goal of inviting more exploration of material or to highlight ambivalence. Often, summary reflections receive an extensive or in depth tally mark on the worksheet.

Examples:

Client: "Right now, using drugs doesn't take care of how bad I feel like it used to. If anything, I feel worse now."

Simple Reflection

- Using drugs makes you feel worse now.

Rephrasing

- So, you have found that using drugs to deal with how badly you feel is not working well for you anymore.

Paraphrasing Using a Double-Sided Reflection

- In the past using drugs helped you feel better when you were having a hard time or feeling badly. Now, it is only making matters worse for you.

Introductions to a Reflective Summary

- Let me see if I understand what you've told me so far…"
- Here is what I've heard you say so far…"

Skill Level Rating Guidelines:

Higher: Higher quality reflections occur when the therapist accurately identifies the essential meaning of what the client has said and reflects it back to the client in terms easily understood by the client (i.e., "direct hit"). The therapist's inflection at the end of the reflection is downward. The therapist pauses sufficiently to give the client an opportunity to respond to the reflection and to develop the conversation. Well-delivered reflections typically are concisely and clearly stated to the client. If the therapist reflects several client statements or intended meanings, the therapist neatly arranges them in a manner that promotes further client introspection, conversation, and motivation for change. Often high quality reflections increase the time spent talking by the client, foster a collaborative tone, and reduce client resistance.

Lower: Low quality reflections often are very inaccurate (i.e., "miss the boat") and may contribute to the client feeling misunderstood. They can be too vague, complicated, or wordy. They also may have an upward inflection at the end and consequently function as disguised closed-ended questions. Typically low quality reflections decrease the time spent talking by the client and may increase the client's resistance. Skill Level ratings also may decrease, even with high frequency reflections, if the reflections are too spread out rather than consecutively linked over the session such that they do not increase introspection, conversation, or motivation to change.

FOSTERING A COLLABORATIVE ATMOSPHERE: To what extent did the therapist convey in words or actions that the therapy is a collaborative relationship in contrast to one where the therapist is in charge? How much did the therapist emphasize the (greater) importance of the client's own decisions, confidence, and perception of the importance of changing? To what extent did the therapist verbalize respect for the client's autonomy and personal choice?

Frequency and Extensiveness Rating Guidelines:

This item captures any explicit effort the therapist makes to seek guidance from the client or to act as though therapy were a joint effort as opposed to one in which the therapist consistently is in control. The therapist emphasizes the (greater) importance of the client's perspective and decisions about if and how to change. Any explicit therapist statements that verbalize respect for the client's autonomy and personal choice are examples of fostering collaboration during the session.

Examples:

Therapist: "What do you think would be a good way to handle this situation in the future?"

"I would have thought you would…, but it sounds like you made a better choice by…"

"Let's look at that issue together."

"We can spend some time talking about your situation at home."

Skill Level Rating Guidelines:

Higher: Higher quality strategies occur in several ways. The therapist may directly and clearly note the greater importance of the client's perception about his/her drug use and related life events in contrast to what the therapist or significant others might think. The therapist may underscore the collaborative nature of the interview by highlighting his or her interest in understanding the client's perspective without bias. Likewise, direct and clear references to the client's capacity to draw his or her own conclusions or to make personal choices about how to proceed with a plan for change receive higher Skill Level ratings. Use of these strategies when the therapist perceives that the client is feeling coerced by significant others can be especially effective and lead to higher Skill Level ratings. Emphasizing viable personal choices rather than choices that are unrealistic to the client also improve Skill Level ratings. For example, a therapist may provide a choice among treatment options within a program rather than highlight the option of program non-enrollment to a client who presents to treatment in a job jeopardy situation; this type of client most likely will see treatment nonparticipation as too risky for losing his job.

Lower: Lower quality strategies occur when the therapist emphasizes personal choices that do not seem realistic to the client. Also, vague, wordy, or poorly timed efforts to articulate the client's personal control, autonomy, and collaborative role in the interview reduce quality ratings. Therapist advice giving in the context of seemingly collaborative statements also receives lower ratings (e.g., "You are obviously in the driver's seat, but I wouldn't do that if I were you.).

MOTIVATION TO CHANGE: To what extent did the therapist try to elicit client discussion of change (self-motivational statements) through questions or comments designed to promote greater awareness/concern for the problem, increase intent/optimism to change, or encourage elaboration on a topic related to change? To what extent did the therapist discuss the stages of change, help the client develop a rating of current readiness, or explore how motivation might be strengthened?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist made attempts to elicit client self-motivational statements, "change talk," or any type of discussion about change. This is often accomplished through questions or comments designed to promote greater awareness/concern for a problem, increase intent/optimism to change, or by encouraging elaboration on a topic related to change. The therapist may steer the client away from remaining overly focused on other people's concerns and instead ask for the client's own concerns and perceptions of any problems and the importance of these concerns.

The focus on eliciting personal statements recognizing a need or intent to change is critical to this item. Effective work in this area will invariably lead to "change talk" or self-motivational statements and movement toward the negotiation of specific plans for change. However, the client does not need to respond in this fashion for this item to be rated highly. Successful work in this area may be facilitated by a more formal discussion of the stages of change, helping the client develop a rating of current readiness, or exploring how motivation might be strengthened?

A *higher Frequency/Extensiveness rating* would be achieved if the therapist attempts to elicit remarks from the client indicating either recognition of a problem, statements of concern, intention to change or optimism about change. The therapist will often use techniques that are rated on other items (e.g., open-ended questions, reflections about substance use and/or about general problem areas related to substance drug use) that, in this case, are meant to encourage "change talk" on the part of the client. The therapist may also explicitly assess the client's current motivation to become abstinent or decrease their substance use, especially if the client continues to use. A *lower rating* would be given when the therapist seldom strategically queries or reflects the motivational issues outlined above.

Examples:

Therapist: "Based on the concerns you have raised, what do you think about your current use of substances."

"What are some reasons you might see for making a change?"

"What do you think would work for you if you decide to change?"

Client: "My wife really believes it is a problem, so she's always on my back about it."

Therapist: "How do you feel about your drug use? What are your concerns and what do you think might need to happen?"

Skill Level Rating Guidelines:

Higher: Higher ratings occur on this item when the therapist uses evocative questions to elicit self-motivational statements targeted to the client's current motivational state. For example, if a client has not recognized drug use as a problem, the therapist asks the client to explore any concerns or problematic aspects of his or her drug use. If a client has recognized drug use as a problem but is uncertain about his or her capacity to change, the therapist directly queries

the client about factors that might impact intent or optimism for change. Higher ratings also occur when the therapist collaboratively explores the client's current readiness to change in depth by combining rating scales and open-ended follow-up questions and reflections that prompt the client's arguments for change, optimism, and self-efficacy.

Lower: Lower ratings on motivation to change strategies occur when the therapist tries to elicit self-motivational statements that are inconsistent with the client's stage of change. Additionally, if a therapist's efforts to elicit self-motivational statements or to assess the client's readiness to change become redundant, they receive lower Skill Level ratings. Therapist efforts to assess readiness to change that pull for resistance or arguments against change also receive lower ratings. For example, a lower quality intervention would occur if after a client selects a readiness to change rating of 6 on a scale of 1 (lowest readiness, to 10 (highest readiness)), the therapist asks, "How come you said a 6 rather than a 10?"

HEIGHTENING DISCREPANCIES: To what extent did the therapist create or heighten the internal conflicts of the client relative to his/her substance use? To what extent did the therapist facilitate or increase the client's awareness of a discrepancy between where her/his life is currently versus where s/he wants it to be in the future? How much did the therapist explore the role of substances in preventing the client from reaching life goals or values?

Frequency and Extensiveness Rating Guidelines:

This item involves efforts by the therapist to prompt the client's increased awareness of a discrepancy between where they are and where they want to be relative to their substance use. The therapist may do this by highlighting contradictions and inconsistencies in the client's behavior or stated goals, values, and self-perceptions. The therapist may attempt to raise the client's awareness of the personal consequences of substance use, and how these consequences seem contrary to other aims stated by the client. The therapist may engage the client in a frank discussion of perceived discrepancies and help the client consider options to regain equilibrium.

Examples:

Therapist: "You say you want to save your marriage, and I also hear you say you want to keep using drugs."

"On the one hand, you want to go out to the bar every night. On the other hand, you have told me how going out to the bar every night gets in the way of spending time with your son."

Skill Level Rating Guidelines:

Higher: Higher quality efforts to heighten discrepancies typically occur when the therapist attempts to make the client aware of a discrepancy in the client's thoughts, feelings, actions, goals or values based upon the client's previous statements. The therapist presents the discrepancies as legitimate conflicts or mixed experiences rather than as contradictions or judgments that prove the client has a drug problem. In addition, higher quality interventions are clear and articulate reflections that encapsulate divergent elements of what a client has said. In short, integration of the client's specific discrepant statements in well-stated terms using a supportive, nonjudgmental tone improves the Skill Level rating.

Lower: Low quality efforts to heighten discrepancies typically occur when the therapist highlights the opposite side of the client's ambivalence without sufficiently counterbalancing it. For example, a client might say he wants to continue to smoke marijuana after previously acknowledging how smoking angers his wife and may lead to an unwanted separation. A rater would give a lower Skill Level rating if the therapist responds by saying, "Yeah, but you said you don't want to be separated," instead of saying, "So even though you've told me you are concerned you wife might leave you, you continue to want to smoke marijuana." Often this approach appears somewhat argumentative and may heighten resistance rather than develop dissonance in the client's position. Abruptness in posing discrepancies ("gotcha!") or stating discrepancies with a hint of accusation also undermines therapist-client collaboration and reduces the overall quality of the intervention. Finally, wordy, cumbersome, or overly complex reflections of discrepant client statements receive lower Skill Level ratings.

PROS, CONS, AND AMBIVALENCE: To what extent did the therapist address or explore the positive and negative effects or results of the client's substance use and what might be gained and lost by abstinence or reduction in substance use? To what extent did the therapist use decisional balancing, complete a cost-benefits analysis, or develop a list of pros and cons of substance use? How much did the therapist express appreciation for ambivalence as a normal part of the change process?

Frequency and Extensiveness Rating Guidelines:

This item focuses on the extent to which the therapist facilitated the discussion of specific consequences of the client's substance use. This may include the positive and/or negative results of the client's past, present, or future behaviors as related to active substance use. Specific **techniques** used include decisional balancing, a cost-benefits analysis, or listing and discussing the pros and cons of substance use. An important stylistic component accompanying these techniques should be the therapist's verbalizing an appreciation for ambivalence as a normal part of the change process?

A *higher Frequency/Extensiveness rating* would be achieved if the therapist discusses ambivalence in detail or explicitly facilitates a costs/benefits analysis with client input concerning change versus remaining the same. A high score on this item typically involves the written completion of a Pros and Cons form (or on a flipchart) either during the session or detailed review of a form completed prior to the session. A *lower rating* occurs when the therapist devotes little time or effort on any of these tasks.

Examples:

Therapist: "What do you see as the positive and negative consequences of your drinking?"

"You have had a lot of chest pain after using cocaine and seem very concerned about your health, your family, and where your life is going. And you have identified many possible benefits of stopping use, such as…."

"So by getting high, you feel good and can avoid painful feelings. What are some of the downsides to using."

Skill Level Rating Guidelines:

Higher: Higher quality efforts to discuss the pros and cons of substance use occur when the therapist approaches the task in a nonjudgmental, exploratory manner. Throughout the examination of pros and cons, the therapist prompts the client to continue detailing dimensions of ambivalence using open-ended questions or reflections about consequences previously noted by the client. Full exploration of the pros and cons of stopping substance use versus continuing use improve quality ratings. During this process, the therapist elicits responses from the client rather than suggesting positive and negative consequences as possibilities not previously mentioned by the client. Additionally, use of summary reflections within each dimension or to compare and contrast them may enhance the Skill Level ratings, particularly when the therapist uses these discussions to tip the client's motivational balance to the side of change. The specific technique of completing or reviewing a decisional balance sheet or simply discussing the pros or cons does not directly affect the Skill Level rating.

Lower: Lower Skill Level ratings occur when the therapist seldom provides the client with opportunities to respond freely to the pros/cons dimensions or to more thoroughly reflect upon meaningful pros and cons to the client. Instead, the therapist provides the client with likely pros and cons and asserts this view to the client in a more closed-ended fashion.

Consequently, the client becomes more of a passive recipient rather than an active participant in the construction of the decisional balance or discussion of factors underlying the client's ambivalence. Lower ratings also occur when the therapist asks the client to list pros and cons one after the other without exploring details or the personal impact of substance use on the client's life. When summarizing the client's pros, cons, or ambivalence, the therapist does not involve the client in the review and simply restates the items in a mechanical or impersonal manner. The therapist makes no effort to strategically tip the client's motivational balance in favor of change.

CHANGE PLANNING DISCUSSION: To what extent did the therapist and client collaboratively develop and make a commitment to a plan for change? How much did the therapist facilitate discussion of the positive and negative aspects of changing, what might get in the way, and how to address impediments to change?

Frequency and Extensiveness Rating Guidelines:

This item measures the extent to which the therapist helps the client develop a change plan and make a commitment to it. This process may involve a more formal process of completing a Change Plan Worksheet or a therapist facilitated discussion of a specific plan. In either case, the intervention must involve an explicit discussion that includes some of the following areas: (1) identification of a target problem, (2) steps to address this problem, (3) impediments to change and how to address them, (4) methods of determining whether the plan has worked, (5) positive and negative aspects of changing, and (6) a client's commitment or readiness to enact the plan. In this latter case, the therapist might use a 10-point commitment scale to facilitate a discussion of the client's readiness for the change plan.

A *higher Frequency/Extensiveness rating* would be achieved if the therapist guides the client through a thorough discussion of change planning. This process does not have to include review of a completed Change Plan Worksheet, but a high score requires the development of a detailed change plan during the session. A *lower rating* occurs when the therapist addresses only a few elements of a change plan and spends little time examining them in detail.

Example:

Therapist: "So, it sounds like you have made a decision to stop using drugs and reduce your drinking. Let's spend some time figuring out a plan that will help you get started working toward that goal. What is the first thing that comes to mind?"

"What do you think might get in the way of this plan or make it hard for you to continue to make these changes?"

Skill Level Rating Guidelines:

Higher: As a prerequisite, a higher Skill Level rating for change planning requires that the therapist develops a detailed change plan that addresses most of the key change planning areas outlined above. The therapist takes sufficient time to explore each area and to encourage the client to elaborate by using open-ended questions and reflections. Overall, the development of the change plan is highly collaborative and serves to strengthen the client's commitment to change. If the client expresses ambivalence during the completion of the plan, the therapist attempts to resolve it in the direction of change instead of pushing forward when the client may not be ready to proceed. If the client is highly motivated to proceed with the plan, the therapist asks for the client's commitment to the plan in a formal manner, thereby "closing the deal" and promoting the client's preparation for change and action.

Lower: Lower Skill Level ratings occur when the therapist approaches the change planning process in a cursory fashion. The therapist does not actively engage the client in change planning or individualize the plan to the unique circumstances of the client. The lowest Skill Level ratings are given when the therapist takes on an authoritative and prescriptive tone while completing the Change Plan with the client.

Motivational Interviewing (MI) Items

(9 Items)

MOTIVATIONAL INTERVIEWING STYLE: To what extent did the therapist provide low-key feedback, roll with resistance (e.g., avoiding arguments, shifting focus), and use a supportive, warm, non-judgemental approach? To what extent did the therapist convey empathic sensitivity through words and tone of voice, demonstrate genuine concern and an awareness of the client's perspectives?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

OPEN-ENDED QUESTIONS: To what extent did the therapist use open-ended questions (i.e., questions that elicit more than yes/no responses) to elicit the client's perception of his/her problems, motivation, change efforts, and plans?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

AFFIRMATION OF STRENGTHS AND SELF-EFFICACY: To what extent did the therapist verbally reinforce the client's strengths, abilities, or efforts to change his/her behavior? To what extent did the therapist encourage a sense of self-efficacy on the part of the client by praising small steps in the direction of change or expressing appreciation of personal qualities in the client that might facilitate successful efforts to change?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

REFLECTIVE STATEMENTS: To what extent did the therapist repeat (exact words), rephrase (slight rewording), paraphrase (e.g., amplifying the thought or feeling, use of analogy, making inferences) or make reflective summary statements of what the client was saying?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

FOSTERING A COLLABORATIVE ATMOSPHERE: To what extent did the therapist convey in words or actions that the therapy is a collaborative relationship in contrast to one where the therapist is in charge? How much did the therapist emphasize the (greater) importance of the client's own decisions, confidence, and perception of the importance of changing? To what extent did the therapist verbalize respect for the client's autonomy and personal choice?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

MOTIVATION TO CHANGE: To what extent did the therapist try to elicit client discussion of change (self-motivational statements) through questions or comments designed to promote greater awareness/concern for the problem, increase intent/optimism to change, or encourage elaboration on a topic related to change? To what extent did the therapist discuss the stages of change, help the client develop a rating of current readiness, or explore how motivation might be strengthened?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

HEIGHTENING DESCREPANCIES: To what extent did the therapist create or heighten the internal conflicts of the client relative to his/her substance use? To what extent did the therapist facilitate or increase the client's awareness of a discrepancy between where his/her life is currently versus where s/he wants to be in the future? How much did the therapist explore the role of substances in preventing the client from reaching life goals or values?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

PROS, CONS, AND AMBIVALENCE: To what extent did the therapist address or explore the positive and negative effects or results of the client's substance use and what might be gained and lost by abstinence or reduction in substance use? To what extent did the therapist use decisional balancing, complete a cost-benefits analysis, or develop a list of pros and cons of substance use? How much did the therapist express appreciation for ambivalence as a normal part of the change process?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

CHANGE PLANNING DISCUSSION: To what extent did the therapist and client collaboratively develop and make a commitment to a plan for change? How much did the therapist facilitate discussion of the positive and negative aspects of changing, what might get in the way, and how to address impediments to change?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

Supplemental Items Guidelines (11 Items)

These items have been developed in various Yale studies. Some are from specific treatments, others are general items, and some may be used as either. Although they have been shown to have adequate interrater reliability and validity, psychometric analyses have suggested that they do not "load" on any particular scale. However, this may not be the case for other investigators evaluating different treatments or populations. Hence, they are included here in case other investigators find them useful.

NOTE: The phrase "*drug of choice*" or "*drug*" appearing in italics is study specific. These items can be changed to reflect the relevant substance in any particular study.

Example: In Assessment of Patient's Commitment to Abstinence or Reduction of Drug Use, the substance relevant to the study population (e.g., cocaine, heroin, marijuana, etc.) can be substituted for *drug.*

EXPLORATION OF PATIENT/THERAPIST RELATIONSHIP: To what extent did the therapist explore the patient's thoughts/feelings regarding the patient/therapist relationship or interactions which occur between patient and therapist?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist addresses issues that arise during the session as a result of the interaction between the therapist and the patient. Attempts may be made by the therapist to explore the therapeutic alliance (i.e. addressing the patient's problematic feelings in relation to the therapist). The therapist may also explore ways in which the patient's thoughts or feelings about the therapist may be similar to thoughts or feelings about other relationships in the patient's life. In a session where there is a significant other present, process comments may also be made regarding the interaction between the couple and the therapist.

For this item to be rated higher, the therapist's primary focus throughout most of the session should be on the therapeutic relationship and the thoughts and feelings about the interactions with the therapist that occur as part of the therapeutic process. A lower rating would be achieved if the therapist mentions or connects what the patient is saying to the therapeutic relationship without exploring it further.

Examples:

T: "It seems like you became angry when I asked you about your *drug* usage. I wonder if you are reacting to me similarly as you react to your wife."

T: "It seems difficult for you to be able to trust me. I wonder what I might have done to make you feel that way."

Skill Level Rating Guidelines:

Higher: A skilled therapist thoroughly explores the patient's thoughts and feelings about the therapeutic relationship itself, as well as how interactions in session may demonstrate how the patient may react to others in his/her life. The therapist's observations can help the patient become aware of how he/she relates to others through the experience of the relationship with the therapist. Sometimes patients are reluctant to discuss the therapeutic relationship and a skilled therapist facilitates the discussion by helping the patient recognize that there are most likely similarities in the relationship with the therapist and how the patient relates to others in his/her life, and that by examining this more closely, the patient may begin to recognize why relationships become problematic.

Lower: A less skilled therapist might ask about the patient's thoughts and feelings about the therapeutic relationship without helping the patient recognize or express problematic issues in the relationship. In addition, efforts would not be made to explore how the therapeutic relationship might be similar to other relationships in the patient's life.

TERMINATION: To what extent did the therapist make attempts to prepare the patient for the end of the patient/therapist relationship, and/or treatment by exploring the patient's thoughts/feelings regarding the termination of the relationship and/or preparing the patient for the termination of the treatment?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist acknowledges and helps prepare the patient for the end of treatment and the end of the relationship with the therapist as well. Higher ratings would include a thorough discussion of the patient's feelings about the end of treatment and/or an elaborate discussion of the effects of the termination of treatment to *drug* use. A low rating would be given if the therapist mentions the number of weeks left in treatment but does not make any attempts to explore the patient's thoughts/feelings/reactions to this.

Examples:

T: "We will meet three more times before your treatment ends. You have been clean since you started treatment, and I wonder if you have any concerns about maintaining your abstinence once treatment ends."

T: "In four weeks, your treatment will be complete and we will no longer be meeting on a weekly basis. Being able to talk about things with me and having random *drug* screens seems to have helped you stay clean. It's not easy to end an important relationship, and it might help to discuss your thoughts and feelings about leaving treatment and the loss of our relationship.

Skill Level Rating Guidelines:

Higher: A skilled therapist would explore the patient's thoughts and feelings about ending treatment and the therapeutic relationship. A careful review would also be conducted, including a discussion of progress made in treatment, ongoing goals post treatment, and to identify possible obstacles to maintaining abstinence. In addition, a skilled therapist would be sensitive to the patient's loss of the therapeutic relationship and facilitate the patient's ability to acknowledge this, even though it may be difficult.

Lower: A less skilled therapist might mention how much time is left in treatment and what will be covered in the remaining weeks. What will be missing is the sensitivity/empathy for the patient's thoughts/feelings about the end of the treatment and the therapeutic relationship and/or concerns the patient might have about maintaining abstinence.

CONFRONTATION OF CONTRADICTION BETWEEN PATIENT REPORT AND ACTUAL LAB RESULTS OF *DRUG* USE: To what extent did the therapist confront the contradiction between the patient's report of *drug* use and the actual lab results?

Frequency and Extensiveness Rating Guidelines:

This item refers to what extent the therapist confronts the discrepancy between the patient's report of *drug* use and the actual lab results. The recognition of the contradiction by the therapist conveys to the patient the level of awareness and concern of the therapist. To be rated highly, the therapist should have explored the contradiction and the implications for treatment, future sobriety, or the patient/therapist relationship in an in-depth manner. For a low rating, the therapist would identify a discrepancy between the patient's reported *drug* use and that identified by lab results. However, little further inquiry is made.

Examples:

T: "Your lab results are positive for *drug* and yet you clearly denied any use before the test was done. It's not clear what represents a level of denial on your part, concern about how this might be addressed, or what other issues might be interfering with your being up front about your use. What are your thoughts about this?"

T: "You said you haven't used and yet your lab results indicate that you have. It looks like you aren't ready to quit."

Skill Level Rating Guidelines:

Higher: A skilled therapist will use the discrepancy between the patient's report of *drug* use and the lab results as an opportunity to explore the patient's ambivalence about becoming abstinent. By confronting the patient, the therapist may increase the patient's awareness of what his/her issues are about getting clean. This can help to foster the patient's motivation for treatment.

Lower: A less skilled therapist may clearly confront the patient, but miss the opportunity to allow the patient to examine why he/she might feel the need to try to hide their drug use. Using confrontation alone often makes the patient feel "caught" and raise their defenses, rather than heighten their curiosity about his/her actions, which may impede treatment progress.

OPTIMISTIC REASSURANCE FOR FUTURE PATIENT EFFORTS (NONMEDICATION):

To what extent did the therapist communicate confidence that patient efforts THAT DO NOT INCLUDE MEDICATION will yield success in the future?

Frequency and Extensiveness Ratings Guidelines:

This item refers to the extent to which the therapist conveyed the idea that patient efforts, in addition to the medication, will be helpful. For this item to be scored as having occurred, the patient effort MUST NOT include medication. This item focuses on the therapist's demonstration of his/her belief that non-medication effects will play an important role in the patient's recovery. To achieve a higher rating, the therapist must identify specific efforts the patient is making or can make that will contribute to the patient's recovery. In addition, a higher rating is given when the therapist explores in-depth the things the patient identifies that could contribute to treatment success. A lower rating is given when the therapist helps the patient identify efforts he/she could make in addition to taking medication without exploring them in any detail and/or supporting the importance of these efforts.

Examples:

P: "If I keep going to AA meetings and call my sponsor when I get an urge to use, I'll be able to stay sober."

T: "That's right! If you do those things, you'll be well on your way to 90 days of sobriety!"

T: "Your decision/choice/level of motivation…helps you stay clean and sober."

Skill Level Rating Guidelines:

Higher: In helping the patient identity the efforts he/she can make in addition to taking medication to improve treatment, a skilled therapist will positively support these efforts. The therapist will express to the patient the utmost confidence in the importance of efforts made, in addition to medication, for success in treatment. The therapist's confidence and optimism promotes important changes in lifestyle and behavior that may have a positive influence on the patient's treatment.

Lower: A less skilled therapist might make the point that a patient might be more successful in their treatment by making efforts in addition to taking medication, without helping the patient identify what these efforts might be, and/or fail to offer reassurance when efforts are made by the patient.

POSITIVE/NEGATIVE CONSEQUENCES OF ADDICTION: To what extent did the therapist address or explore the positive and/or negative consequences/results of the patient's addictive behavior as related to past, present, or future active *drug* intake?

Frequency and Extensiveness Rating Guidelines:

This item focuses on the extent to which the therapist facilitated the discussion of specific consequences of the patient's addiction. This may include the positive and/or negative results of the patient's past, present, or future addictive behaviors as related to active *drug* intake. A higher rating is achieved on this item when the therapist identifies specific addictive behaviors and helps the patient identify the positive and negative consequences of the behavior as it relates to *drug* use. A lower rating is achieved when the therapist identifies the consequences of addictive behavior without relating them to drug use.

Examples:

T: "What do you see as the positive and negative consequences of your *drug* use?"

T: "Your lab results show that your liver functioning is impaired due to your alcohol intake."

T: "By getting high, you were able to avoid painful feelings."

Skill Level Rating Guidelines:

Higher: A skilled therapist would thoroughly explore the patient's understanding of the positive and negative consequences of his/her addictive behavior, being careful to connect these behaviors to past, present or possible future *drug* use. The therapist may also encourage the patient to explore how *drug* use might be affected by changing the addictive behaviors and having other ways to achieve positive consequences without using *drug.*

Lower: A less skilled therapist might help the patient identify the positive and negative consequences and connect them to *drug* use, but stop there. No further exploration would be done to foster the patient's ability to pursue positive consequences without using *drug*.

THERAPIST'S BELIEF IN ABSTINENCE RATHER THAN REDUCTION: To what extent did the therapist advocate a goal of abstinence rather than reduction of *drug* for the patient?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist explicitly discussed the rationale for/advantages of a treatment goal of abstinence OR the disadvantages of a treatment goal of reduction of *drug* use? To be rated highly, the therapist must express directly to the patient that the approach of the treatment advocates complete abstinence from *drug* as opposed to reduction in intake. In addition, the discussion should include the rationale for cessation versus reduction. A lower rating would be achieved if the therapist advocates complete abstinence without offering a rationale for this stance.

Examples:

T: "In this treatment the goal is abstinence from *drug*. There are other treatments that support a goal of reduction of *drug* use rather than abstinence. However, based on the progressively worsening effects of continued *drug* use, it has been our experience that patients benefit from treatment the most when they are not using at all.

T: "In this treatment success is measured by abstinence from *drug* use."

Skill Level Rating Guidelines:

Higher: In discussing the rationale for abstinence rather than reduction of *drug* use, a skilled therapist would first help the patient identify consequences related to *drug* use and use the patient's experiences to support the belief that, until he/she is abstinent, progress cannot be made in other areas in the patient's life. Once abstinence is achieved, the patient can begin to deal with other negative consequences stemming from *drug* use. The therapist won't ignore areas that the patient presents as problems, but rather will focus on the primary goal of abstinence as essential to treatment success. In addition, the therapist would caution the patient against the possibility of relapse by simply reducing *drug* use.

Lower: A less skilled therapist would simply put forth the belief that abstinence rather than reduction in drug use is the goal of treatment, without providing the rationale for this stance. Not providing the rationale often results in the patient not understanding why this is the goal of treatment and this may make it more difficult for the patient to make a commitment to abstinence.

ABSTINENCE VS. LOSS OF CONTROL: To what extent did the therapist express the view that any *drug* consumption would inevitably lead to loss of control and relapse?

Frequency and Extensiveness Rating Guidelines:

This item refers to the belief that if a patient takes even one drink or uses *drug* once, the patient will lose control over the *drug* and it will lead to a full-blown relapse. To achieve a higher rating the therapist must include the rationale for total abstinence versus reduction in drinking/*drug* usage. A lower rating would be achieved on this item if the therapist simply raises this as an issue.

Examples:

T: "You cannot control your drinking by trying to drink less. If you pick up one drink, you will lose control and be right back where you started."

T: "You know from experience that one drink is never enough and leads to full-blown relapse. The primary goal here must be abstinence because without abstinence there is no control over drinking and/or *drug* use."

Skill Level Rating Guidelines:

Higher: A skilled therapist will put forth the rationale for total abstinence and that without abstinence there is no control and the patient cannot work on problem areas until he/she becomes abstinent. The only control is whether or not the patient uses in the first place. Once the substance is in the body, there is no control. In addition, the therapist will carefully and thoroughly elicit examples from the patient's life that support this approach to treatment.

Lower: A less skilled therapist will emphasize the belief that one drink or one use of *drug* will lead to a full-blown relapse, without anchoring it in the rationale for total abstinence.

GENERAL PRAISE FOR PAST MEDICATION COMPLIANCE: To what extent did the therapist compliment, or cheer, and/or praise the patients reported *study medication* compliance?

Frequency and Extensiveness Guidelines:

This item refers to what extent the therapist enthusiastically and explicitly praises the patient's past medication compliance. For this item to be rated highly, the therapist consistently reinforces and/or praises the patient's past compliance with *study medication*. A lower rating would be achieved when the therapist asks if the patient has been compliant with *study medication* without praising his/her compliance.

Examples:

P: "I took my *study medication* every day this week."
T: "Good for you!"

T: "It is terrific that you have been taking your *study medication* as prescribed since we last met. Even with some side effects early on, you stuck it out and now the side effects have resolved and you are experiencing the benefits of the *study medication.* That is just great!

Skill Level Rating Guidelines:

Higher: A skilled therapist will compliment and praise the patient's medication compliance to support and foster continued compliance. Often, there are unpleasant side effects of *study medication* that can make compliance difficult for the patient. The therapist will recognize this, explain the possible benefits of the *study medication*, while acknowledging that the side effects can be tough, but may also resolve as long as the patient keeps taking the medication. The therapist's praise and enthusiasm encourages the patient to keep with it long enough to gain the potential benefits of the medication.

Lower: A less skilled therapist may acknowledge the patient's past compliance with *study medication* without expressing praise or encouragement. In addition, a less skilled therapist might fail to acknowledge side effects the patient may be experiencing or issues the patient may have about taking medication in the first place. These empathic failures can contribute to medication noncompliance in the future.

PATIENTS' GOALS FOR TREATMENT: To what extent did the therapist discuss, review, or reformulate the patient's goals for treatment?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist collaborated with the patient in a discussion of what the patient's goals for treatment were, or whether the patient's goals were realistic. This would include a discussion of how problems, which were not a target of the treatment, could be addressed outside or after the study protocol.

To be rated highly, the therapist should help the patient identify specific goals that s/he wants to work on, determine if the goals are realistic, determine which of these goals are appropriate to work on in the study, and which should be addressed in treatment after the patient completes the study. A lower rating would be given if the therapist simply asks what the patient's goals are for treatment with no additional exploration.

Examples:

T: "You have indicated that your primary goal is to stop using. What other goals do you have for treatment?"

T: "In addition to becoming abstinent from drugs and/or alcohol, let's identify some other goals that might support that effort. We need to determine what goals are realistic and can be addressed in this treatment. There may be some goals that need to be addressed outside of this treatment (e.g., enduring psychiatric issues, changing jobs).

Skill Level Rating Guidelines:

Higher: A highly skilled therapist will encourage the patient to identify goals for treatment that support the patient's recovery and attempt to solve problems that contribute to the patient's current problems. The therapist will collaborate with the patient to set goals that are important and attainable. For goals that are not targeted for the treatment, a skilled therapist will acknowledge their importance and help the patient understand that there are some goals that must be addressed outside of treatment and give appropriate referrals when possible.

Lower: A lower skilled therapist will ask for patient goals without offering feedback as to their appropriateness for treatment and/or whether or not the goals seem attainable.

ASSESSMENT OF PATIENT'S COMMITMENT TO ABSTINENCE OR REDUCTION OF *DRUG* USE: To what extent did the therapist discuss or address the patients' current commitment to abstinence or their commitment to reduction of *drug* use?

Frequency and Extensiveness Rating Guidelines:

For higher ratings, the therapist must explicitly assess the patient's current motivation to become abstinent or decrease their substance use, especially if the patient is continuing to use *drug(s)*. To achieve a lower rating, the therapist might imply that the patient wants to maintain abstinence or reduce drug use, but does not explicitly ask for the commitment from the patient.

Examples:

T: "From what you have told me about your last slip, it's clear that you are having difficulty stopping your *drug use*. How strongly do you feel today about becoming abstinent?

T: "It's clear from what you've said today that many people have urged you to stop using, but I was wondering what you think?"

T: "It sounds like you're making a decision to reduce your *drug use*. Is that so?"

Skill Level Rating Guidelines:

Higher: A skilled therapist will ask series of questions that help identify the patient's level of commitment to become abstinent or decrease their substance use. The therapist will tease out issues that may contribute to any ambivalence about their substance use, in an effort to help the patient make a commitment to abstinence or reduction of substance use or to clarify treatment goals.

Lower: A less skilled therapist may ask the patient about their commitment to abstinence or reduction of substance use without following up to get at issues that may interfere with patient's level of motivation/commitment.

SKILLFULNESS: How would you rate the therapist's general level of skillfulness?

Skillfulness is the consistent demonstration by the therapist of his/her expertise, competence, commitment to a therapeutic process, appropriate timing and matching of intervention strategies, and ability to assist the patient.

Rating	Definition
1	*Very Poor.* The therapist is not skillful in facilitating a therapy or counseling session. The therapist shows little expertise in any particular approach to treatment. The therapist is excessively passive and non-interactive with the patient or domineering during the session. The therapist lacks precision and may intervene with the patient in ambiguous or haphazard ways. The patient does not benefit from the interaction with the therapist and may become more symptomatic and less engaged in a therapeutic process in response to the therapist's behaviors.
2	*Poor.* The therapist marginally demonstrates therapeutic skillfulness. The therapist shows a limited repertoire of intervention skills and uses these skills in redundant, inflexible, and unimaginative ways. Selected interventions are not part of a coherent treatment approach. Crafting and matching interventions to the patient does not occur. Often the therapist seems uncertain about how to proceed in the session. While the client may not benefit from the session, he/she is unlikely to worsen symptomatically or fully disengage from the therapy process in response to the therapist's behaviors.
3	*Acceptable.* The therapist makes consistent attempts to conduct therapy according to a treatment model, but often wavers from a coherent approach and does not implement interventions with the fidelity expected of average therapists. At times, the therapist may be wordy, overly abstract, or inattentive to the patient's statements and behaviors. His/her timing of interventions may be awkward. The therapist's approach may appear technically correct, but clumsy in style. These therapist shortcomings significantly limit the therapist's effectiveness with patients who are resistant to change or present with more complex problems.
4	*Adequate.* The therapist guides most therapeutic interventions according to a coherent treatment model. Some transgressions from the treatment model occur, but these transgressions do not seriously undermine or contradict the therapist's overall approach. The therapist renders most interventions with sufficient clarity, appropriateness, and timing. The therapist, however, may demonstrate less skillfulness when confronted with more difficult clinical circumstances (e.g., patient resistance) and waiver in his/her approach as the therapist attempts to determine his/her next move. The patient generally benefits from the interaction with the therapist unless the complications and motivational deficits presented by the patient exceed the therapist's "average" abilities.
5	*Good.* The therapist guides his/her therapeutic interventions according to a coherently defined treatment model. Transgressions from the model seldom occur. If present, these transgressions are minor and never contradictory to the therapist's overall approach. The therapist modifies his/her approach based upon the patient's responses, thereby demonstrating attentiveness and flexibility during the session. The therapist manages instances of client resistance well, although occasionally seems unsure about how to resolve a clinical quagmire during the session. Typically, the therapist is helpful to the patient. Only the most difficult-to-treat patients exceed the capacity of the "good" therapist.
6	*Very Good.* The therapist guides all therapeutic interventions according to a coherently defined treatment model. The therapist does not transgress from the model. The therapist handles all

circumstances well, even when the patient interacts with the therapist in clinically challenging ways (minimally talkative or responsive, passive-aggressive, argumentative). The therapist remains even-keeled and steadfast in approaching the patient in a therapeutic way. The patient benefits from the interaction and appears to make progress during the session.

7 *Excellent.* The therapist renders all therapeutic interventions according to a coherently defined treatment model with notable facility and innovation. The therapist clearly understands the patient and very successfully engages the patient in a therapeutic process. Therapist comments and interventions appear uniquely crafted for the patient. They are well stated and strategically timed. The therapist skillfully handles all clinical dilemmas. Even initially resistant patients become disarmed by the therapist's therapeutic finesse and ultimately benefit from the interaction. The patient makes treatment progress during the session.

Supplemental Items

(11 Items)

NOTE: The phrase "*drug of choice*" or "*drug*" appearing in italics is study specific. These items can be changed to reflect the relevant substance in any particular study.

Example: In Therapist's Belief in Abstinence versus Reduction, the substance relevant to the study population (eg., cocaine, heroin, valium, etc.) can be substituted for *drug*.

EXPLORATION OF PATIENT/THERAPIST RELATIONSHIP: To what extent did the therapist explore the patient's thoughts/feelings regarding the patient/therapist relationship or interactions which occur between patient and therapist?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

TERMINATION: To what extent did the therapist make attempts to prepare the patient for the end of the patient/therapist relationship/treatment by exploring the patient's thoughts/feelings regarding the termination of the relationship and/or preparing the patient for the termination of the treatment?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

CONFRONTATION OF CONTRADICTION BETWEEN PATIENT REPORT AND ACTUAL LAB RESULTS OF USE: To what extent did the therapist confront the contradiction between the patient's report of *drug* use and the actual lab results?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

OPTIMISTIC REASSURANCE DUE TO FUTURE PATIENT EFFORTS (NONMEDICATION): To what extent did the therapist communicate confidence that patient efforts THAT DO NOT INCLUDE MEDICATION will yield success in the future?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

POSITIVE/NEGATIVE CONSEQUENCES OF ADDICTION: To what extent did the therapist address or explore the positive and/or negative consequences/results of the patient's addictive behavior as related to past, present, or future active *drug* intake?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

THERAPIST'S BELIEF IN ABSTINENCE RATHER THAN REDUCTION: To what extent did the therapist advocate a goal of abstinence rather than reduction of *drug* use for the patient?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

ABSTINENCE VS LOSS OF CONTROL: To what extent did the therapist express the view that any *drug* consumption would inevitably lead to loss of control over *drug* use and relapse?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

GENERAL PRAISE FOR PAST MEDICATION COMPLIANCE: To what extent did the therapist compliment, or cheer, and/or praise the patient's reported *study medication* compliance?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

PATIENT'S GOALS FOR TREATMENT: To what extent did the therapist discuss, review, or reformulate the patient's goals for treatment?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

ASSESSMENT OF PATIENT'S COMMITMENT TO ABSTINENCE OR REDUCTION OF *DRUG* USE: To what extent did the therapist discuss or address the patient's current commitment to abstinence or their commitment to reduction of *drug* use?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

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Appendices

APPENDIX A

A General System for Evaluating Therapist Adherence and Competence in Psychotherapy Research in the Addictions

Kathleen M. Carroll, Ph.D.[1], Charla Nich, M.S.[1], Rachel L. Sifry, Ph.D.[2], Kathryn F. Nuro, Ph.D.[1], Tami Frankforter, B.S.[1], Samuel A. Ball, Ph.D.[1], Lisa Fenton, Psy.D.[1], & Bruce J. Rounsaville, M.D.[1]

[1] *Department of Psychiatry, Yale University School of Medicine*

[2] *Connecticut Psychological Group Behavioral Health Resources*

Abstract

The Yale Adherence and Competence Scale (YACS) is a general system for rating therapist adherence and competence in delivering behavioral treatments for substance use disorders. The system includes three scales measuring 'general' aspects of drug abuse treatment (Assessment, General Support, Goals of Treatment), as well as three scales measuring critical elements of three treatments that are frequently implemented as control or comparison treatments in clinical research in the addictions (Clinical Management, Twelve Step Facilitation, and Cognitive-Behavioral Treatment). Validation of the YACS using data from a randomized clinical trial indicated that the scales have excellent reliability, factor structure, concurrent and discriminant validity. Correlations between adherence and competence scores within scales were in the moderate range, indicating independence (and thus nonredundancy) of these dimensions. Strategies for using the YACS in both psychotherapy and pharmacotherapy research in the addictions are described.

1. Introduction

The number of randomized clinical trials evaluating behavioral treatments for drug abuse disorders has historically lagged far behind the number of trials evaluating pharmacotherapies. This has occurred for several reasons, one of the chief being that, compared with the delivery of pharmacotherapies, it is difficult to specify the independent (treatment) variable and deliver it in a uniform way. The nature of most psychotherapies is that they are flexible, dynamic, and highly individualized. This flexibility is an essential strength of behavioral treatments. However, it is also an important weakness, as the dynamic nature of behavioral treatments also made them enormously difficult to evaluate systematically in the context of a clinical trial.

A set of recently developed methodological advances, generally referred to as the technology model of psychotherapy research (Carroll & Rounsaville, 1990; Waskow, 1984), has revolutionized the field and has greatly enhanced investigators' ability to systematically specify and rigorously evaluate behavioral treatments. The technology model is a strategy for reducing error variance in trials where psychotherapies are evaluated by specifying and delivering them in a manner analogous to the specification and delivery of pharmacotherapies in clinical trials. This model requires specification of behavioral therapies in terms of their 'dose' (the frequency and number of sessions), their active and 'inert' ingredients (clarification of unique and common elements of the therapy), the conditions under which they are administered and assessment of whether the treatment was adequately delivered to all patients (compliance). Adoption of a technology model has led to broader use of a number of methodological features associated with this model, many of which have now become 'virtual requirements' in clinical trials involving behavioral treatments. These include: (1) specification of treatments in manuals, (2) training and supervision of therapists to delivery the treatment as uniformly as possible, and (3) monitoring of treatment delivery (Carroll & Nuro, 1997).

While two of these three key methodological elements associated with the technology model, treatment manuals and therapist training protocols, are becoming more widely adopted in clinical trials in the addictions, systematic evaluation of the adequacy of treatment delivery remains rare (Morely et al. 1996; Miller et al., 1995). This occurs in large part because it is difficult, expensive and time-consuming to develop psychotherapy rating systems, train process raters, and establish reliability of ratings. Despite these challenges, evaluation of treatment implementation is of great importance, as these evaluation can address a number of critical issues regarding the internal validity of a trial: Were the study treatments implemented according to manual guidelines? Were the treatments evaluated discriminable from each other? To what extent did the treatments overlap (e.g., was there contamination of the independent variable)? How much variation was there in treatment delivery across therapists (or sites)? Did the delivery of the treatment change across time (e.g., did the treatment 'weaken' as it was delivered over the course of treatment?) or throughout the course of the study (e.g., did the therapists 'drift' as they delivered the treatment to a number of patients)? Process analyses can also address important questions about how a given treatment worked: Were particular interventions associated with good (or poor) outcome? Did the therapists vary in their delivery of a treatment to different types of patients (e.g. did more severe patients receive different types of interventions than less severe ones)? Is treatment 'purity' (e.g., delivering only interventions as defined in the manual) associated with better outcomes than more eclectic approaches?

In this report we describe the psychometric development and validation of the Yale Adherence and Competence Scale. Because the Yale Psychotherapy Development Center for Opioid and Cocaine Dependence focuses on developing and evaluating a range of innovative psychotherapies for drug use disorders, our intention was to develop a general psychotherapy rating system that could be utilized in a wide range of studies. Therefore, the YACS includes several scales that assess 'general' interventions the are common to most behavioral treatments in the addictions, as well as scales that assess several specific treatments that are commonly used as comparison or platforms in clinical trials. We will describe the development and psychometric validation of the rating system and then demonstrate how the data generated by this system can be used to address key questions regarding the internal validity of psychotherapy outcome studies in the addictions.

2. Methods

2.1 Development of the Yale Adherence and Competence Scale

The Yale Adherence and Competence Scale (YACS) is a 55-item scale tapping general (therapist interventions or behaviors common to most therapies) and unique (interventions unique to specific therapies) elements of behavioral treatments for drug use disorders in three 'general' and three 'treatment' scales, described below. Sample items from each of the scales are provided in the Appendix.

2.1.1 Assessment (5 items)

This is one of the three 'general' scales tapping interventions that would be expected to occur in most treatment approaches. The items evaluate the extent to which the therapist assessed the patient's drug and alcohol use, as well as their general functioning, current level of family or social support, and psychiatric symptoms and problems.

2.1.2 General Support (5 items)

The second 'general' scale, this scale taps the therapist's empathy, the quality of the therapeutic relationship, and the degree to which the therapist provided optimistic reassurance and support to the patient.

2.1.3 Goals of Treatment (5 items)

The third 'general' scale, this taps the degree to which the therapist facilitated discussion of the patient's goals for treatment, the patient's commitment to abstinence, or implemented strategies intended to bolster the patient's motivation for change.

2.1.4 Clinical Management (CM), (10 items)

One of the 'treatment-specific' scales, CM is a psychotherapy control condition that has been frequently used in clinical trials that involve a medication component (e.g., Carroll et al., 1994; Carroll et al., 1998; O'Malley et al., 1992). Also called Compliance Enhancement, this approach has been adapted for use with drug dependent individuals (Carroll & O'Malley, 1996) from the guidelines developed by Fawcett (et al., 1987) for the NIMH Collaborative Study on the Treatment of Depression (Elkin et al., 1985). The goals of Clinical Management are: (1) to provide nonspecific, common factors of a psychotherapeutic relationship, including a supportive doctor-patient relationship, education, empathy, and the instillation of hope, without providing active ingredients specific to other 'active' psychotherapies, (2) to provide medication management as well as opportunity to monitor patients' clinical status and treatment response, and (3) to provide a convincing therapeutic rationale and so foster greater retention in treatment protocols and compliance with medication.

2.1.5 Twelve Step Facilitation (TSF), (9 items)

The second of the tree treatment-specific scales, TSF is often implemented in therapy outcome studies to represent 'treatment as usual' as it is practiced in many clinical substance abuse programs in the United States. As described in the manual (Baker, 1998), was adapted for use with drug-dependent individuals from the guidelines for Twelve Step Facilitation Treatment from Project MATCH (Nowinski, Baker & Carroll, 1992; Project Match Research Group, 1993). Grounded in the concept of substance dependence as a spiritual and medical disease, the major goals of TSF are abstinence from all psychoactive substances and fostering active participation in self-help groups (AA, CA, NA). The content of TSF is intended to be consistent with the Twelve Steps of Alcoholics Anonymous (AA), with primary emphasis given to Steps 1 through 5. Patients are actively encouraged to attend AA or other self-help meetings, become involved in traditional fellowship activities, and maintain journals of their self-help group attendance and participation.

2.1.6 Cognitive-Behavioral treatment (CBT), (6 items)

CBT is one of the most frequently studied treatments for substance use disorders, and thus is often used as a comparison or 'reference' condition in clinical trials evaluating novel behavioral approaches. CBT has often been used as a behavioral 'platform' in pharmacotherapy trials (e.g., to provide an adequate and consistently behavioral treatment to all trial participants). The goal of CBT is abstinence from all psychoactive substances through identification of high risk situations for substance use and the implementation of effective coping strategies. As described in the manual (Carroll, 1998), skill training is offered in a number of areas, including: (1) reducing exposure to drug cues, (2) fostering resolution to stop drug use through exploring positive and negative consequences of continued use, (3) self-monitoring to identify high risk situations, (4) recognition of conditioned craving and development of strategies for coping with craving, (5) identification of seemingly irrelevant decisions which could culminate in high risk situations, (6) preparation for emergencies and coping with a relapse to substance use, and (7) identifying and confronting thoughts about substance use.

2.2 Item generation

Items for the YACS were generated directly from review of session videotapes and from the treatment manuals. As recommended by Waltz and colleagues (1993), the following types of items are generated:

1. Interventions, behaviors, or processes that are unique and essential to each treatment evaluated (an example would be encouragement to find a sponsor in TSF treatment, which is essential in TSF but would not be expected to be found in other approaches).
2. Interventions, behaviors, or processes that are essential to the treatments evaluated but not unique to them (an example would be discussing the patients goals for treatment, which is essential in most treatments but not unique to any of them).
3. Interventions, behaviors, or processes that are acceptable but neither essential nor unique (an example might be the use of therapist self-disclosure within TSF treatment, as this behavior is not prescribed in the treatment manual but often occurs within this treatment approach).
4. Interventions, behaviors, or processes that are proscribed. Examples of proscribed interventions would be those that should not occur in any therapy (e.g., discussion of clearly irrelevant topics), as well as interventions that should be unique to a comparison approach (e.g., providing TSF interventions in a CBT treatment).

Because the YACS is intended to assess therapist adherence and competence in the delivery of the treatment, items are written so as to focus exclusively on therapist, not patient, behavior. Thus, each item is phrased as, "To what degree did the therapist encourage or facilitate....". To increase reliability, items were worded so as to be as specific and concrete as possible and to focus on observable therapist behaviors. For example, "To what degree did the therapist assess the patient's general functioning since the last session" would be preferable to the more general and subjective, "To what degree did the therapist seem concerned about the patient".

2.3 Format of the ratings

All YACS items use a common Likert-type format. For each item, two dimensions are rated: The first dimension is a 'quantity' or 'adherence' rating that taps the degree to which the intervention was present in that session (e.g., whether it occurred and with what intensity). The second dimension for each item is a 'quality' or 'skillfulness' rating that indicates skill with which the therapist delivered the intervention (and is rated only if the intervention occurred within the session rated).

This quantity/quality rating system has several advantages: First, it recognizes that therapist adherence and competence are not necessarily highly related. That is, a therapist can deliver an intervention exactly as described in the treatment manual but do so ineffectively (e.g., in a wooden manner or at an inappropriate time). Second, older process rating systems like those developed for the NIMH Collaborative Study on the Treatment of Depression (DeRubeis et al., 1982), often required each session to be rated by two types of raters if both adherence and competence evaluations were needed. That is, because is was necessary for the evaluation of discriminability that independent raters who were 'blind' to treatment assignment evaluated therapist adherence, the 'blind' raters would then be unable to assess therapist competence (because global ratings of competence require knowledge of the treatment condition. Therefore, additional ratings by treatment 'experts' who were familiar with the treatment manual were needed to provide ratings of therapist competence. The YACS saves time and the expense of a second set of ratings by having each item scored for both adherence (how much it occurred in a session) and competence (how well the therapist delivered it). Thus, the need for global ratings of therapist competence is eliminated. This approach has been used successfully by other investigators (Barber, Mercer, Krakauer, & Calvo, 1996; Barber, Krakauer, Calvo, Badgio, & Faude, 1997); however, evaluations of those scales have indicated that correlations between adherence and competence ratings have been quite high, calling into question the need for the two types of ratings for those scales.

2.4 Rater guidelines

A detailed rater's manual for the YACS, based on that developed by Hollon and colleagues for the NIMH Collaborative Study (DeRubeis et al., 1982) was developed to train raters and foster a consistent and reliable approach to performing the ratings (Sifry et al., 1994). The manual summarizes general guidelines for the rating task, such as instructing raters to watch the whole tape before making ratings, to avoid 'haloed' ratings, to use the manual each time they do ratings, to rate only observable behaviors, and so on. The manual also provides, for each item, a detailed description with examples of the item, guidelines for making lower versus higher ratings for that item, and describes how each item should be distinguished from other closely related items.

2.5 Rater selection and training

Because of the complexity of the rating task, it is important that raters be experienced clinicians themselves (Moras & Hill, 1991). Process raters for the YACS were predominantly masters-level clinicians who have experience in treating substance users and who often have experience in one or more of the study treatments evaluated in the YACS (e.g., CBT, TSF, or CM).

Procedures for rater training largely parallel those used to train therapists for psychotherapy outcome studies (Carroll, Kadden et al., 1992; Carroll & Nuro, 1997). First, rater trainees attend a didactic seminar which includes detailed review of the rating manual as well as several group practice ratings using taped examples. Second, rater trainees rate at least 10 practice tapes, which are evaluated with respect to 'expert' consensus ratings of those tapes. Raters are 'certified' only after their ratings achieve acceptable reliability

with respect to the consensus ratings. Rater recalibration sessions are held regularly to monitor and prevent rater drift. Reliability is formally evaluated several times while the rating task is ongoing. This is done using a small set of session tapes that are each rated by each of the raters, and where the where raters are unaware of which tapes are used to calculate interrater reliability.

2.6 Overview of the clinical trial

Because this report focuses on the development of the process rating system, we will only briefly describe the clinical trial from which data were drawn to validate the YACS. This study (Carroll, Nich, Ball et al., 1998) was a randomized clinical trial evaluating five treatments for individuals meeting current DSM-III-R criteria for cocaine dependence and concurrent alcohol abuse or dependence: Cognitive-Behavioral Treatment (CBT) plus disulfiram; Twelve Step Facilitation (TSF) plus disulfiram; Clinical Management (CM) plus disulfiram; CBT plus no medication; TSF plus no medication. Individuals were excluded who (1) were currently physically dependent on opiates or barbiturates, or whose principal drug of dependence was not cocaine, (2) met lifetime DSM-III-R criteria for a psychotic or bipolar disorder, or expressed significant current suicidal or homicidal ideation, (3) had a current medical condition which would contraindicate use of disulfiram, (4) had been treated for substance use during the previous two months or who were currently involved in psychotherapy or pharmacotherapy for any other psychiatric disorder, or (5) had conditions of probation or parole requiring reports of drug use to officers of the court (and hence undercut the validity of self-reports of substance use). Treatments were delivered to patients in weekly individual sessions offered over twelve weeks. All participants signed a consent form for treatment and for videotaping that had been approved by the Yale University School of Medicine Human Investigations Committee.

The 122 individuals who were randomized to treatment were predominantly young (mean age 30.0, SD 5.5), African American (55% African American, 39% white, 5% other) males (73%), with a high school education (47%). Slightly more than half were unemployed (57%). Participants reported a mean of 14 days (SD 8.3) of cocaine use and 17 days (SD 7.9) of alcohol use in the month preceding treatment entry. Participants reported an average of 7.5 years (SD 4.4) of cocaine dependence and 7.3 years of alcohol abuse (SD 6.2). All participants met current DSM-III-R criteria for cocaine dependence, 85% for alcohol dependence, and 15% met criteria for alcohol abuse. Regarding non-substance psychiatric disorders, 20% met criteria for a lifetime affective disorder, 8% met criteria for a lifetime anxiety disorders, 53% met criteria for antisocial personality disorder, and 51% for any other Axis II disorder.

Of the 122 subjects randomized, 117 (96%) initiated treatment. The mean number of sessions completed was 7.5 (sd 4.7). The CBT/disulfiram group had the highest rate of retention (mean 8.8 weeks), followed by CM/disulfiram (8.4 weeks), TSF/disulfiram (8.0), CBT/no medication (6.3) and TSF/no medication (5.3). Subjects assigned to disulfiram treatment were retained significantly longer than those assigned to no medication (8.4 versus 5.8 weeks, $F=8.7$, $p<0.05$). No significant differences in retention by psychotherapy condition were found.

We attempted to rate all of the sessions conducted as part of this study; the most common reasons that sessions were not rated were equipment failure or failure of the therapist to record a session. Of the 877 sessions completed, 741 were rated (85%). In cases where two sessions were conducted in the same week for a patient, the first session that week was used, for a total sample size of 576. There were no significant differences across treatment conditions in the percent of sessions rated or included in the analysis samples.

3. Results

3.1 Evaluation of reliability

Intraclass correlation coefficients (ICC) were calculated to provide an estimate of item and scale reliabilities, using a reliability sample of 19 randomly selected tapes that were each rated by the 5 raters (n=95) and are presented in Table 1. Using the Shrout and Fleiss (1979) random effects model (2,1) to estimate reliabilities for independent samples, the six scales were highly reliable. Intraclass correlation coefficients ranged from 0.80 to 0.95 for the adherence ratings and from 0.71 to 0.97 for the competence ratings. For individual items, quantity (adherence) ratings ranged from 0.28 to 0.84, and quality (competence) ratings ranged from 0.06 to 0.81.

Table 1
Yale Adherence and Competence Scale: subscale reliabilities based on intraclass correlation coefficients[a]

Subscale	Reliability
Assessment (five items)	
Adherence	0.80
Competence	0.85
General support (five items)	
Adherence	0.83
Competence	0.71
Goals (five items)	
Adherence	0.85
Competence	0.83
Clinical Management (CM) (ten items)	
Adherence	0.95
Competence	0.98
Twelve Step Facilitation (TSF) (nine items)	
Adherence	0.93
Competence	0.93
Cognitive-Behavioral Treatment (CBT) (six items)	
Adherence	0.88
Competence	0.88

[a] From Shrout and Fleiss (1979) model (2,1).

3.2 Factor structure

The factor structure of the YACS was evaluated using adherence ratings from a sample of 83 tapes from early (session 2) treatment sessions. Early sessions were selected to avoid bias associated with dropout occurring later in treatment. Because item generation was theoretically driven, and each item was intended to be associated with a specific subscale, we used confirmatory factor analysis and structural equation modeling (see Bollen, 1989; Floyd & Widaman, 1995; Loehlin, 1992) to evaluate the hypothesized factor structure of each scale, rather than exploratory factor analysis. AMOS software (Arbuckle, 1996) was used for these analyses.

As shown in Table 2, which presents multiple goodness-of-fit statistics, each of the six scales satisfied all or most of the major current criteria for evaluating goodness of fit (e.g., a chi-square/degrees of freedom ratio of less than 2, GFI and CFI indices of 0.9 or above, RMSEA less than 0.10). In addition, there are two items (extra-session assignment and review of whether the patient did the assignment) that occur in both TSF and CBT. Consequently, these two items were not included in the confirmatory factor analyses reported above. When these two items are included, the fit for both the TSF and CBT scales were less than optimal (TSF: GFI 0.85, CFI 0.95, CBT: GFI 0.93, CFI 0.89).

Table 2
Goodness-of-fit indices for Yale Adherence and Competency from confirmatory factor anaylsis (adherence dimension only)[a] (n = 83 sessions)

Scale	Model statistics						
	# Items	X^2	df	p	GFI	CFI	RMSEA
Assessment	5	3.21	5	0.667	0.985	1.0	0.000
General support	5	5.78	4	0.216	0.973	0.958	0.074
Goals	5	4.78	5	0.443	0.977	1.0	0.000
Clinical Management	10	42.69	30	0.062	0.915	0.956	0.072
Twelve Step Facilitation	9	31.84	20	0.045	0.925	0.981	0.085
Cognitive-Behavioral Treatment	6	17.51	8	0.025	0.939	0.891	0.120

[a] Sample composed of second sessions only.

3.3 Concurrent validity 1: Relationship between scales

Table 3 presents Pearson product-moment correlations between the adherence dimensions of each scale for the sample as a whole (576 sessions). The magnitude of the correlations was moderate, suggesting independence of the six scales. The three treatment scales had significant negative correlations (TSF/CM – 0.29, TSF/CBT – 0.21, CM/CBT – 0.10), suggesting that as expected, high scale scores on one of the treatment scales was associated with lower scores on the others. The CBT scale had significant positive correlations with each of the general scales. The TSF scale had significant positive correlations with the General Support and Goals scales, but had a significant negative correlation with the Assessment scale. The CM scale was significantly positively related to the Assessment scale, negatively related to the General Support scale, and had a nonsignificant negative correlation with the Goals scale.

Regarding the general scales, the Assessment scale was significantly positively correlated with the Goals scale, but was negatively correlated with the General Support scale. The Goals scale was significantly positively correlated with both the Assessment and the General Support scale.

Table 3
Yale Adherence and Competency Scale: relationships among adherence dimensions, Pearson correlations[a] (n = 576 sessions)

	Assessment	Support	Goals	CM	TSF
Support	−0.09				
Goals	0.19**	0.27**			
CM	0.14*	−0.24**	−0.01		
TSF	−0.22**	0.39**	0.26**	−0.29**	
CBT	0.12*	0.27*	0.22**	−0.10	−0.21**

[a] CM, Clinical Management; TSF, Twelve Step Facilitation; and CBT, Cognitive-Behavioral Treatment.
* p<0.05
** p<0.01

Table 4 presents intercorrelations of the competence dimensions of the six subscales. Note that because the competence dimension can be rated only if a given item occurs in a session, the n's for these analyses vary across scales. In general, the pattern of intercorrelation of the competence scales is more consistent than that of the adherence scales. That is, for the sample as a whole, all of the competence scales had positive significant correlations (range 0.12 – 0.54). This suggests higher competence scores on one scale were associated with higher scores on the others. In other words, the relationship of the adherence dimensions varied across treatments and scales, but the competence dimensions had stronger and more consistent relationships across scales.

Table 4
Yale Adherence and Competency Scale : relationships among adherence dimensions, Pearson correlations[a]

	Assessment	Support	Goals	CM	TSF
Support	0.32** (529)				
Goals	0.33** (380)	0.41** (355)			
CM	0.12* (356)	0.18** (323)	0.30** (231)		
TSF	0.21** (372)	0.51** (350)	0.54** (265)	0.11 (210)	
CBT	0.30** (385)	0.39** (367)	0.46** (263)	0.20** (242)	0.31** (237)

[a] Sample size for each pair of subscales varies and is given in parentheses because competence dimensions can only be scored if the item occurred in a given session. CM, Clinical Management; TSF, Twelve Step Facilitation; and CBT, Cognitive-Behavioral Treatment.
* $p<0.05$
** $p<0.01$

Finally, examination of the variances for each scale by treatment condition also support the concurrent validity of the YACS in that variances for the three treatment scales were significantly higher for sessions from that treatment than for comparison treatments. For example, the mean variance for the TSF scale was significantly higher in TSF sessions than for CBT or CM sessions (0.25 versus 0.01 and 0.008, respectively, $F=48.1$, $p<0.001$). Similarly, the mean variance for the CBT scale was significantly higher for CBT sessions compared with TSF and CM (0.09 versus 0.05 versus 0.04, $F=6.8$, $p<0.001$). The mean variance for the CM scale was significantly higher for CM sessions compared with TSF and CBT (0.07 versus 0.008 versus 0.01, $F=24.3$, $p<0.001$).

3.4 Concurrent validity 2: Relationship of scales to alliance measures

The relationship of the YACS scales to standardized measures of the treatment process is also of interest in establishing its validity. For example, we predicted that the 'general' scales and particularly the General Support scale would have high and significant correlations with instruments assessing the therapeutic alliance, whereas we would expect less consistent and weaker relationships between the three treatment-specific scales and measures of the alliance. Table 5 presents correlations of the six YACS subscales (adherence ratings only) with four commonly used observer-rated measures of the therapeutic alliance: the Working Alliance Inventory, Observer version (WAI-O, Horvath & Greenberg, 1986), the California Psychotherapy Alliance Scale (CALPAS; Marmar et al., 1986), the Penn Helping Alliance Rating Scale (Penn; Luborsky et al., 1983), and the Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley & Strupp, 1983). Alliance ratings were obtained from a process substudy where 6 independent raters rated 79 sessions using each of these instruments. Psychometric analyses of these scales indicated that each measure had good interrater reliability, as estimates of reliability based on intraclass correlation coefficients ranged from 0.69 (Penn) to 0.81 (WAI). In addition, we found that all observer-rated instruments appeared to tap a similar construct, as they were all significantly intercorrelated (pearson r range 0.43 – 0.60) (Cecero et al., in press).

Table 5 presents correlations between the YACS scales and the therapeutic alliance measures for a subset of 58 sessions where both the YACS and alliance ratings were available for the same session (typically session 2, when patients and therapists were also asked to complete alliance ratings). As expected, both the adherence and competence ratings of the General Support scale had significant positive correlations with each of the measures of alliance, providing strong evidence of its concurrent validity. Both adherence and competence ratings of the TSF scale had significant positive correlations with three of the four alliance measures. Some negative correlations were apparent as well; adherence (but not competence) ratings of the Assessment scale were negatively correlated with the four alliance scales, and both adherence and competence ratings of the Clinical Management scale were significantly negatively correlated with the alliance scales.

Table 5
Yale Adherence and Competence Scale: relationship of subscale scores to four observer-rated therapeutic alliance scales, Pearson correlation coefficients for 58 matched sessions[a]

Subscale	WAI-O	VTAS	Penn	CALPAS[a]
Assessment				
Adherence	−0.31**	−0.26**	−0.23*	−0.30
Competence	0.13	0.14	−0.07	0.01
General support				
Adherence	0.47***	0.48***	0.28**	0.34***
Competence	0.57***	0.43***	0.30**	0.45***
Goals of treatment				
Adherence	0.04	0.04	−0.14	−0.10
Competence	−0.08	−0.14	−0.14	−0.22
CM				
Adherence	−0.39***	−0.42***	−0.27**	−0.31**
Competence	−0.37***	−0.32***	−0.18	−0.34***
TSF				
Adherence	0.29**	0.30**	0.19	0.41***
Competence	0.25*	0.35***	0.21	0.43***
CBT				
Adherence	0.19	0.14	0.17	0.08
Competence	0.26**	0.19	0.16	0.22*

[a] Total scores were used for all alliance scales. WAI-O, working alliance inventory-observer version; VTAS, Vanderbilt therapeutic alliance scale; Penn, Penn helping alliance rating scale; CALPAS, California psychotherapy alliance scale.
* $p<0.05$
** $p<0.01$
*** $p<0.001$

3.5 Relationships between adherence and competence ratings

Table 6 presents simple correlations between adherence and competence scores for each of the six subscales for the sample as a whole. As above, the sample sizes vary, because the adherence dimensions can only be scored if the item occurred in a given session. All correlations were statistically significant and in the moderate positive range, again suggesting some independence of these dimensions (that is, adherence had a moderate positive relationship with competence). There was also some variability in the magnitude of the correlations across the six scales. Mean correlations by treatment were 0.31 for CM, 0.40 for TSF, and 0.38 for CBT.

Table 6
Yale Adherence and Competency Scale : relationships among adherence dimensions by subscale, Pearson correlations[a]

Adherence rating	Competence rating					
	Assessment	Support	Goals	CM	TSF	CBT
Assessment	0.27** (575)					
Support		0.54** (531)				
Goals			0.42** (380)			
CM				0.21** (356)		
TSF					0.62** (374)	
CBT						0.45** (386)

[a] Sample size for each pair of subscales varies and is given in parentheses because competence dimensions can only be scored if the item occurred in a given session. CM, Clinical Management; TSF, Twelve Step Facilitation; and CBT, Cognitive-Behavioral Treatment.
** $p<0.05$

Table 7
Item discriminability, all sessions (adherence items only)

	p	Tukey
Assessment		
Assessment of alcohol use	0.008	CM>TSF
Assessment of cocaine use	0.000	CM>TSF
Assessment of other substances	0.000	CM>TSF, CBT
Assessment of psychopathology	0.000	CM, CBT>TSF
Assessment of general functioning	0.000	CBT>TSF, CM
General support		
Praise patient efforts	0.000	TSF, CBT>CM
Explore feelings	0.000	TSF, CBT>CM
Explore level of family support	0.187	NS
Optimistic reassurance	0.000	TSF>CBT>CM
Show natural spontaneity	0.000	TSF>CBT>CM
Goals of treatment		
Explore patient's goals for treatment	0.010	CM>CBT
Increase discrepency between behavior and goals	0.631	NS
Assessment commitment to abstinence	0.000	TSF, CBT>CM
Reflective listening	0.000	CBT>TSF>CM
Feedback about urine results	0.234	NS
Clinical Management		
Biochemical rationale	0.000	CM>TSF, CBT
Concerns about medication	0.000	CM>TSF, CBT
Connect compliance and response	0.000	CM>TSF, CBT
Stress importance of compliance	0.000	CM>TSF, CBT
Review of medication dosage	0.000	CM>TSF, CBT
Review of medication schedule	0.000	CM>TSF, CBT
Review of medication compliance	0.000	CM>CBT>TSF
Explain medication reaction	0.000	CM>TSF, CBT
Review side effects	0.000	CM>TSF, CBT
Management of side effects	0.000	CM>TSF, CBT
Twelve Step Facilitation		
Encourage AA involvement	0.000	TSF>CBT, CM
Self disclosure	0.000	TSF>CBT, CM
Confrontation of denial	0.000	TSF>CBT, CM
Explore resistance to TSF recovery	0.000	TSF>CBT, CM
Disease model of addiction	0.000	TSF>CBT, CM
TSF recovery	0.000	TSF>CBT, CM
Spirituality	0.000	TSF>CBT, CM
Stress importance of abstinence	0.000	TSF>CBT, CM
Explore denial	0.000	TSF>CBT, CM
Cognitive-Behavioral Treatment		
Skills training	0.000	CBT>TSF, CM
Debrief past high risk situations	0.000	CBT>TSF, CM
Cognitions	0.000	CBT>TSF, CM
Plan for future high risk situations	0.000	CBT>TSF, CM
Difference between slip *vs* relapse	0.047	CBT>CM
Conditioning	0.001	CBT>TSF, CM

3.6 Item discriminability

To evaluate whether the items composing the six subscales, and particularly the three treatment scales 'worked' as intended (by discriminating the three treatments), simple ANOVAs were calculated and are presented in Table 7. In general, the items performed as expected. That is, for the three treatment scales, each of the items composing the treatment scales was significantly higher for that treatment than the two comparison treatments. In other words, all CM items were significantly higher for CM treatment compared

with CBT and TSF treatment, TSF items were significantly higher for TSF treatment, and CBT items were significantly higher for CBT treatment. For the three general items, treatment differences were less marked and consistent. However, 4 of 5 Assessment scale items were significantly higher for CM sessions than TSF or CBT. TSF and CBT sessions were significantly higher than CM on most of the General Support scale items. For the Goals scale, no clear pattern emerged.

3.7 Discriminant validity

There are two major strategies typically used to evaluate treatment discriminability in process analyses: (1) simple comparisons of mean scale scores by treatment and (2) multiple groups profile analysis (Harris, 1985). The former is a comparatively simple approach that addresses how well the scales do in discriminating different treatment conditions, while the latter is particularly useful in psychotherapy research, as it allows simultaneous evaluation of variance in scale scores as a function of multiple factors: treatment condition, therapist, rater, time in treatment, and so on. Both strategies were used to evaluate the YACS.

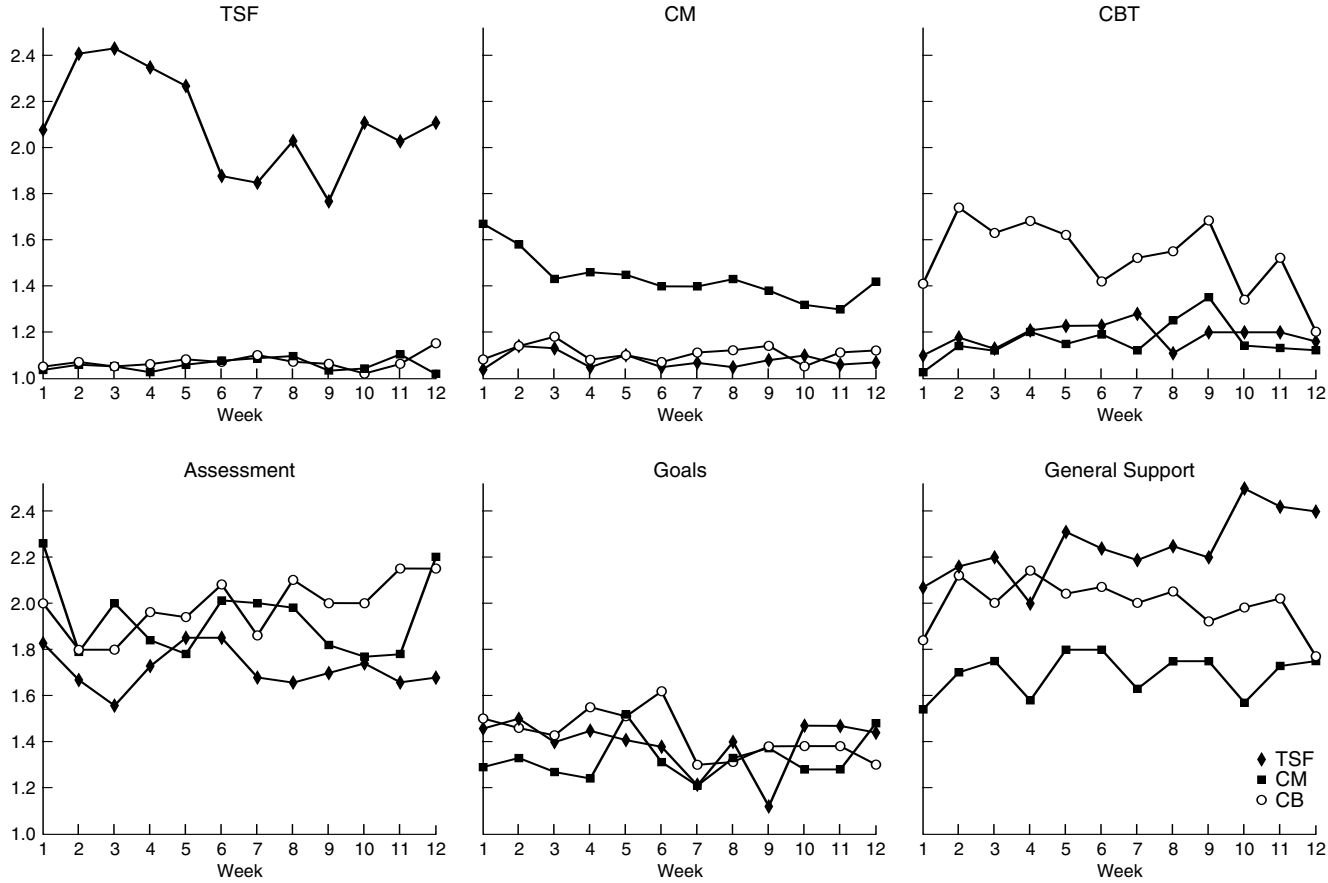

Figure 1
Discriminant validity: adherence ratings. Mean subscale scores across time by treatment condition for each of the three treatment conditions, Twelve Step Facilitation (TSF), Clinical Management (CM), and Cognitive-Behavioral Treatment (CBT).

As illustrated in Figure 1, which presents mean scale scores over time by treatment, the three 'treatment' scores (TSF, CM, CBT) were significantly different in the expected directions by treatment condition. That is, mean TSF scale scores were significantly higher for subjects assigned to TSF compared with CBT or CM for all treatment weeks. Mean CM scores for subjects assigned to CM treatment were significantly higher than for subjects assigned to TSF or CBT for all treatment weeks, and mean CBT scores for subjects assigned to CBT treatment were significantly higher than for subjects assigned to TSF or CM for all

treatment weeks, with the exception of Weeks 6 and 12. Thus, the three treatment scales work as intended, with each scale able to differentiate the treatments in the expected directions.

Figure 1 also shows that fewer treatment differences were seen for the three 'general' scores (Assessment, Goals, General Support), as these scales were intended to tap elements and interventions common to all psychotherapies for substance dependence. Few consistent or statistically significant differences by treatment condition were seen for the Assessment or Goals scales. More consistent treatment differences were seen for the General Support scale, however, with TSF patients having higher mean scores than CBT patients, who in turn had higher scores than CM patients. Finally, mean scores on the three 'general' scales tended to be higher than those for the three 'treatment' scores, suggesting that while the treatments were highly discriminable and comparatively little overlap occurred between treatments on the three treatment-specific items, the magnitude of scales tapping general, common aspects of substance abuse treatment suggested these tended to be present at higher levels than many treatment-specific elements.

The second method that is commonly used to establish construct validity of scales as well as discriminability of treatments is multiple groups profile analysis (Harris, 1985; for examples see Hill, O'Grady & Elkin, 1992; Carroll et al., 1998). Multiple groups profile analysis allows for simultaneous evaluation of the magnitude different sources of variance in subscale scores, such as treatment type, therapist, session, site, rater, and so on. Although this approach has several advantages over ANOVA models because it facilitates clearer understanding of, for example, whether the treatments themselves or the therapists who delivered them accounted for more of the variance in treatment scores, it has some disadvantages as well. For instance, as in the present study where therapists were 'nested' within treatment modalities, therapists are not independent, or fixed, units of analysis. Rather, therapists are 'within treatment' or random effects. This requires setting up a balanced model, that is, equal number of therapists per condition or site, complete data at all treatment points, and so on. Because few psychotherapy studies are designed in this way, use of multiple groups profile analysis in psychotherapy research usually requires analysis on a balanced subset of data (e.g., deletion of therapists who saw only a few cases if therapist is a factor, deletion of patients who dropped out of later sessions if time is a factor). The statistic for multiple groups profile analysis is Roy's theta (comparable to canonical R2), which indicates the percent of variance accounted for by each factor coefficient of determination. The statistics do not sum to 1 because each effect represents a different set of predictor variables in the equation.

Based on the balanced subsamples of cases (a sample size of 36) and using a model that included the three treatment subscores (TSF, CBT, CM), the largest contributor to variance was treatment condition (theta=0.91), followed by therapist within treatment (theta=0.31). Time accounted for relatively little of the variance in scores (theta=0.16). Thus, this suggests that the largest contributor to variance in treatment subscale scores was treatment condition, confirming that subscales differentiate these three treatments well. When a second model was evaluated that included only the three 'general' scales (assessment, goals, support), therapist was actually a larger contributor to variance than was treatment (0.57 versus 0.37), suggesting that the therapists accounted for more variance in these scales than did the treatments themselves.

3.8 Relationship of observer ratings to therapist ratings

Another feature of the YACS is the availability of versions that are completed by the therapists after each session. These "Therapist Checklists" have been used in several ways in the course of conducting our psychotherapy trials (see Carroll, Nich & Rounsaville, 1998). First, we have found therapist checklists to be useful in therapist training and supervision. Because the Therapist Checklists list the critical, unique elements of each treatment type, they provide a regular reminder to each therapist of the types of manual-specified interventions they are to deliver (an "adherence prompter"). Although we have not evaluated the use of Therapist Checklists in this way, we believe that asking therapists to monitor and report on their own adherence is a useful strategy to foster better adherence. In addition, our therapy supervisors use the checklists when reviewing session videotapes to identify discrepancies between the therapist's and the supervisor's report of the interventions delivered in the session. The data from the YACS and the checklists become the basis of supervision, where supervisors use them to provide guidance to trainees

about their choice to use or not use specific interventions, discuss problems or issues in the therapists' implementation of specific interventions, and monitor changes in therapists' implementation of a treatment over the course of training.

Second, the Therapist Checklists are useful in psychotherapy development research, as they can be used to identify which interventions therapists find effective and utilize frequently, as well as those which they report using less frequently or only with particular types of patients (that is, which interventions or strategies are 'endorsed' by therapists). By using the therapist checklist system to monitor therapists' self-reported use of manual-specified interventions, we are able to identify interventions which therapists report using infrequently in practice, discuss with the therapists the real or perceived obstacles in delivering those interventions, and use that information to further refine the treatment in terms of its applicability in clinical settings.

However, it should be noted that because different observers of the process of treatment seldom correspond (Dill-Standiford et al., 1988; Mintz et al., 1973; Tichenor and Hill, 1989), therapist ratings should not substitute for independent ratings of the therapeutic process. In this study, therapists in each condition completed Therapist Checklists for the treatment they delivered (CBT, TSF, or CM) that were identical to those comprising these scales for the YACS. We found poor correspondence between adherence ratings from the observer and therapist perspectives, as intraclass correlation coefficients between the YACS and the Therapist Checklists for the TSF, CM and CBT scales were 0.65, 0.26. and 0.37, respectively. Moreover, therapists consistently indicated higher levels of adherence than did the raters: Of the 741 sessions from which ratings were available from both the therapist and rater, in 71% the therapist's rating was higher than the independent raters (scores were identical in 23% of sessions and in only 6% were the rater's scores higher than the therapists).

4. Discussion

In this report we describe the development of the Yale Psychotherapy Center Rating Scale (YACS), a general system for rating therapist adherence and competence in commonly-used psychosocial treatments in the addictions. Initial validation of the YACS indicated that the six scales have excellent reliability, factor structure, and concurrent validity. Relationships between the six scales also provided strong evidence of the scale's discriminant validity. Correlations between adherence and competence scores within scales were in the moderate range, indicating independence (and thus nonredundance) of these dimensions. Beyond its promising psychometric properties, other advantages of the YACS include that it is comparatively brief and encompasses multiple treatment approaches rather than a single treatment. Moreover, if it is further validated in other studies, the YACS may be appropriate for use with a range of studies and treatments in the addictions.

4.1 Adherence, competence, and general therapist skills

A number of interesting findings regarding the relationship of adherence, competence, and general therapist skills emerged from these analyses. First, the stronger intercorrelations between the competence dimensions with respect to the adherence dimensions suggests more variability in adherence than competence. That is, 'good' therapists may use a variety of techniques, but may tend to do so with fairly consistent levels of skillfulness. Alternatively, there may be less of a 'halo' effect in rating application of techniques versus the skill with which they are applied. Second, we found that variability in treatment-specific scales was largely accounted for by treatment condition, whereas the therapists who delivered each treatment accounted for more variability in the general scales than did treatment condition. Together, these findings suggest that, as intended, the use of manuals does not invariably lead to artificial, 'cookie cutter' treatments. Our analyses suggest that therapists do implement manualized therapist in ways that are distinguishable; however, there is substantial variability in the skill with which they do so that appears to be largely independent of the specific treatment they are implementing.

4.2 Ratings from different observers of the process

Consistent with an earlier study on the relationship of therapist and independent raters' reports of manual-

driven techniques (Carroll, Nich & Rounsaville, 1998), we found that therapists tend to overreport their level of adherence relative to that reported by independent raters. This may occur for several reasons. For example, the therapists may have been overly liberal in reporting their use of specific interventions because they wished to portray themselves as adhering closely to the manuals or indicated when they had intended to deliver an intervention rather than when they actually did so. Conversely, although observer ratings are a reasonable 'gold standard' against which to evaluate concordance of therapist reports of delivery of specific interventions, they are not infallible. For example, the observers may have missed detecting some interventions because the rating manual did not cover all possible cases or examples of particular interventions, the raters may not have seen the full interaction between patient and therapist (e.g., beginnings and ends of sessions may not always be recorded), limitations due to the videotapes themselves (e.g., sound quality may be variable, only the therapist was visible on the tapes to protect patient confidentiality, or some therapists or patients may have been difficult to understand). It is also possible the raters are more removed from the treatment process and thus may have missed some more subtle interventions or those that were embedded in references to previous discussions (particularly because they were instructed to rate only explicit, observable therapist behaviors). Future studies might evaluate sources of variability in ratings from both the therapist and rater's perspectives to gain a better sense of why it is so difficult to achieve consensus on therapist use of specific techniques.

4.3 How might the YACS be used in other studies?

We believe there is value in the availability of a 'generic' rating system such as the YACS, for several reasons. First, it may facilitate more emphasis on process research in the addictions. Despite compelling evidence that various psychotherapies for addictive disorders are effective (DeRubeis & Crits-Christoph, 1998; Miller et al., 1995, O'Brien & McLellan, 1996), we know very little about how those treatments work, what makes them work, whether some interventions are more effective than others, and so on. Process analyses of clinical trials data are a promising strategy for identifying therapist behaviors and specific interventions that may be particularly effective (as well as those that are ineffective or even 'toxic') and thus may help researchers improve the effectiveness of treatment. Second, the YACS was designed to be used in a number of studies and with a range of drug use disorders and can easily be adapted for use with a variety of treatment types (although further demonstration of its validity and applicability to other treatments and substance abusing populations is needed before it is used more broadly). If validated in other studies, investigators might use adaptations of the YACS to avoid the considerable time and expense involved in developing and validating process rating systems. This may prove particularly valuable in treatment development projects, where limited resources can be directed toward developing scales for newly developed treatments, and investigators might use the general and treatment-specific scales of the YACS with little or no adaptation for comparison treatments. Third, availability of a general psychotherapy rating system may foster a more consistent approach to process analyses in the addictions, thus facilitating cross-study comparisons of process and a greater understanding of elements or techniques that are effective across treatments.

Process rating systems such as the YACS can be used in many ways. For example, in pharmacotherapy studies, there is increasing awareness of the need to deliver study medications in the context of a consistently delivered psychosocial 'platform', as a strategy to foster patient retention and compliance, reduce noise variance, and offer all patients at least a minimal psychosocial approach (Carroll, 1997). While a number of pharmacotherapy researchers are adopting this approach and training clinicians to provide manual-guided therapies to patients participating in pharmacotherapy trials (Blaine, Tai & Mason, 1998), clinician training alone may be insufficient to provide a consistent behavioral 'platform'. Psychotherapy process systems such as the YACS could be used to: (1) serve as an objective basis for providing ongoing supervision and quality control while a study is ongoing, with supervisors reviewing and using the YACS to evaluate a portion of sessions, and (2) evaluate whether the treatment was in fact implemented consistently across therapists, patients, and sites.

In psychotherapy studies, process rating systems like the YACS have many potential applications. These include: (1) establishing that psychotherapies were implemented according to manual guidelines, (2) identifying differences between effective and less effective therapists, (3) relating adherence and

competence to outcome, (4) evaluating the relative contribution of general and treatment-specific elements of treatment to outcomes, (5) identifying sources of site differences and therapist effects when these occur, (6) training 'real world' clinicians to perform manual-guided treatments and evaluating their implementation of the treatment relative to criterion (e.g., comparing their ratings with those from clinical trials), (7) identifying processes associated with good versus poor outcome, and (8) exploring how the treatment process varies with patient characteristics (e.g., motivation, severity of dependence, alliance with the therapist).

Acknowledgements

Support was provided by the National Institute on Drug Abuse grants P50-DA09241 and K02-DA00248 (KMC). We gratefully acknowledge Stuart Baker, M.S., Michael Barrios, Ph.D, Joseph Nowinski, Ph.D., David Sekowitz, M.D., Amal Tenagho, M.D., Thomas Truitt, M.D., Kathryn Walsh, Ph.D., Arthur Woodard, M.S.W., and Douglas Ziedonis, M.D. who made many contributions to the success of this project through their work as therapists, the raters who assisted us with the tape ratings task, as well as Joanne Corvino, M.P.H., Roseann Bisighini, M.S., and Theresa Babuscio who assisted in the data collection and analyses. The YACS and the Rating Manual are available through Dr. Carroll.

Appendix A. Format and sample items from YACS subscales:

Quantity:

1	2	3	4	5
Not at all	A Little	Somewhat	Considerably	Extensively

Quality:

1	2	3	4	5
Not at all	A Little	Somewhat	Considerably	Extensively

All items were scored for both quantity (adherence) and quality (competence) using the scale below:

A.1. Assessment scale:

Assessment of drug use: To what extent did the therapist assess the patient's cocaine use since the last session, including the pattern of cocaine use (if any)?

Assessment of general functioning: To what extent did the therapist assess the patient's general level of functioning in major life spheres (e.g., work, intimate relationships, family life, social life, everyday stress, etc.)?

A.2. General support:

Praise patient efforts: To what extent did the therapist compliment or praise patient efforts to change?

Optimistic reassurance: To what extent did the therapist communicate confidence that patient efforts will yield success in the future?

A.3. Goals of treatment:

Explore patient goals for treatment: To what extent did the therapist discuss, review, or reformulate the patient's goals for treatment?

Assess commitment to abstinence: To what extent did the therapist discuss or address the patient's current commitment to abstinence or his/her commitment to reduction of cocaine or alcohol use?

A.4. Clinical Management:

Review of medication compliance: To what extent did the therapist inquire about or discuss the patient's compliance/non-compliance with the prescribed medication regimen since the last session?

Connect compliance and treatment response: To what extent did the therapist relate positive or negative changes in behavior (or substance use) to medication compliance or non-compliance (e.g., relate good compliance to abstinence, relate non-compliance to continued cocaine and alcohol use)?

A.5. Twelve Step Facilitation:

Encourage AA involvement: To what extent did the therapist encourage the patient to become active in AA/CA/NA (e.g., through Twelve Step meeting attendance, getting a sponsor, or planning specific AA/CA/NA-related activities for the week such as speaking or helping at a particular meeting, use of the telephone, or encouraging the patient to use AA/CA/NA as a means of coping?)

Resistence to TSF Recovery: To what extent did the therapist explore the patient's denial/resistance to Twelve Step Recovery (e.g., avoiding meetings, minimizing negative consequences, discussing the patient's resistance to following Twelve Step Recovery, in terms of his/her denial, or discussing the patient's need to surrender)?

A.6. Cognitive-Behavioral Treatment:

Skills training: To what extent did the therapist attempt to teach, model, rehearse, review, or discuss specific coping skills, label them as such, and link them to past or future substance use?

Debrief past high risk situations: To what extent did the therapist discuss any high risk situations encountered in the past (including since the last session) and explore any specific actions that were taken to avoid or cope with the situation(s)?

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APPENDIX B

Tape Rating Scale Item Guidelines

1. ASSESSMENT OF ALCOHOL USE: To what extent did the therapist assess the patient's drinking since the last session, including the pattern of alcohol use (if any)?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent which the therapist evaluated the patient's pattern of alcohol use since the last session.

This item would receive a "0" rating if the therapist asks the patient how they are doing with no specific mention of alcohol. A higher rating would be achieved if the therapist explores the patient's consumption of alcohol on a day by day basis since the last session, with thoroughness comparable to assessment of the patient's drug of choice. In studies where drug abuse is being targeted, this item refers specifically to alcohol use as distinguished from illicit drug use. Some studies may find it useful to include other behaviors of interest as well (eg., smoking).

Examples:

T: "Have you had anything to drink since we last met?"

T: " Let's go through each day and look at when you drank, how much you drank and what kinds of events, thoughts and feelings may have contributed to your drinking."

Skill Level Rating Guidelines:

Higher: A therapist conducts a higher quality assessment of alcohol use by asking about day to day consumption, as well as, carefully analyzing and identifying what caused the patient to drink. In addition, the therapist assesses the extent of the patient's drinking, encouraging his/her full disclosure.

Lower: Lower skill level ratings occur when the therapist asks about alcohol in a non-specific manner and does not follow-up the initial inquiry with more detailed questions.

2. SLIP VS. RELAPSE: To what extent did the therapist convey to the patient that a slip does not necessarily mean that the patient will experience a full-blown relapse?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist explicitly conveys to the patient that a single drinking or drug experience (a slip) does not have to lead to out of control usage (a relapse). A higher rating would be achieved when the therapist engages the patient in an in-depth discussion regarding the differences between a slip and a relapse. The therapist should clearly convey that he/she is in no way giving the patient permission to use drugs; however, should an episode of substance use occur, the therapist should emphasize the importance of learning from a slip (e.g., identifying personal, situational, or environmental factors that may have contributed to the patient's decision to drink alcohol or use drugs and better ways to cope with these factors), so as to prevent the occurrence of another slip, as well as strategies for keeping a single episode of use from turning into an extended relapse..

A lower rating would be assigned when the therapist does not discuss with the patient in detail and at length the meaning of a slip and a relapse as well as the difference between the two. In addition, a lower rating would indicate that the therapist fails to engage the patient in discussion regarding the importance of identifying the factors (personal, situational, environmental, etc.) that may contribute to a slip in order to prevent the occurrence of another slip.

Examples:

T: "We are all faced with difficult situations no matter how well we may plan or attempt to avoid them. Therefore, it is important for us to talk about what may happen if you are faced with a difficult/high risk situation and end up using. This one time use is referred to as a "slip." This is different than a "full-blown relapse" where you use in a way that is more similar to your previous pattern of use. You might think about it like a fire drill-one hopes there won't every be a fire, but knowing what to do just in case is really important and keep a difficult situation from turning into a disastrous one"

T: "While we hope that a slip does not happen, for some people it does, and, therefore, it is extremely important to understand what a slip is and how it can be an important learning experience. As slips can lead to extremely difficult thoughts and feelings such as shame and/or guilt, how one handles a slip can determine if it remains a slip or becomes a full-blown relapse. The more we can learn from your slip, the better prepared you will be to use new coping skills and not use the next time you are faced with a high risk situation. "

Skill Level Rating Guidelines:

Higher: A higher quality rating for this item occurs when the therapist explicitly identifies and discusses the terms "slip" and "relapse" and engages the patient in a detailed discussion regarding the differences between the two. To be rated highly, the therapist must explicitly convey to the patient that a slip can be treated as a learning experience. As such, identifying triggers that precipitated the slip and coping behaviors that could be utilized, can help the patient to prevent a full-blown relapse. The use of specific situations related to the patient's experiences may also be included regardless of whether discussing an actual slip or the notion of a slip in general.

Lower: A lower quality rating for this item occurs when the therapist fails to clearly identify and discuss the terms "slip" and "relapse," including a detailed discussion of the differences between the two. In addition, a lower quality rating would indicate that the therapist has failed to identify and emphasize the idea that a slip can be treated as a learning experience, including using a slip to prevent a full-blown relapse. The therapist may also fail to use specific patient-related experiences in discussing an actual or hypothetical slip.

3. PATIENTS' GOALS FOR TREATMENT: To what extent did the therapist discuss, review, or reformulate the patient's goals for treatment?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist collaborated with the patient in a discussion of what the patient's goals for treatment were, or whether the patient's goals were realistic. This would include a discussion of how problems, which were not a target of the treatment, could be addressed outside or after the study protocol.

To be rated highly, the therapist should help the patient identify specific goals that s/he wants to work on, determine if the goals are realistic, determine which of these goals are appropriate to work on in the study, and which should be addressed in treatment after the patient completes the study. A lower rating would be given if the therapist simply asks what the patient's goals are for treatment with no additional exploration.

Examples:

T: "You have indicated that your primary goal is to stop using. What other goals do you have for treatment?"

T: "In addition to becoming abstinent from drugs and/or alcohol, let's identify some other goals that might support that effort. We need to determine what goals are realistic and can be addressed in this treatment. There may be some goals that need to be addressed outside of this treatment (eg., enduring psychiatric issues, changing jobs).

Skill Level Rating Guidelines:

Higher: A highly skilled therapist will encourage the patient to identify goals for treatment that support the patient's recovery and attempt to solve problems that contribute to the patient's current problems. The therapist will collaborate with the patient to set goals that are important and attainable. For goals that are not targeted for the treatment, a skilled therapist will acknowledge their importance and help the patient understand that there are some goals that must be addressed outside of treatment and give appropriate referrals when possible.

Lower: A lower skilled therapist will ask for patient goals without offering feedback as to their appropriateness for treatment and/or whether or not the goals seem attainable.

4. REFLECTIVE STATEMENTS: To what extent did the therapist repeat (exact words), rephrase (slight rewording), paraphrase (e.g., amplifying the thought or feeling, use of analogy, making inferences) or make reflective summary statements of what the client was saying?

Frequency and Extensiveness Rating Guidelines:

Reflective statements made by the therapist restate the client's comments using language that accurately clarifies and captures the meaning of the client's communications and conveys to the client the therapist's effort to understand the client's point of view. The therapist uses this technique to encourage the client to explore or elaborate on a topic. These techniques include repeating exactly what the client just stated, rephrasing (slight rewording), paraphrasing (e.g., amplifying thoughts or feelings, use of analogy, making inferences) or making reflective summary statements of what the client said. Reflective summary statements are a special form of reflection in which the therapist selects several pieces of client information and combines them in a summary with the goal of inviting more exploration of material or to highlight ambivalence. Often, summary reflections receive an extensive or in depth tally mark on the worksheet.

Examples:

Client: "Right now, using drugs doesn't take care of how bad I feel like it used to. If anything, I feel worse now."

Simple Reflection

- Using drugs makes you feel worse now.

Rephrasing

- So, you have found that using drugs to deal with how badly you feel is not working well for you anymore.

Paraphrasing Using a Double-Sided Reflection

- In the past using drugs helped you feel better when you were having a hard time or feeling badly. Now, it is only making matters worse for you.

Introductions to a Reflective Summary

- Let me see if I understand what you've told me so far…"
- Here is what I've heard you say so far…"

Skill Level Rating Guidelines:

Higher: Higher quality reflections occur when the therapist accurately identifies the essential meaning of what the client has said and reflects it back to the client in terms easily understood by the client (i.e., "direct hit"). The therapist's inflection at the end of the reflection is downward. The therapist pauses sufficiently to give the client an opportunity to respond to the reflection and to develop the conversation. Well-delivered reflections typically are concisely and clearly stated to the client. If the therapist reflects several client statements or intended meanings, the therapist neatly arranges them in a manner that promotes further client introspection, conversation, and motivation for change. Often high quality reflections increase the time spent talking by the client, foster a collaborative tone, and reduce client resistance.

Lower: Low quality reflections often are very inaccurate (i.e., "miss the boat") and may contribute to the client feeling misunderstood. They can be too vague, complicated, or wordy. They also may have an upward inflection at the end and consequently function as disguised closed-ended questions. Typically low quality reflections decrease the time spent talking by the client and may increase the client's resistance. Skill Level ratings also may decrease, even with high frequency reflections, if the reflections are too spread out rather than consecutively linked over the session such that they do not increase introspection, conversation, or motivation to change.

5. TASK ASSIGNMENT (NON TWELVE STEP MEETING INVOLVEMENT): To what extent did the therapist develop one or more specific assignments for the patient to engage in between sessions (not including twelve step meeting involvement)?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist focuses on the explicit assignment and discussion of new extra-session tasks (homework). A higher rating would be achieved when the therapist devotes a significant amount of time and engages in a detailed and extensive discussion of the new homework assignment(s). For a higher rating, the therapist must present and explain a homework assignment, provide a rationale for it (or a general rationale for homework), explore the patient's understanding of the assignment, and explore any barriers to doing the assignment. The assignment(s) must be a specific, concrete task(s) to be done prior to the next session and should not be confused with a discussion of the patient's goals on which he/she may be working between sessions. Higher ratings would also be given in cases where the therapist initiates the assignment or provides examples within the session to assure the patient understands the assignment. Higher ratings would also be given in cases where the therapist and patient develop an assignment collaboratively.

A lower rating would be assigned when the therapist fails to engage in an explicit and detailed discussion of extra-session tasks. A lower rating may also indicate a general review of the patient's identified goals rather than a focus on specific task assignment(s).

Example:

T: "Let's talk about this week's homework assignment. Since we have been discussing cravings/urges to use, including how you experience a craving/urge and plans for dealing with cravings/urges, I think it might be very helpful for you to begin to track your cravings/urges outside of sessions.The form I have here is a "Daily Record of Cravings". Let's spend some time reviewing the form and how you would complete it over the next week. I also have an example here for us to review. How does that sound?"

Skill Level Rating Guidelines:

Higher: A higher quality rating for this item occurs when the therapist explicitly identifies and assigns the specific activity/task as homework or practice to be done in between sessions. This assignment process would include extensive discussion and clarification of what completion of the task will entail, as well as explicit identification of the benefits and rationale for the assignment. For a higher quality rating to be achieved, the therapist must also clearly convey that the completion (or lack thereof) of the assignment will be reviewed during the patient's next session and makes it very clear how doing the assignment will be helpful to the patient. In addition, the skilled therapist will consistently integrate discussion of the new assignment with the underlying rationale of treatment ("to learn to do anything new, you have to practice it"). Specifically for this item, the therapist may focus on helping the patient to see his/her substance use as a learned behavior and, therefore, to appreciate the idea that he/she may then learn other behaviors, including more positive and healthy coping skills, through the use of homework assignments. In addition, the therapist may emphasize such ideas as "practice makes perfect" in explaining to the patient the importance and meaning of homework assignments. In order to increase the likelihood of the above discussion's effectiveness, a skilled therapist would also consistently "check-in" with the patient to determine the patient's level of understanding regarding the new assignment as well as the rationale being presented.

Lower: A lower quality rating for this item may occur when the therapist fails to explicitly identify and assign a homework assignment(s). In addition, a lower quality rating may be assigned if the therapist does not facilitate a detailed discussion of the specific assignment(s), including the expectations regarding completion as well as explanation of the benefits and rationale for the assignment(s). A lower quality rating may also indicate a failure to connect the homework assignment(s) to the ongoing therapy by clearly conveying that the assignment will be reviewed during the patient's next session. Finally, the therapist may also fail to connect the specific homework assignment(s) to the underlying rationale for extra-session assignments and the role of practice in skill development. Specifically, a lower quality rating would indicate that the therapist does not explicitly demonstrate for the patient the connection between the homework assignment(s) and learning theory, including the idea that, with practice, new and healthy coping skills can be learned just as substance use was learned.

6. ASSESSMENT OF GENERAL FUNCTIONING: To what extent did the therapist assess the patient's general level of functioning in major life spheres (e.g., work, intimate relationships, family life, social life everyday stress, etc.)?

Frequency and Extensiveness Rating Guidelines:

This item measures the extent that the therapist assessed the patient's functioning in each of the major aspects of the patient's life (e.g., intimate relationships, family matters, friendships, other social relationships, and vocational pursuits).

Rating of:

1 Therapist makes no mention or inquiry of areas of major life spheres.

2 Therapist may mention major life sphere(s) but only inquires very superficially.

3 Therapist inquires about one major life sphere in a somewhat superficial manner.

4 Therapist inquires about one major life sphere in a very in depth manner (i.e. with a lot of exploration).

5 Therapist inquires about two or more life spheres in a somewhat in depth manner (i.e. with some exploration).

6 Therapist inquires about two or more life spheres in an in depth manner.

7 Therapist inquires about more than two major life sphere in an expanded and in depth manner.

This enhances accuracy of the ratings because raters will be reminded of information that is relevant to rating the items, and keeps the rater focused on what actually occurred in the session. Because raters are asked to make fine distinctions, it is essential that the rater watch the session carefully and without distraction.

Examples:

T: "Tell me about your job. How long have you been in your current position and what would be your next step in the company?

T: "You mentioned that you work the night shift on your job. What is working all night like since your wife and children are on a completely different schedule? Sometimes that can be stressful."

Skill Level Rating Guidelines:

Higher: A skilled therapist would fully explore the sphere(s) of the patient's life and connecting them to sum up the quality of the patient's life based on what is disclosed by the patient. This can facilitate the patient's recognizing in what aspects of his/her life there are problems and where things are going all right. When there is a particular area of compromised functioning (e.g., relationship with significant other), the therapist would examine that thoroughly and relate it back to the patient's overall level of functioning.

Lower: A less skilled therapist might inquire about different life sphere(s) without asking any follow-up questions, and without relating the different sphere(s) to the patient's overall functioning.

7. HEIGHTENING DISCREPANCIES: To what extent did the therapist create or heighten the internal conflicts of the client relative to his/her substance use? To what extent did the therapist facilitate or increase the client's awareness of a discrepancy between where her/his life is currently versus where s/he wants it to be in the future? How much did the therapist explore the role of substances in preventing the client from reaching life goals or values?

Frequency and Extensiveness Rating Guidelines:

This item involves efforts by the therapist to prompt the client's increased awareness of a discrepancy between where they are and where they want to be relative to their substance use. The therapist may do this by highlighting contradictions and inconsistencies in the client's behavior or stated goals, values, and self-perceptions. The therapist may attempt to raise the client's awareness of the personal consequences of substance use, and how these consequences seem contrary to other aims stated by the client. The therapist may engage the client in a frank discussion of perceived discrepancies and help the client consider options to regain equilibrium.

Examples:

T: "You say you want to save your marriage, and I also hear you say you want to keep using drugs."

T: "On the one hand, you want to go out to the bar every night. On the other hand, you have told me how going out to the bar every night gets in the way of spending time with your son."

Skill Level Rating Guidelines:

Higher: Higher quality efforts to heighten discrepancies typically occur when the therapist attempts to make the client aware of a discrepancy in the client's thoughts,feelings, actions, goals or values based upon the client's previous statements. The therapist presents the discrepancies as legitimate conflicts or mixed experiences rather than as contradictions or judgments that prove the client has a drug problem. In addition, higher quality interventions are clear and articulate reflections that encapsulate divergent elements of what a client has said. In short, integration of the client's specific discrepant statements in well-stated terms using a supportive, nonjudgmental tone improves the Skill Level rating.

Lower: Low quality efforts to heighten discrepancies typically occur when the therapist highlights the opposite side of the client's ambivalence without sufficiently counterbalancing it. For example, a client might say he wants to continue to smoke marijuana after previously acknowledging how smoking angers his wife and may lead to an unwanted separation. A rater would give a lower Skill Level rating if the therapist responds by saying, "Yeah, but you said you don't want to be separated," instead of saying, "So even though you've told me you are concerned you wife might leave you,you continue to want to smoke marijuana." Often this approach appears somewhat argumentative and may heighten resistance rather than develop dissonance in the client's position. Abruptness in posing discrepancies ("gotcha!") or stating discrepancies with a hint of accusation also undermines therapist-client collaboration and reduces the overall quality of the intervention. Finally, wordy, cumbersome, or overly complex reflections of discrepant client statements receive lower Skill Level ratings.

8. PAST HIGH RISK SITUATIONS: To what extent did the therapist discuss any high risk situations the patient encountered in the past, and explore any specific actions that were taken to avoid or cope with the situation(s)?

Frequency and Extensiveness Rating Guidelines:

This item is based on the extent to which the therapist actively encourages the patient to identify a high risk situation(s) that occurred in the past and identify the coping skills that he/she employed to manage the situation(s). A higher rating would be achieved when the therapist engages the patient in a thorough and detailed discussion regarding the meaning of a "high risk situation," specific high risk situation(s) faced by the patient in the past, and the specific actions taken by the patient to avoid or cope with the identified situation(s). A higher rating would also include the therapist's facilitation of exploration and discussion regarding alternative, more effective coping skills for use in the identified high risk situation.

A lower rating would be assigned when the therapist fails to engage the patient in an in-depth discussion regarding high risk situations. This would include a failure to discuss the definition of a high risk situation and identify a specific high risk situation(s) encountered by the patient as well as a failure to explore the coping skills used by the patient at the time. In addition, a lower rating would be assigned when the therapist fails to facilitate a discussion of more positive and effective coping skills the patient may have used in the given high risk situation.

Example:

T: "Let's begin by trying to get a sense of those situations that have been most difficult for you in the past, particularly those situations in which you have been most likely to use. This way we can get a sense of what you were thinking and feeling in those situations as well as what you ended up doing to manage the situations. We will call the situations in which you were most likely to use "high risk situations." By discussing your high risk situations, we can get a better idea of what (people, places, and/or things) triggers your substance use. Then, we can help you to identify better ways to cope with those and/or similar situations should they occur in the future.

Skill Level Rating Guidelines:

Higher: A higher quality rating for this item occurs when the therapist explicitly and consistently focuses on the topic of "high risk situations," particularly past high risk situations encountered by the patient. The therapist must convey in a clear and understandable manner the meaning of a "high risk situation." In addition to the general introduction and definition of a "high risk situation," the therapist must actively engage the patient in discussion regarding a high risk situation(s) that is specific to the patient. For a higher quality rating to be achieved, the therapist must help the patient to not only identify the high risk situation(s), but also facilitate discussion of what led to the situation(s), the coping skills used at the time, and specific alternative ways that the patient could use to cope with this high risk situation(s). The therapist may refer to such past high risk situations as "dangerous," "risky," "people, places,and things," or"conditioned cues." Overall, a higher quality rating indicates that the therapist has made a direct connection between the patient's substance use and the reasons a specific situation may be identified as "high risk." In other words, it is clear which particular aspects of a situation are problematic for the patient.

Lower: A lower quality rating for this item may occur for several reasons. For example, the therapist may fail to engage the patient in a detailed,comprehensive, and patient-specific discussion regarding the topic of high risk situations, including the definition. The therapist may also

fail to pursue a detailed discussion of a high risk situation(s) that has been described by the patient, including an in-depth description of the situation itself and the coping skills used by the patient at the time. In addition, a lower quality rating may be assigned when the therapist fails to identify specific alternative ways the patient could use to cope with the high risk situation(s) being discussed. Finally, a lower quality rating may indicate that the therapist does not explicitly connect the patient's substance use to the identified high risk situation and/or identify which aspects of the situation are actually problematic for the patient.

9. SUPPORT BY FAMILY MEMBERS/SIGNIFICANT OTHERS: To what extent did the therapist inquire about or discuss the availability and nature of support from family members and/or significant others for the patient's involvement in treatment or efforts to become abstinent?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist attempted to ascertain whether the patient's family and/or significant others could be used as a resource in treatment OR could attend sessions to explain the patient's treatment to the family OR how drug use in a family member could adversely affect the patient. This item can also be addressed if there is a clear lack of family support.

Significant others are defined as people with whom the patient has a familial relationship (i.e. parent of patients' child) or as people living with the patient (i.e. a lover). This item does not include significant friends, neighbors, or coworkers who do not live with the patient. For this item to receive a rating greater than "1", this relationship should be evident to the rater.

This item would be rated higher in collateral (spouse) sessions, which thoroughly explored the spouse's real or perceived level of support for the patient, means of providing support or barriers to support. A lower rating would be achieved if the therapist merely asked if the patient has any support from family members or significant others, without pursuing their availability or specific nature of their support.

Examples:

T: "You mentioned that you are close to your older sister and feel she is supportive and pleased your want to become abstinent. Is she willing to take you to meetings since you don't have a car?

T: "Your brother Bob seems to be someone you really confide in and trust. Since you need a place to stay for a while, is he someone you could ask?

T: "From the sound of it, you really have alienated your family and your wife is still using. I wonder how your lack of support might interfere will your becoming abstinent."

Skill Level Rating Guidelines:

Higher: A skilled therapist would help the patient identify specific family members/significant others who could be supportive of the patient's wanting to stop using drugs. Further, the therapist helps the patient identify the specific ways different people would available to the patient. For example, who might attend sessions with the patient, and who is someone the patient can go to with problems or when he/she feels like using? If it is determined that there is a total lack of support in the patient's life, the therapist would also facilitate a discussion with the patient around how to develop a supportive social network that will support his abstinence, (eg., self-help groups like AA/NA).

Lower: A less skilled therapist might help the patient identify whether or not there are any supportive people in his/her life, without exploring the specifics of how different people could be available.

10. PROS, CONS, AND AMBIVALENCE: To what extent did the therapist address or explore the positive and negative effects or results of the client's substance use and what might be gained and lost by abstinence or reduction in substance use? To what extent did the therapist use decisional balancing, complete a cost-benefits analysis, or develop a list of pros and cons of substance use? How much did the therapist express appreciation for ambivalence as a normal part of the change process?

Frequency and Extensiveness Rating Guidelines:

This item focuses on the extent to which the therapist facilitated the discussion of specific consequences of the client's substance use. This may include the positive and/or negative results of the client's past, present, or future behaviors as related to active substance use. Specific techniques used include decisional balancing, a cost-benefits analysis, or listing and discussing the pros and cons of substance use. An important stylistic component accompanying these techniques should be the therapist's verbalizing an appreciation for ambivalence as a normal part of the change process?

A higher Frequency/Extensiveness rating would be achieved if the therapist discusses ambivalence in detail or explicitly facilitates a costs/benefits analysis with client input concerning change versus remaining the same. A high score on this item typically involves the written completion of a Pros and Cons form (or on a flipchart) either during the session or detailed review of a form completed prior to the session. A lower rating occurs when the therapist devotes little time or effort on any of these tasks.

Examples:

T: "What do you see as the positive and negative consequences of your drinking?"

T: "You have had a lot of chest pain after using cocaine and seem very concerned about your health, your family, and where your life is going. And you have identified many possible benefits of stopping use, such as…."

T: "So by getting high, you feel good and can avoid painful feelings. What are some of the downsides to using."

Skill Level Rating Guidelines:

Higher: Higher quality efforts to discuss the pros and cons of substance use occur when the therapist approaches the task in a nonjudgmental, exploratory manner. Throughout the examination of pros and cons, the therapist prompts the client to continue detailing dimensions of ambivalence using open-ended questions or reflections about consequences previously noted by the client. Full exploration of the pros and cons of stopping substance use versus continuing use improve quality ratings. During this process, the therapist elicits responses from the client rather than suggesting positive and negative consequences as possibilities not previously mentioned by the client. Additionally, use of summary reflections within each dimension or to compare and contrast them may enhance the Skill Level ratings, particularly when the therapist uses these discussions to tip the client's motivational balance to the side of change. The specific technique of completing or reviewing a decisional balance sheet or simply discussing the pros or cons does not directly affect the Skill Level rating.

Lower: Lower Skill Level ratings occur when the therapist seldom provides the client with opportunities to respond freely to the pros/cons dimensions or to more thoroughly reflect upon meaningful pros and cons to the client. Instead, the therapist provides the client with likely pros and cons and asserts this view to the client in a more closed-ended fashion. Consequently, the client becomes more of a passive recipient rather than an active participant

in the construction of the decisional balance or discussion of factors underlying the client's ambivalence. Lower ratings also occur when the therapist asks the client to list pros and cons one after the other without exploring details or the personal impact of substance use on the client's life. When summarizing the client's pros, cons, or ambivalence, the therapist does not involve the client in the review and simply restates the items in a mechanical or impersonal manner. The therapist makes no effort to strategically tip the client's motivational balance in favor of change.

11. USE OF OTHER SUBSTANCES: To what extent did the therapist assess the patient's use of substances other than *drug of choice* (e.g., drugs, cigarettes, caffeine) since the last session, and relate the use of these substances *drug of choice* use?

Frequency and Extensiveness Rating Guidelines:

This item refers to the extent to which the therapist explored the patient's attitudes or beliefs regarding the use of other substances in the context of his/her attempt to become abstinent from *drug of choice*. This may be scored only if the therapist explicitly asks about drugs other than *drug of choice* or if the therapist asks about the use of "anything else" only after having inquired about *drug of choice* usage.

This item would receive a lower rating if the therapist asks about other drug use without relating it to *drug of choice* use. It would receive a higher rating if the therapist makes the connection between *drug of choice* use and other drug use, especially when the patient increases the use of other drugs once he/she is abstinent from *drug of choice*, and nearly the entire session is devoted to the assessment of the use of other substances.

Examples:

T: "Since you have been abstinent from *drug of choice* this week, how is it going with the marijuana? Have you used any more/less than usual since our last session?

T: (After having asked about *drug of choice* use) "Have you used anything else?"

Skill Level Rating Guidelines:

Higher: A higher quality assessment includes the therapist asking a thorough series of questions about the use of drugs other that the patient's drug of choice. This includes relating other substance use to abstinence from *drug of choice* and/or non-use of other substances to abstinence from the drug of choice.

Lower: Less skilled assessment would involve merely asking about other drug use, without connecting this to the use of the patient's drug of choice, or without exploring the individualized patterns of use for the individual, his or her reactions to the episode of use, antecedents or consequences of substance use, etc.

APPENDIX C

Tape Rating Scale

1. ASSESSMENT OF ALCOHOL USE: To what extent did the therapist assess the patient's use of 'primary drug' since the last session, including the pattern of substance use (if any)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

2. SLIP VS. RELAPSE: To what extent did the therapist convey to the patient that a slip does not necessarily mean that the patient will experience a full-blown relapse?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

3. PATIENT'S GOALS FOR TREATMENT: To what extent did the therapist discuss, review, or reformulate the patient's goals for treatment?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

4. REFLECTIVE STATEMENTS: To what extent did the therapist repeat (exact words), rephrase (slight rewording), paraphrase (e.g., amplifying the thought or feeling, use of analogy, making inferences) or make reflective summary statements of what the client was saying?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

5. TASK ASSIGNMENT (NON TWELVE-STEP MEETING INVOLVEMENT): To what extent did the therapist develop one or more specific assignments for the patient to engage in between sessions (not including 12 step meeting involvement)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

6. ASSESSMENT OF GENERAL FUNCTIONING: To what extent did the therapist assess the patient's general level of functioning in major life spheres (e.g., work, intimate relationships, family life, social life, everyday stress, etc.)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

7. HEIGHTENING DISCREPANCIES: To what extent did the therapist create or heighten the internal conflicts of the client relative to his/her substance use? To what extent did the therapist facilitate or increase the client's awareness of a discrepancy between where her/his life is currently versus where s/he wants it to be in the future? How much did the therapist explore the role of substances in preventing the client from reaching life goals or values?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

8. PAST HIGH RISK SITUATIONS: To what extent did the therapist discuss any high risk situations the patient encountered in the past, and explore specific actions that were taken to avoid or cope with the situation(s)?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

9. SUPPORT BY FAMILY MEMBERS/SIGNIFICANT OTHERS: To what extent did the therapist inquire about or discuss the availability and nature of support from family members and/or significant others for the patient's involvement in treatment or efforts to become abstinent?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

10. PROS, CONS, AND AMBIVALENCE: To what extent did the therapist address or explore the positive and negative effects or results of the client's substance use and what might be gained and lost by abstinence or reduction in substance use? To what extent did the therapist use decisional balancing, complete a cost-benefits analysis, or develop a list of pros and cons of substance use? How much did the therapist express appreciation for ambivalence as a normal part of the change process?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

11. USE OF OTHER SUBSTANCES: To what extent did therapist assess the patient's use of other substances other than *drug of choice* (eg., drugs, cigarettes, caffeine) since the last session, and relate the use of these substances to *drug of choice* use?

FREQUENCY & EXTENSIVENESS:

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Not at all A Little Infrequently Somewhat Quite a Bit Considerably Extensively

SKILL LEVEL:
9 = Not done at all

1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7
Very Poor Poor Acceptible Adequate Good Very Good Excellent

APPENDIX D

Tape Rating Worksheet

Rating Item	Frequency & Extensiveness	Skill Level Comments
1. ASSESSMENT OF ALCOHOL USE (p. 01)		
2. SLIP VS. RELAPSE (p. 02)		
3. PATIENT'S GOALS FOR TREATMENT (p. 03)		
4. REFLECTIVE STATEMENTS (p. 04)		
5. TASK ASSIGNMENT (NON TWELVE-STEP MEETING INVOLVEMENT (p. 06)		
6. ASSESSMENT OF GENERAL FUNCTIONING (p. 08)		
7. HEIGHTENING DISCREPANCIES (p. 09)		
8. PAST HIGH RISK SITUATIONS (p. 10)		
9. SUPPORT BY FAMILY MEMBERS/SIGNIFICANT OTHERS (p.12)		
10. PROS, CONS, AND AMBIVALENCE (p. 13)		
11. USE OF OTHER SUBSTANCES (P. 15)		

ALWAYS CONSULT RATING GUIDE WHEN TRANSFERRING FROM WORKSHEET TO RATING FORM, ESPECIALLY WHEN UNCERTAIN

	FREQUENCY AND EXTENSIVENESS		**SKILL LEVEL**	
NOTATION	BEHAVIOR OCCURRED	RATING	BEHAVIOR	RATING
None	(never occurred) =	*Not at all (1)*	(Unacceptable, toxic) =	*Very poor* (1)
/	(once but not in depth) =	*A little(2)*	(Lack of expertise, competence) =	*Poor* (2)
/ /	(more than once, but not in depth) =	*Infrequent(3)*	(Fair; below average) =	*Acceptable* (3)
Ø	(once and in some depth) =	*Somewhat(4)*	(Average) =	*Adequate* (4)
Ø / /	(more than once and once in depth) =	*Quite a bit* (5)	(Above average) =	*Good* (5)
Ø / Ø	(more than once in depth) =	*Considerably* (6)	(Skill and expertise shown) =	*Very good* (6)
Ø Ø Ø / Ø Ø)	(dominated session, many times in depth) =	E*xtensively* (7)	(High level of mastery) =	*Excellent*

APPENDIX E

Agenda for Didactic Seminar to Train Independent Tape Raters

I. **Introduction**

II. **Importance of Tape Rating System**

- Provides a way to systematically evaluate 'Your treatment'
- Provides a common language for talking about 'Your treatment'.
- Provides a way to determine if therapists perform 'your treatment' correctly.
- Provides a way to determine if therapists use other approaches that are distinctly different from 'Your treatment'.
- Provides a way to determine common therapist strategies that occur in 'Your treatment' and treatment-as-usual.
- It helps identify the frequency of different therapeutic strategies.
- It helps determine the quality or skill in which therapists deliver specific therapeutic strategies.
- It provides a mechanism for determining which therapeutic strategies are associated with good or poor treatment outcomes.
- It allows us to examine how therapists vary what they do relative to different types of patients they see.

III. **Tape Rater Guide**

A. Overview of major sections and subsections
B. Three categories of items
    1. Specific adherence and competence items
        a. Frequency and Extensiveness Rating Guidelines
        b. Examples
        c. Skill Level Rating Guidelines
    2. General ratings of therapist
C. Tape Rating Worksheet

IV. **General Tape Rating Etiquette**

General Guidelines:

1. Rate observable therapist behaviors.
2. Rate therapist facilitation.
3. Avoid haloed ratings.
4. Rate all applicable items for each observed therapist behavior.

5. Use the Guide during each rating session.
6. Tally and notate while reviewing the entire session.
7. Rate every item by circling whole numbers.
8. Protect confidentiality.
9. Rating frequency and extensiveness versus rating skill level.

V. **The Rating System**

A. Review of Frequency and Extensiveness subsection.
B. Review of the Skill Level subsection.

VI. **The Specific Therapist Adherence and Competence Rating Items**

A. Review of Items
B. Activity: Tape Rating Warm-Up.

VII. **Putting It All Together: Rating an Entire Tape Together**