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Part 2

Strategies for Enhancing Therapist Compliance

The Use and Development of Treatment Manuals

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Overview

Treatment manuals that specify and discriminate treatments as well as provide guidelines to therapists for their implementation have revolutionized psychotherapy and treatment research.[103,104] Therapy manuals have become a virtual requirement in clinical treatment research in that they define the independent variable.[105] They are becoming increasingly important in clinical practice as changes in the health care system put greater pressure on clinicians to define and evaluate the effectiveness of their services. They also help meet the increasing demands on training programs to evaluate their methods for training therapists for clinical practice.

Psychotherapy manuals also serve many other purposes. These include providing a means for objective comparisons of different psychotherapies, setting standards for training and evaluation of therapists, establishing clear treatment goals and clinical care standards, fostering replication of clinical trials to other settings, facilitating transfer of promising treatments from research to clinical settings, providing a means of linking treatment processes to outcome, and reducing variability in outcome due to therapist effects.[103,104,106-108]

Manuals and Treatment Compliance

A major function of manuals is to define what therapists and clients should and should not do in the course of treatment. Defining and clarifying client expectations is very important in facilitating compliance, and the use of manuals can assure a clear understanding between client and therapist about their respective roles and all aspects of the protocol.

Manuals define the theoretical underpinnings of a treatment, the

goals of a treatment, the strategies the therapist uses to reach those goals, and how that treatment is different from other treatments. They also articulate a set of guidelines that steer the therapist through the conduct of that treatment. Thus, manuals define behaviors prescribed and proscribed for both therapist and clients in the course of a treatment.

Manuals also sharpen distinctions between specific and nonspecific aspects of a given therapy. Nonspecific ingredients refer to aspects of treatment that are common across most psychotherapies, including education, support, attention, a convincing rationale, expectations of improvement, the skill of the therapist, and the quality of the therapeutic relationship.[109,110]

Specific components refer to a treatment's active ingredients—those techniques and interventions that are unique to or characterize particular psychotherapies. Examples of specific ingredients include skills training in cognitive-behavioral approaches, transference interpretations in psychoanalytic approaches, eliciting self-motivational statements in motivational approaches, and fostering the client's involvement in Alcoholics Anonymous (AA) in 12-step facilitation.

Therapist Compliance

Therapist compliance can be defined as the degree of adherence to the guidelines specified in a treatment manual. Treatment manuals define standards by which therapist adherence may be monitored along several dimensions.

- *Structural.* The ideal or minimal number, duration, or frequency of sessions. Group, individual, or family format. How topics are introduced and processed. How the session flows.

- *Goals and subgoals.* Is the treatment goal abstinence or reduced drinking? The process by which the client and therapist will reach their goals (e.g., skills training, increased insight, involvement with self-help). Other target symptom and problems that might be addressed by this treatment.

- *Active ingredients.* The characteristic or unique aspects of the treatment through which therapeutic effects are expected to occur. The process through which these active ingredients are expected to affect drinking behavior and other target problems.

- *Treatment boundaries.* The range of topics, interventions, or processes that would be expected to define this treatment. Topics, interventions, or processes that would be proscribed or discouraged in this treatment.

- *Nonspecific aspects.* Nonspecific aspects (e.g., providing education, a supportive relationship) that are important to the outcome of this treatment. How the therapeutic relationship is to be characterized. Aspects this treatment shares with other treatments. How therapists should handle the balance between specific and nonspecific elements of therapy. Whether sessions are primarily didactic or collaborative and how structured they are.

Compliance Versus Competence

There is an important distinction between adherence/compliance, that is, the degree to which the therapist follows the guidelines laid out in the therapy manual, and therapist competence, which refers to the therapist's level of skill in delivering that treatment. Adherence and competence are not necessarily closely related. A therapist can follow a treatment manual word for word and not deliver that treatment competently or skillfully (e.g., with an appropriate level of flexibility and understanding of a particular client, using appropriate timing and language).

In some cases, extremely high adherence (e.g., a wooden, mechanistic, rote repetition of material in the manual) may be indicative of very low competence in a therapist. High compliance and low skillfulness may also occur when a therapist delivers a technique perfectly but at an inappropriate time that is insensitive to the needs of a particular client.

Conversely, cases of high skillfulness and low competence can exist, for example, when a therapist empathetically responds to the client and provides incisive interpretations at the precise moment they are most likely to be helpful, but rarely touches on material described in the manual.

Moreover, a therapist's adherence and competence are not necessarily static entities. For example, adherence may vary across time, where some therapists may start a treatment with high adherence but drift away from following manual guidelines during the course of treatment. Similarly, a therapist's competence may vary across clients, for example, with client difficulty, psychopathology, or the therapist's liking for the client.

Furthermore, competence is not necessarily a generic factor that is uniform across different types of therapies. Instead, competence should be conceived and assessed relative to the specific treatment the therapist is expected to deliver.[111] Although traditional nonspecific aspects of therapy (e.g., empathy, warmth, support) have been assumed to be universal indicators of therapist skillfulness, these nonspecific indicators may not be accurate nor even adequate proxies for skillfulness in all therapies. For exam-

ple, empathy and warmth may be important indices of competence in some therapies (e.g., Rogerian) but may be superfluous to others. Therefore, manual developers should lay out guidelines for determining competence that are specific to their type of therapy.

Linkage of Client and Therapist Compliance

Therapist adherence and client compliance are inextricably linked. A client cannot be expected to comply with a given suggestion or intervention unless the therapist complies with the treatment manual by delivering that intervention. Several dimensions of client compliance are linked with treatment integrity and therapist adherence. For example, whether clients comply with an intervention depends entirely on whether the therapist asks them to do it and to a large extent on whether or not the therapist specifies exactly what the assignment or suggestion would entail, asks the clients if they would comply, makes clear how complying with the intervention or suggestion might be helpful, works through possible obstacles and resistances, and follows through by asking the clients whether they did comply.

This implies that complete assessment of client compliance entails a several-step process that emphasizes linkage of client and therapist compliance. First, did the therapist prescribe the client behavior (e.g., ask the client to go to a 12-step meeting, ask the client to record his cravings for alcohol during the next week)? Second, did the therapist prescribe the client behavior adequately and competently (e.g., did the therapist provide a rationale for 12-step meetings or self-monitoring, discuss the steps that would be necessary to locate, select, and go to a meeting or do the self-monitoring, ask the client whether s/he was likely to comply with the prescription, was the prescription appropriately timed for that particular client). Finally, did the client follow through on the prescription. Thus, assessment of client compliance for some aspects of treatment would be predicated on assessment of therapist adherence.

This also suggests that an important strategy to foster client compliance would be clearly specified expectations for client compliance (e.g., number of sessions, policy around missed or canceled sessions, extra-treatment assignments, in-session behavior). Strategies and techniques to address client noncompliance are important as well.

Manual Content

While the specific content of a manual will vary with each treatment and with each population, a number of generic features are common to most manuals. Table 3.1 provides a checklist for domains that should be considered in developing a new treatment

Table 3.1. Treatment manual checklist

☐ Overview, description and rationale
- General description of approach
- Background and rationale for treatment
- Theoretical mechanism of action (what makes this treatment work?)
- Empirical evidence supporting the effectiveness of this approach
- How is the treatment described to the client?

☐ Conception of alcohol abuse/dependence
- Etiological factors
- Factors associated with cessation of use
- Agent of change (e.g., client, therapist, group affiliation)
- What is the conceptual framework around which cases are formulated and understood?
- How are alcohol use and associated problem assessed by the therapist?

☐ Goals and goal-setting
- Overall treatment goal (abstinence, harm reduction)
- Evaluating client goals
- Identification of other target behaviors and goals
- Negotiation of changes in therapeutic goals and contracts negotiated?

☐ Contrast to other treatments for alcohol and related disorders
- Approaches which are most similar to this approach
  - How does this approach differ from similar approaches?
- Approaches most dissimilar to this approach

☐ Specification of active ingredients, therapist behaviors prescribed and proscribed
- What are the specific active ingredients which are unique and essential to this treatment?
- What interventions are essential to this treatment but not unique?
- What interventions or processes are recommended but not essential or unique?
- What interventions or processes are prohibited or not characteristic of this treatment?
- What interventions may be harmful or countertherapeutic in the context of this treatment?

☐ Client-counselor relationship
- What is the ideal therapist role in this treatment (educator, collaborator, teacher, peer, adviser)
- How important is the therapeutic relationship to the outcome of the treatment?
- Strategies the therapist uses to develop desired relationship
- Strategies the therapist uses to address poor or weak therapeutic relationship

☐ Format
- Variations for individual, group, family, other formats
- Variations for different settings: inpatient, outpatient, residential, aftercare, other
- Recommended frequency and duration of sessions
- Variations for closed and open-ended formats

Table 3.1. Treatment manual checklist (continued)

☐ Session format and content

What is the format of a 'typical' session?

How does the session begin and end?

Are there a series of topics or themes to be covered?

Are there required versus elective sessions?

How are session topics or sequences selected?

How structured are the sessions? Is level of structure important to outcome?

- Who talks more?
- How directive is the therapist?
- Is an explicit agenda set? How is the agenda set?

Is the client given extra-session tasks?

- What is the purpose of these tasks?
- How are assignments selected?
- How are assignments given to the client?
- How does the therapist respond to the client's completion of an assignment? How is it integrated into the work of therapy?
- How does the therapist respond to the client's failure to complete an assignment?

Session by session content (e.g., Session 1):

- How does the therapist introduce him/herself?
- What information does the therapist collect about the client? What does s/he especially listen or probe for?
- How is the disorder (usually alcohol abuse or dependence) characterized to the patent?
- How are treatment goals negotiated?
- How is the treatment strategy introduced to the client?
- Do the therapist and client agree on a treatment contract? What does it consist of (e.g., number and type of sessions, policy about canceling and lateness, extra-treatment phone calls)?
- What, if any, extra-session tasks are assigned? What rationale does the therapist provide about extra-session tasks?

Troubleshooting: What problems are usually encountered in the first session? What are some methods the therapist might use to avoid or address these problems in a manner consistent with the general theory of this treatment?

Session 2–Session N

- How does the therapist greet the client?
- How does the therapist assess substance use since the last session?
- How does the therapist review completion of any extra-session assignment?
- What is the second session topic and goals? How is it selected? How is it introduced?
  - How is it introduced in the context of the clients current concerns and problems?
  - What are the key ideas to be introduced in the second session?

Table 3.1. Treatment manual checklist (continued)

Managing transitions

- How does the therapist determine the client's readiness to move on to a new stage of therapy?
- How does the therapist judge the core issues to be covered in the treatment?
- How does the therapist decide whether to work through or repeat old material or move on?
- How does the therapist determine the client's readiness for termination? How is termination introduced and discussed?
- How does the therapist time key interventions or activities to maximize their usefulness to the client?

☐ Compatibility with adjunctive treatments (e.g., pharmacotherapy, family therapy)

How are adjunctive treatments integrated and monitored?

Role of AA and other self-help groups

☐ Clinical care standards

How does the therapist assess substance use that may have occurred since the last session?

How does the therapist assess treatment progress?

How does the therapist respond to lack of progress or clinical deterioration?

How does the therapist assess and respond to expressions or hints of suicidal or homicidal ideation?

How does the therapist respond to a contradiction between a client's self-report of alcohol use and a collateral source?

☐ Troubleshooting: Strategies for dealing with common clinical problems

Therapist response to lateness

Therapist response to missed sessions

Strategies for dealing with low motivation

Strategies for dealing with recurrent crises

Therapist's response to slips and relapses

Therapist's response to clients who come to sessions while intoxicated

Strategies for clients who appear to understand but don't follow through on agreed upon suggestions

Strategies when the client's significant others convey disagreement with goals of therapy or interfere in the client's progress.

☐ Target population

Characteristics of individuals who are well-suited for this approach

Characteristics of individuals who might be poorly suited for this approach

Table 3.1. Treatment manual checklist (continued)

☐ Meeting the needs of special populations. Suggested variations in the treatment for clients who have the following common comorbid problems
- Depression
- Anxiety and posttraumatic stress disorders
- Antisocial personality disorder
- Concurrent drug use
- Psychotic disorders
- Cognitive impairment
- Medical problems
- Unstable living situations

☐ Therapist characteristics and requirements
- Training, credentials, and experience required:
- Therapist recovery status (essential, helpful, irrelevant)
- Ideal personal characteristics of counselor

☐ Therapist training
- Components and goals of training, training materials available
- Training cases required
- Common problems encountered in training
- Standards for determination of therapist competence
- Availability of ratings and assessments of therapist competence

☐ Supervision
- Recommendations of type (group, individual) and intensity of supervision
- Common problems involved in training novice therapists to use this approach
- Common problems involved in training more experienced therapists to use this approach
- Strategies to address therapist drift in treatment delivery
- Strategies to help therapists balance adherence and competence
- Strategies for supervision sessions; use of videotapes and rating systems.

or describing a standard one. Not all of them will apply to a given manual, but they should all be considered when attempting to thoroughly define a treatment. The more comprehensive and specific the manual, the easier it will be for therapists to follow and the less likely a therapist will deviate from the intentions of the program when faced with a clinical situation or problem not specified in the manual.

Treatment Definition

- *Overview and theoretical rationale.* The background or rationale for the treatment, how it works, how and when the therapist explains the treatment to the client. Include empirical evidence that supports the effectiveness of the treatment with the given population.

- *Conception of the disorder.* How the treatment conceives the etiology of alcohol use disorders, the essential steps or processes needed to reduce alcohol use and alcohol-related problems, and the agent of change for this treatment—the client, the therapist, particular treatment processes, group affiliation?

- *Goal setting.* Whether the treatment is abstinence oriented or focuses on the reduction of alcohol use and how this is introduced to the client. How the therapist should respond to a client who does not share the treatment goal; how goals relating to other target behaviors and problems (e.g., psychopathology, marital discord) are defined; and how treatment goals are determined, monitored, and renegotiated as well as how important transitions in the treatment are negotiated.

- *Differentiation from other treatments.* Other types of treatment that are most similar and those that are most dissimilar to this treatment. Exactly how this treatment differs from similar treatments for this disorder. See table 3.2 for a sample chart that highlights differences between the treatments used in Project MATCH.

- *Therapist behaviors prescribed and proscribed.* Specific ingredients that are unique to or characterize this treatment. Interventions or processes required to be delivered to each client. Interventions or processes that are recommended but not unique. Proscribed interventions or processes. Interventions that might be countertherapeutic to deliver in the context of this treatment. Are there interventions that might have a negative effect on some clients?

Treatment Implementation

- *Client-therapist relationship.* Therapist's role, client's role, optimal client-therapist relationship. Importance of relationship issues relative to other aspects of the therapy and to the outcome of the therapy. Strategies a therapist might use to develop the desired relationship and to address poor or weak therapeutic relationships.

- *Treatment format.* How the treatment is delivered (individual, group, self-guided, family). The recommended length and frequency of sessions, the recommended duration of treatment, and variations of the treatment that would be required for different settings (inpatient, outpatient) or formats (group versus individual).

- *Session format and content.* How typical sessions begin and end, whether a series of topics are to be covered, and how

Table 3.2 Contrasts between Project MATCH therapies

	Twelve-Step Facilitation	Cognitive-Behavioral	Motivational Therapy
Goals of treatment	Encourage person to accept his/her alcoholism and understand it as a progressive fatal disease. Facilitate integration into AA.	Help person master coping behaviors as effective alternatives to alcohol use. Increase self-efficacy.	Maximize the person's motivation and commitment to change his/her drinking.
Therapy approach	Disease oriented.	Cognitive-behavioral.	Motivational.
Agent of change	Treatment Fellowship/Higher Power	Treatment Mastery of skills	Patient
Labeling	Labeling the patient as "alcoholic" is encouraged, as this label provides the framework for treatment. Acceptance of the diagnosis is necessary; it determines a set of symptoms (e.g., lack of control, denial) and the steps required for recovery.	Labeling discouraged; alcohol abuse/dependence is conceived as over-learned behavior that can be broken down into a finite set of discrete problem situations and behaviors.	Labeling is strongly discouraged. Alternative conceptions of alcohol-related problems are accepted and encouraged.
Control	Emphasis on loss of control. The patient cannot control drinking, has the disease of alcoholism and is powerless to control. Patients can control whether they have the next drink, use AA or accept the idea that drinking can be controlled.	Emphasis on self-control. Patients make decisions regarding drinking over which they have control. Patient can learn to understand and better control the decisionmaking process. Patient can exert self-control by choosing alternative behaviors and cognitions.	Emphasis on choice. Patient has full control over the decision to alter drinking.
Responsibility	Patient is not responsible for disease of alcoholism but is responsible for own sobriety, by "working" the 12-step program.	Patient responsible for own behavior. Emphasis on enhancing self-efficacy through skills training.	Patient responsible for own choices. Emphasis on autonomy.
Conception of craving	Because of disease process, patient's body will crave alcohol periodically. First drink will trigger craving: "one drink, a drunk."	Craving as conditioned response. Craving can be coped with and reduced through stimulus control, urge control, etc.	Patient free and capable of developing strategies for dealing with craving on his/her own.
Strategies for addressing ambivalence and motivation	Remember last drunk. Alcoholism is a disease that motivates denial; educate patient about "sinister" aspects of the disease. Current problems attributed to disease.	Positive/negative consequences of decisions to drink or stay abstinent. Instill belief that effective coping will provide alternatives to drinking.	Acknowledge validity of patient's feelings; elicit self-motivational statements. Provide feedback. Empathic listening, primacy of patient's choice. Deploy discrepancy.
Therapist's response to alcohol use	External, uniform approach. Use AA social network (call sponsor, go to meeting). Remember and use slogans.	Individualized approach. Examine antecedents, behaviors and consequences. Develop and use individualized set of coping strategies (challenge cognitions, problem-solve, etc.)	Internal, individualized approach. Review progress, review/evaluate initial plan, renew motivation and commitment. Reevaluate decision and plan based on new information gained from drinking.
	"Do not think you can control the consequences of use."	"You can learn skills to avoid lapses and prevent lapses from becoming relapses."	"It's up to you whether you drink or not."
Coping behaviors	AA fellowship/network constitute a ready-made set of strategies and the one preferred solution.	Individualized set of strategies, generalizable problem-solving approach. Specific training in drink refusal skills, urge control, altering cognitions, emergency planning, social skills, affect management, job seeking skills, etc.	Patient free to develop own coping strategies. Development of strategies encouraged, but these are *not provided* by the therapist. Encourage to use personally effective coping strategies.
Negative cognitions	Generally interpreted as evidence of rationalization and denial (e.g., "stinking thinking").	Identified, examined and challenged; encourage alternative perceptions/cognitions.	Accepted as valid; met with exploration, reflection and feedback.
Phone calls/crises	Refer patient to AA/sponsor. "Use the fellowship."	Encourage patient to implement coping strategies.	Meeting patient's concerns with reflection and elicitation of client's plan of action.
	Two permissible emergency sessions.	Two permissible emergency sessions.	Two permissible emergency sessions.

Source: Donovan et al. 1994.[121] Reprinted with permission from *Journal of Studies on Alcohol, Supplement* No. 12, pp. 138-148, 1994. Copyright by Alcohol Research Documentation, Inc., Rutgers Center of Alcohol Studies, Piscataway, NJ 08855.

the therapist determines what issues are to be covered in each session. Whether the treatment involves a set of required topics to be delivered and if there are elective topics or sessions. The specific goals or aims of each topic. How the therapist decides which elective sessions are to be delivered to the client. Whether sessions are structured. If clients are given extra-session tasks, how these are introduced and monitored.

- *Adjunctive treatments.* Compatibility with other treatments, such as family therapy or pharmacotherapy. How these are integrated into the treatment and monitored. The role of AA or other self-help groups.

- *Clinical care standards.* How, and how often, alcohol and other substance use is monitored (e.g., breathalyzers, urine toxicology screens). How contradictions between client self-reports and collateral sources are discussed with the client. How the therapist responds to a client who is suicidal or homicidal. How the therapist determines the need to refer the client to a more intensive level of care.

- *Troubleshooting.* How the therapist should respond to common clinical problems that arise in the course of alcoholism treatment, e.g., missed sessions, lateness, frequent crises, coming to sessions while intoxicated, other forms of noncompliance. Whether these strategies are largely generic or specific to the type of treatment being delivered.

- *Variations for special populations.* How the treatment is adapted to meet the needs of client types typically encountered in alcohol treatment settings. Variations or changes necessary for clients who may be depressed, antisocial, anxious, cognitively impaired or have posttraumatic stress disorder, few social resources, and so on. Particular client types or characteristics for which this treatment is ill-suited. Limits on the flexibility therapists may use in tailoring the treatment to meet individual client needs.

Therapist Training and Supervision

- *Therapist characteristics and training.* Any training or education required for therapists to conduct this treatment effectively. Procedures used to train therapists to conduct this treatment. Available training materials (e.g., trainers manuals, videotaped examples). Standards that must be met before a therapist is certified to deliver this treatment.

- *Therapist competence.* What determines how well the therapist performs the treatment. The characteristics that would

describe a therapist performing this treatment optimally and how this is assessed. The characteristics that would identify a therapist performing this treatment poorly. Relevance of generic therapist skills (e.g., empathy, spontaneity, warmth) to the conduct and outcome of this treatment. Any assessment instruments available for evaluating therapist adherence and competence.

- *Supervision.* Training or education required for supervisors. Level and intensity of supervision recommended or required for therapists delivering this approach. Important aspects of treatment delivery for supervisors to monitor. Any aspects of treatment delivery or competence that are particularly difficult for novice therapists to master. Common mistakes made by more experienced therapists, and some strategies a supervisor would use to address therapist drift in adherence.

Manual Style

An important general strategy to enhance therapist compliance and adherence with therapy guidelines is to make it easy for therapists to understand and thus to follow the manual. Because a manual is more or less a set of instructions for undertaking a highly complex task, the clearer, more specific, and detailed those instructions, the more likely the treatment as practiced will reflect the manual writer's intentions and the greater consistency across therapists (see table 3.3).

Table 3.3. Therapist-friendly manuals

Anticipate common clinical problems
Anticipate client heterogeneity
Provide troubleshooting guidelines
Cover process as well as technique
Build in flexibility and clarity
Include summaries and outlines
Provide guidance around therapeutic choice points

Anticipate Real-World Problems

Manuals should anticipate that some clients will be poorly motivated, ambivalent, psychiatrically unstable, inarticulate, cognitively impaired, involved in abusive relationships (or all of the above) and should provide explicit guidance for addressing these issues. Similarly, if a treatment is contraindicated for a particular client type, the manual should say so explicitly.[107] This is particu-

larly important when a manual might be used by novice or inexperienced therapists.

Manuals are often written around the ideal client, but there are few ideal clients in actual clinical practice. Manuals geared only to such clients are likely to have limited usefulness to therapists. Moreover, while therapist adherence is likely to be high with easy clients, adherence is less likely with more impaired or difficult clients. Therapists may be most likely to drift from manual guidelines with more difficult clients, as they struggle to address complex clinical issues.

Include Troubleshooting Guidelines

Just as there are few ideal clients, few treatments proceed without some snags and difficulties along the way. Therapists are most likely to deviate from manual guidelines and borrow from other approaches when they encounter such clinical problems. Therapist-friendly manuals anticipate and provide guidance for handling common clinical problems encountered in alcohol treatment in a manner consistent with the theoretical background of the treatment.

Issues where specific guidelines are most likely to be helpful include:

- Lateness to sessions
- Missed sessions
- Clients who come to sessions while intoxicated
- Clients whose lives are so consumed by alcohol-related crises that they cannot settle down to do the work of therapy
- Clients with little or no intention of stopping substance use
- Client's whose self-reports of substance use do not match those of collateral sources
- Spouses or significant others who are substance abusers
- Clients who say their sponsors told them not to be compliant with treatment

Manuals should also provide some guidance to the therapist in determining when these problems have eclipsed the benefits the treatment might provide, that is, when it is time to refer the client to another type or more intensive form of treatment.

Cover the Basics

Point out that adherence to the manual should be balanced with clinical judgment. Therapists are frequently anxious about their performance when working with a manual. Although this anxiety usually abates during training and as they become more confident in the treatment and their own experience, the manual itself can attempt to directly confront this apprehension.

No supervisor would encourage a therapist to plunge ahead with difficult therapeutic tasks without first establishing rapport, formulating the case, agreeing on treatment goals, and building a working alliance. However, few manuals explicitly point out the importance of these more fundamental tasks of treatment as a prerequisite for moving ahead to other, treatment-specific tasks. The central importance of clinical competence and nonspecific elements of therapy should not be ignored when developing treatment manuals.

Thus, a therapist-friendly manual should:

- Stress and articulate definitions of therapist competence (as well as adherence) in the conduct of the specific treatment
- Specify the role of nonspecific aspects of treatment and how they are to be balanced with treatment-specific techniques
- Define the fundamental requirements and indicators of progress that must be present before each new stage or technique is undertaken
- Discuss techniques that therapists might use to address problems in nonspecific aspects of therapy, particularly the therapeutic alliance.

Required Versus Optional Elements

Manuals should have built-in flexibility rather than giving the impression that all interventions are created equal and that they should be delivered frequently or in all sessions. Treatment developers usually expect some interventions to be present in all sessions and some in only selected sessions, as appropriate. Thus, therapist adherence may be facilitated to the degree that there is clarity regarding the essential, key, active ingredients of the therapy that must be delivered and those that are optional or indicated only for specific clients or in particular circumstances.

Specification of which interventions fall into the following categories will make the treatment developers' intentions clearer to the therapists and thus easier to follow:

- Interventions, behaviors, or processes that are unique and essential to that treatment
- Interventions, behaviors, or processes that are essential to the treatment but not unique to it
- Interventions, behaviors, or processes that are acceptable within the therapy but are not essential or unique
- Interventions, behaviors, or processes that are proscribed.[111]

Tailor the Treatment

Specifying the strategies by which the therapist can tailor the treatment to meet the needs of specific clients is important. Examples include the distinction between core versus elective sessions in the Cognitive Behavioral Therapy (CBT) and Twelve-Step Facilitation (TSF) treatments in Project MATCH, and the four problem types of Interpersonal Psychotherapy (IPT).[112]

Manuals should also make clear the range of interventions and therapist styles that are acceptable practice within the confines of the treatment and which interventions or behaviors are proscribed in the therapy. If a commonly used therapeutic intervention is proscribed, then the manual should suggest an alternate intervention.

A clear statement regarding possible negative effects or countertherapeutic interventions is likely to enhance the helpfulness of a manual to therapists.[107] In other words, clarity about what not to do or what might actually hurt the client is a key aspect of treatment definition and is particularly important if a treatment is to be taught to relatively novice therapists.

Summaries and Outlines

Therapists may find it helpful to refer to brief session summaries or outlines to remind them of a few key points to be conveyed. This may be particularly useful in treatments with a more didactic focus, where a number of points are to be covered in a single session. An example of a therapist reminder sheet used in Project MATCH is given in table 3.4. Similarly, treatment outlines to which therapists may refer just before a session may be extremely helpful in cuing them to key elements to convey during the session.

Decision Points

Therapists conducting manual-guided treatments are often faced with a wide array of possible interventions and strategies, with comparatively little guidance about which intervention to select at different phases of treatment. Manuals should define important transition points in therapy (e.g., early to late abstinence, focus

Table 3.4. Twelve-step facilitation checklist

Form ___/___
CRU ___/___
Client ID ___/___/___/___
Therapist ID ___/___/___/___
Date ___/___/___/___/___/___
Treatment week (1-12) ___/___
Session number ___/___

PLEASE COMPLETE THE FOLLOWING BASED ON THIS SESSION WITH THE CLIENT– Do not complete if this was an emergency session or if the session was truncated due to client intoxication.

1. Was this a core or elective session?
   1=Core 2=Elective

2. What session topic was covered this week?
   1=Introduction
   2=Step 1 / Acceptance
   3=Steps 2 & 3 / Surrender
   4=Getting Active
   5=Genogram
   6=Enabling
   7=People, Places, Things
   8=HALT
   9=Steps 4 & 5 / Moral Inventory
   10=Sober Living
   11=Conjoint Session 1/Enabling
   12=Conjoint Session 2/Detaching
   13=Termination

Approximately how many minutes of this session were devoted primarily to discussion of the manual session topic for this week? ___ ___ minutes

3. Did you check completion of last sessions's recovery tasks?
   1=No 2=Yes 9=N/A none assigned last session

4. How many AA meetings (any type) did the client attend since the last session? ___ ___

5. Did the client make journal entries since the last session? 1=No 2=Yes 9=N/A

6. Did the client read assigned AA literature since the last session? 1=No 2=Yes 9=N/A

   If so, from what source(s)?
   1=Big Book 3=Living Sober 2=12/12 4=Other: _____

7. To what extent did you review the client's REACTIONS TO LAST SESSION'S RECOVERY TASKS (e.g., 12 Step meetings, assigned readings, obtaining a sponsor, using the telephone to contact AA peers, written assignments)?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

8. Did you ASSIGN A RECOVERY TASK for next week?
   1=No 2=Yes. Please describe: _____

Table 3.4. Twelve-step facilitation checklist (continued)

9. To what extent did you discuss the client's acceptance of his/her disease, its implications, or its symptoms or discuss the DISEASE CONCEPT OF ALCOHOLISM?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

10. To what extent did you explore the client's DENIAL/resistance (e.g., avoiding meetings, minimizing negative consequences), OR discuss the client's resistance to following 12 Step recovery in terms of his/her denial OR discuss the client's need to surrender?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

11. To what extent did you encourage the client to BECOME ACTIVE (e.g., 12 Step meeting attendance, getting a sponsor) OR plan specific AA-related activities for the week (e.g., speaking or helping at a particular meeting, use of the telephone) OR encourage the client to use AA involvement as a means of coping?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

12. To what extent did you explicitly refer to 12 STEP RECOVERY OR interpret or explain a particular step to the client OR invoke a particular step concept during the session OR discuss the client's progress through the steps?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

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

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

14. To what extent did you ASSESS THE CLIENT'S DRINKING since the last session?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

15. To what extent did you discuss or address the client's current COMMITMENT TO ABSTINENCE?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

16. To what extent did you discuss, review, or reformulate the client's GOALS FOR TREATMENT?

1	2	3	4	5
Not at all	a little	somewhat	considerably	extensively

solely on alcohol to greater focus on psychiatric symptoms, when to focus on termination-related issues) and provide clear guidance to therapists about moving through them. Decision trees for determining a client's stage in treatment and readiness to move on may also be helpful and may minimize excessive drift at these decision points in clinical practice.

Providing rules of thumb or general strategies the therapist can use to organize complex treatments and maintain appropriate treatment goals is likely to enhance the usefulness of a manual. An excellent example of this approach is the use of the Core Conflictual Relationship Theme method[113] to focus dynamically oriented therapies.

Criticism of Manuals

As influential as treatment manuals have been to both research and clinical practice, they have also been subject to a number of criticisms. Those which are relevant to issues of therapist adherence and compliance are summarized briefly below, while broader issues have been reviewed elsewhere.[114] These are included here to heighten awareness of individuals interested in developing treatment manuals to their common pitfalls and problems and to encourage attempts to address these limitations.

Form Versus Substance

A frequent, and important, criticism of psychotherapy manuals is that they emphasize the form rather than the substance of therapeutic competence.[114-116] That is, manuals emphasize specific techniques over competent delivery of those techniques in the context of a positive therapeutic relationship. Part of this view of manuals arises from the recency of manuals as a methodological development in psychotherapy research. Most of the pioneering manuals written in the 1980s were developed for use in large-scale psychotherapy research studies, which used experienced and closely supervised therapists. Thus, these manuals were designed not to teach basic psychotherapy process skills to novice therapists, but to efficiently convey the specific techniques to be integrated into the repertoire of seasoned clinicians as a means of reducing variability in the treatment variable. However, the more recent proliferation of manuals into clinical practice and their more widespread use in the training of therapists[107,117-119] has led to a greater emphasis on the need to address more fundamental therapist skills in the training process. While there is emerging consensus that adherence can be enhanced through the use of manuals, whether manuals can teach competence is much less clear. For example, a recent study found that although manual-guided training did enhance therapist adherence, it may have led to unanticipated and potentially negative changes in other aspects of therapist interpersonal behavior.[120]

Thus, rather than a complete repudiation of manuals, this criticism should drive home the point that manuals are merely a tool. Manuals were not intended to be substitutes for training and supervision of therapists, nor are they in and of themselves sufficient to train therapists. This highlights that manuals should be used as adjuncts to, but not substitutes for, careful, thorough training and supervision of therapists as well as careful therapist selection. Thus, it is strongly urged that manuals include a section on recommended procedures for training and supervising therapists to use the approach, as well as specification of basic educational and experience requirements for therapists.

Mechanization of Therapy

As discussed above, manualization of a treatment involves defining, specifying, and distinguishing it from other treatments. Thus, a frequent criticism is that manuals emphasize the codification of often artificial differences between treatments at the price of nonspecific beneficial aspects of therapy, such as spontaneity and flexibility. In other words, the aspects of psychotherapy that are more "art" than "science" are frequently omitted or underemphasized in the process of manualization, which can render manualized treatments as rigid, mechanistic "cookbooks" devoid of reference to important therapeutic processes. Moreover, some of the complex processes of therapy may not be adequately captured in manualized form, and therapies that are less prescriptive or behavioral lend themselves less well to specification in manuals.[104]

In practice, rigidity in manuals is often offset by an emphasis on flexibility and competence in training and supervision. However, manual developers might do well to try to take on the task of building greater flexibility and sophistication into manuals, for example by including detailed case examples, stressing the importance of therapist responsiveness at key therapeutic choice points, and developing videotaped training aids that illustrate therapists exhibiting effective therapeutic versatility while adhering to manual guidelines.

Update Often

It is very useful to develop second-generation manuals that incorporate the clinical wisdom that is accumulated gradually by conducting and supervising therapy in clinical practice but is rarely articulated and reflected in manuals. Psychotherapy manuals, particularly those used in clinical trials, are often constructed quite quickly, often in the first few months of a trial. Thus, they do not reflect the clinical sophistication and richness that is gained during the course of the study, as the treatment is implemented with a wide variety of clients and as omissions in the original manual are identified and filled in.

Supervisors, therapists, and other involved personnel should keep notes that can be used to broaden and enrich subsequent versions of the treatment manual. It should be considered a work in progress rather than a finished product.

A Case Study in Clinical Supervision: Experience From Project MATCH

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This chapter describes the rationale, practice, and outcome of the supervision in Project MATCH, where compliance was a critical component of the research design. The primary and most important aim of the supervision was to ensure the delivery of high-quality, effective treatment services in a professional and ethical manner to all clients. Maintaining the consistency of treatment obviously is vital to making sense of outcomes in psychotherapy research: poor therapist compliance to the treatments being assessed is a major factor contributing to inconclusive results in large clinical trials. Thus, a second primary goal of the supervision was to assure the homogeneity of treatment across time, across settings, and across therapists: to make certain that a given treatment replicated, as closely as possible, the treatments detailed in the manuals, and that it did so for the duration of the research project.

Levels of Supervision

Prior to starting the treatment phase of the research, two levels of supervision were established. Responsibility for on-site clinical and administrative overview was delegated to the site directors, who were responsible for daily details of the project. Typically, site supervisors met weekly for supervision with therapists and were available as needed for urgent clinical and procedural questions.

Each therapist also had a central supervisor, not based at the local site. Having a central supervision team in addition to the site supervisors was a component of the project explicitly designed to ensure compliance with the treatment manuals across sites, and to prevent "drift" either within a site or across sites over time.

This goal was accomplished through several procedural and structural details. Each central supervisor was responsible for only one treatment type, for example, cognitive-behavioral therapy, but was assigned a number of therapists to supervise, from more than one site. Thus, any divergence of practice for that treatment, from either a particular therapist or site, would be immediately evident.

The central supervisors themselves met regularly as a group to discuss common themes or problems emerging in the individual supervision and worked as a team to standardize supervision for the project as a whole. This had the aim of reducing variability in the advice given to therapists, within and across treatment components, and ensuring consistent supervision across all sites for the duration of the project. Whenever a project has a central supervision group, that team should meet regularly to discuss problems in the overall study.

Pilot Phase Therapist Training

Following training, each clinician was assigned at least two training cases and treated these cases following the manuals, under close supervision. During this pilot phase, supervision from both the local site and central supervision team was conducted weekly. Every session was videotaped and reviewed to ensure detailed coverage of techniques and the structure of the entire sequence of each protocol. After two cases were completed to the satisfaction of the site and central supervisors, the clinician could be certified as a study therapist. A small number of clinicians is expected to decline participation at this stage, due to the constraints of manual-guided therapy and the demands of close supervision.

Main Study Supervision Procedures

During the main phase of treatment, individual telephone supervision was conducted every other week between the central supervisors and therapists about specific sessions and general clinical issues related to each case. Procedurally, the centralized supervision involved having the site therapists videotape every session with every client. Of interest to the supervision was the requirement that the camera be directed at the therapist, not at the client. This allowed supervision of the nonverbal aspects of treatment and helped maintain client confidentiality.

Once a given session was recorded, a tape was sent to the central supervision site. The central supervisor viewed approximately

one-quarter of the sessions, taking a sample from the beginning, middle, and end of therapy. The supervisor also rated each tape using several scales—one to assess specific techniques in each treatment manual and others to rate general therapist skillfulness and therapeutic alliance.

These ratings gave the supervisors specific behaviors and techniques that therapists would be expected to demonstrate over the course of treatment sessions, and provided a ground for discussion of technique in supervision, in addition to the manuals. The central team supervisors discussed these ratings frequently to assure consistency in ratings across supervisors and treatment conditions.

A formal reliability check midway through a study in which supervisors rate a sample of tapes from different treatment conditions is recommended to establish levels of interrater reliability and ensure that the ratings are applied similarly across therapists and treatments.

Telephone supervision, based at a central site, entailed benefits to the project, some not immediately apparent at the outset. At a basic level, it afforded the therapists a private discussion focused entirely and purely on therapeutic issues: the central supervisors were unconnected with the local questions of hiring, administration, and evaluation at the sites. This gave the therapists scope to engage freely with the supervisors on clinical questions, with license to admit and correct mistakes, without fear of the effects on performance evaluation. However, giving site supervisors some feedback about the performance of site therapists, whether in the form of a summary of objective ratings or informally, appears necessary to redirect local supervision or review training.

In addition to individual supervision, sites were also given periodic group supervision for each treatment condition, usually via a conference call, on a monthly basis. The purpose of these exchanges was to discuss compliance or treatment issues that had risen for the site in general, and to review the objective feedback provided to the sites by the central supervisors.

Site supervisors participated in the group supervision for each treatment condition, to ensure that important issues were clearly understood between the local and central teams, thus easing potential frictions or miscommunications. For example, supervisors did not initially have an explicit policy for managing clinical deterioration (defined as a client needing a high or more intensive level of care, whether urgently or subacutely). Group supervision provided a forum for free discussion of this problem in a way that addressed the needs and concerns of the clinicians, the research needs of the site supervisors, and the compliance issues of the

central supervision team, leading to an explicit policy that had the support of all involved.

The general quality of the treatment was monitored over time as well as compliance with the manuals. If a therapist's performance deviated either from good levels of competence or adherence to the manual, as measured by the central supervisor's ratings, for more than two sessions, that clinician was "redlined" for special attention. These therapists received no new clients, and the frequency of supervision increased from monthly to weekly until performance again returned to a satisfactory level. At times, tapes from other therapists who were more successful at a particular treatment were used to supplement the training of a redlined therapist. If these measures failed to change a therapist's performance, decertification was used to prevent problems for the research or harm to clients.

General Issues in Supervision

Central supervisors attempted to observe a number of basic principles to ensure the effectiveness of supervision (table 4.1). For example, supervisors clearly defined their roles relative to the site directors and within the research program. Given the possibility of confusion, with two types of supervision, central supervisors strove to maintain consistency at basic levels such as regularity of appointments and structure of the supervision, as well as in presenting a consistent approach to supervision. Supervision was

Table 4.1. Checklist for effective supervision and enhancing therapist compliance in manual-guided therapies

- ☐ Define participants' roles and parameters of supervision.
- ☐ Clarify goals of supervision.
- ☐ Discuss limits of confidentiality in a research project.
- ☐ Clarify the role of measures of therapist performance in treatment research.
- ☐ Keep supervision concrete and structured.
- ☐ Use examples from session videotapes and audiotapes.
- ☐ Refer frequently to the manual.
- ☐ Provide supervision as soon as possible after sessions are conducted, at a consistent time and date.
- ☐ Update therapists with newsletters and memos describing interesting examples, clarification of materials in manuals, and creative strategies for handling clinical problems.
- ☐ Provide effective alternate interventions for proscribed techniques.

presented as a collaborative endeavor, with mutual respect and a positive emphasis on the clinician's strengths and competence was highlighted whenever feasible.

A crucial clarification the supervision team addressed early in the project involved the constraints of therapy and supervision in treatment research. The limited goal of research supervision—to enhance therapist compliance with the treatment manuals while providing quality care—was openly stated, in contrast to more typical aims of supervision, such as preparation for licensure, advanced training, and so forth.

As a corollary, the limited parameters of the supervisor relationship within the confines of a research study, and for a limited time period, were explicitly described as well. The limited role of the therapists themselves in conducting time-limited therapy for a circumscribed set of problems was another theme constantly reinforced, particularly given the natural tendency to expand the scope of treatment for those accustomed to open-ended therapy. Together, these reminders tended to keep the supervision tightly focused on the treatments and the clients, and reduced digressions.

All supervision shared a commitment, insofar as possible, to provide specific behavioral feedback ("use this technique here"). In part, this was a reflection of the structure and detail of the treatment manuals themselves, but it also derived from a belief that behavioral feedback was more useful to clinicians and would be likely to increase compliance as well. A review[122] of evaluations of trainees and supervisors noted that trainees rate supervision as better when it is structured and provides clear feedback, the most effective feedback being that which embodies clearly stated objectives.

Increasing structure in supervision through outlines of techniques or other adjunctive material appears to lead to more change in trainees as well.[122] Moreover, others[108] have suggested that the use of manuals with explicit techniques can facilitate mastery in trainees, even as rated by clients, in addition to supervisors. Central team supervision generally tried to refer to the treatment manual in every supervision session to emphasize its centrality, especially as the study continued and clinicians assumed that they knew and remembered the manuals perfectly, without checking. This constant return to the manuals served as a check on the tendency of even well-trained and committed therapists to drift over time.

On the other hand, overly strict adherence to the manuals represented a clear problem in supervision, especially with less experienced therapists (table 4.2). For example, some clinicians would

become so focused on the suggested topics or interventions in a specific model that client concerns would not be addressed, or material relevant to the client would not be offered. The problem tended to diminish as the therapists became more familiar with the treatment protocols, and viewed them more as "second nature".

Table 4.2. Common problems in therapist compliance with manual-guided therapies

- ☐ Overly strict conformance to the manual
  - — Failure to select interventions appropriate to client
  - — Giving the impression that the manual, rather than the client, determines the course of therapy
- ☐ Failure to adapt treatment to client
  - — Use of inappropriate language or terms
  - — Failure to attend to client concerns
- ☐ Looseness in conforming to the manual
  - — Covering manual material only at end of session
  - — Failure to fully cover core interventions
- ☐ Contamination
  - — Using techniques from other treatments
  - — Using language and terms associated with other treatments

A crucial function of supervision in this respect was to reframe client problems and characteristics within the terms of the respective models of treatment and to search for alternate, appropriate interventions that were congruent with the model. More subtle problems, such as using language and concepts appropriate to the client, were also addressed within the models. Thus, the therapists were gradually led, through supervision, to view the treatment manuals not only as collections of distinct techniques, but as embodying concepts and principles that had the flexibility to meet the needs of each client.

Variants in the clinicians themselves also required changes in supervision. Pertinent individual differences included level of training and experience, level of skill, defensiveness, resistance, and openness to change, to mention only the characteristics most striking to supervisors. Differing skills and experiences led supervisors to alter the content of supervision to best meet the needs of the clinicians. For example, relatively inexperienced or less well-trained therapists clearly required, and wanted, intense work on developing specific skills such as role-playing or relaxation training. More advanced clinicians, who had shown mastery of these skills, were more interested in discussing formulations, or relationship issues. Supervisors attempted to respect these interests by acknowledging competence, but keeping the discussion with

the parameters of the particular model. For example, cognitive-behavioral therapy (CBT) supervisors would contain discussions of formulations or transference within the behavioral model, and would discourage examining cases from other theoretical perspectives not in the manual.

Therapists also differed considerably in their defensiveness or resistance to structured feedback, with those who had worked previously in research settings generally being more receptive to direct feedback. Clearly, having one's performance as a therapist videotaped rendered certain kinds of resistance more difficult, and on a more subtle level, gave therapist and supervisor something concrete to which both could refer in making comments. Using detailed and highly structured manuals as a basis for supervision also appeared to make clinicians less defensive and more receptive to direct feedback, since this structure was an acknowledged fact that limited the scope of clinician judgement and exposure.

The highly structured, time-limited nature of the interventions also served to alter the classical model of supervision. From a psychodynamic perspective, supervision develops in a parallel process to therapy, and an exploration and resolution of relationship issues, such as transference, in the supervision affects the outcome of the therapy as well. The clear structure, and emphasis on concise, immediate behavioral feedback in manual-driven therapy, minimized these issues for supervisors and clinicians alike.

So much was structured and focused, not by the supervisor, but by the research requirements and manuals, that transferential elements had limited scope. Supervisors did not view this as a problem, since the aims of supervision were not to explore these issues, but to ensure therapist compliance. This is not to say that relationship issues were unimportant, but they did not form the central focus of supervision. An objective assessment of the quality of supervision by the study therapists suggested that even in structured, manual-guided therapy, empathy remained an important aspect of effective supervision nonetheless.

Another issue in supervision, more unique to treatment research, concerned the problem of perceived mismatches between the client and the treatment modality. Experienced clinicians in particular often quickly noticed that some clients were not the best fit for a certain therapy; a natural response in this case would be to alter one's treatment to best meet the needs of the client. However, such alterations, if they deviated substantially from the manual and particularly if they overlapped with a comparison condition, would adversely affect treatment integrity. Supervisors thus were faced with the task of reconciling the needs of the clients

and the therapist's inclination with the restrictions of treatment-matching research. In part, this problem was addressed by the treatment manuals themselves, which had incorporated some flexibility. For example, the CBT manual offered the clients a choice of topics or issues once the core six sessions were covered; often a client's requests could be accommodated by simply promising to discuss the issue soon, when the essential materials had been reviewed.

In other cases, the supervisors and therapists faced more difficult choices. If, in the judgement of the central and site supervisors, a client's problems could not be addressed with the treatment outlined in the manual, therapists could deviate from the protocol. Even in these instances, supervisors attempted to preserve treatment integrity by suggesting interventions consistent with the model that underlay the manuals, for example, a 12-step intervention rather than a dynamic or behavioral intervention for a 12-step client. In cases of clinical deterioration, clients were referred immediately to the most appropriate type and level of care. Clinicians choosing not to abide by the manuals were a relatively rare occurrence in this study, and in the opinion of the supervisors, represented less of a threat to treatment integrity than gradual drift.

Treatment-Specific Issues in Supervision

Cognitive-Behavioral Therapy

The cognitive-behavioral treatment manual contained a number of possible interventions and a choice of elective sessions in contrast to the 12-step and motivational enhancement interventions. A frequent problem that emerged in CBT as a consequence was a failure to select appropriate electives and interventions that suited the client's problems. Supervision attempted to address this problem by helping the therapist develop a comprehensive formulation of the client in CBT terms, and an overall treatment plan, rather than simply responding to the client's symptoms in a piecemeal fashion.

Other problems encountered in CBT included neglect of homework assigned to clients and failure to use role plays. These simpler problems tended to diminish over time with reminders and with practice as the therapists became more familiar with the interventions.

Other common mistakes involved the use of incompatible terminology, such as Alcoholics Anonymous phrases or family systems terms, but these were easy to illustrate and correct with videotapes. Future supervision efforts with manual-guided treatments might achieve even greater compliance by addressing pitfalls explicitly during training and the early phases of supervision.

Twelve-Step Facilitation

Although the 12-step facilitation manual was clearly written and easy to follow, several consistent problems with 12-step facilitation therapists had to be addressed early in the process of supervision. A frequent problem with this group of therapists was too much self-disclosure. Approximately one-half of this model's therapists were themselves in recovery, and there was the tendency to slip into personal anecdotes sometimes unrelated to what the client was discussing. While some self-disclosure might be helpful in establishing a positive relationship, as a general rule, self-disclosure can foster further resistance and shift the focus away from the client and should be avoided.

A second problem frequently seen in the 12-step therapists was being too rigid about clients' completion of between-session assignments. Some of the therapists would become anxious and frustrated by noncompliance in the early sessions as they began to introduce the 12-step material, rather than being more facilitative. Directing supervision to the needs of the client rather than the therapist typically was effective in addressing this problem.

Measures of Supervision

To assess the quality and consistency of the supervision itself, researchers might consider using objective measures of supervision effectiveness in treatment outcome studies. A review of current questionnaires in the research literature revealed no available questionnaires that could be adapted to a model of supervision that was based on treatment manuals and videotape.

The Psychotherapy Supervision Questionnaire (table 4.3) is a brief, 32-item survey designed specifically to assess the process of supervision in manual-guided therapy. Several study supervisors devised items, following four dimensions frequently discussed in the literature as important in the supervision process:

- *Level of Comfort* with a supervisor
- *Level of Congruence* between the therapist and supervisor on interventions, goals, and strategies that could be utilized in psychotherapy with particular clients
- *Rapport* (i.e., openness, honesty, and respect
- Supervision that is *Consistent* with a particular theoretical model.

The scale items were evaluated using standard reliability and validity procedures and then were employed to evaluate supervision in the project.

Table 4.3. Psychotherapy Supervision Questionnaire

Below are a series of statements on the quality of supervision in psychotherapy. Please rate each statement about your psychotherapy supervision by circling a number after each statement indicating the degree to which your supervision reflected that statement. Please base your ratings *only* on the past *90 days* of supervision.

1) My supervisor taught me specific therapy skills or techniques as related to the treatment manual.

Never		Sometimes		Aways
1	2	3	4	5

2) My supervisor helped me understand my client's personality and how this affects the treatment process.

Never		Sometimes		Aways
1	2	3	4	5

3) My supervisor helped me understand better my feelings, thoughts, and behaviors toward my clients.

Never		Sometimes		Aways
1	2	3	4	5

4) My supervisor helped me understand better my clients' style of relating to me as their therapist.

Never		Sometimes		Aways
1	2	3	4	5

5) My supervisor helped me understand how my own personal characteristics or behavior helped or hindered my effectiveness as a psychotherapist with a particular client.

Never		Sometimes		Aways
1	2	3	4	5

6) My supervisor was overly critical of me.

Never		Sometimes		Aways
1	2	3	4	5

7) My supervisor was direct and clear in informing me of my strengths as a therapist.

Never		Sometimes		Aways
1	2	3	4	5

8) My supervisor expected me to do most of the problem solving in supervision rather than give me the answers.

Never		Sometimes		Aways
1	2	3	4	5

Table 4.3. Psychotherapy Supervision Questionnaire (cont.)

9) During supervision, my supervisor helps me focus on the goals of the treatment sessions as described in the treatment manual.

Never		Sometimes		Aways
1	2	3	4	5

10) My supervisor explored my personal background to help me overcome problems I was having.

Never		Sometimes		Aways
1	2	3	4	5

11) My supervisor reviewed with me specific selections of the videotapes of my therapy.

Never		Sometimes		Aways
1	2	3	4	5

12) My supervisor and I agree on the appropriate treatment plans for my clients.

Never		Sometimes		Aways
1	2	3	4	5

13) My supervisor gave me immediate feedback on my cases.

Never		Sometimes		Aways
1	2	3	4	5

14) My supervisor expressed reservations about the style in which I interacted with my clients.

Never		Sometimes		Aways
1	2	3	4	5

15) My supervisor was open to critical feedback regarding my satisfaction with supervision.

Never		Sometimes		Aways
1	2	3	4	5

16) My supervisor was supportive of me when I made mistakes.

Never		Sometimes		Aways
1	2	3	4	5

17) My supervision was direct and clear in informing me of my weaknesses as a therapist.

Never		Sometimes		Aways
1	2	3	4	5

Table 4.3. Psychotherapy Supervision Questionnaire (cont.)

18) My supervisor gave me a clear idea of how he or she really regards my work.

Never		Sometimes		Aways
1	2	3	4	5

19) My supervisor provided supervision that challenged me to rethink my psychotherapeutic approach.

Never		Sometimes		Aways
1	2	3	4	5

20) My supervisor's basic approach to therapy is different from mine.

Never		Sometimes		Aways
1	2	3	4	5

21) My supervisor encouraged me to express my thoughts and feelings regarding his/her supervision of me.

Never		Sometimes		Aways
1	2	3	4	5

22) My supervisor made me feel anxious when talking with him or her.

Never		Sometimes		Aways
1	2	3	4	5

23) My supervisor was honest with me.

Never		Sometimes		Aways
1	2	3	4	5

24) My supervisor kept to the plan about content of supervision.

Never		Sometimes		Aways
1	2	3	4	5

25) My supervisor and I thought similar about the ways of intervening with clients.

Never		Sometimes		Aways
1	2	3	4	5

26) During the process of supervision, my supervisor adhered to the model of therapy presented in the treatment manual.

Never		Sometimes		Aways
1	2	3	4	5

Table 4.3. Psychotherapy Supervision Questionnaire (cont.)

27) During the course of the supervision, my supervisor frequently referred back to the treatment manual when explaining a point.

Never		Sometimes		Aways
1	2	3	4	5

28) During supervision time, my supervisor and I were able to resolve any differences that arose between the two of us about the client's treatment plan.

Never		Sometimes		Aways
1	2	3	4	5

29) My supervisor related to me more as a colleague during our supervision time rather than as someone who had authority over me.

Never		Sometimes		Aways
1	2	3	4	5

30) My supervisor gave me suggestions about my cases that were confusing.

Never		Sometimes		Aways
1	2	3	4	5

31) Because of my supervisor, I have a better understanding of how my therapy style can become more consistent with the treatment manual.

Never		Sometimes		Aways
1	2	3	4	5

32) My supervisor helps me adapt my therapeutic interventions into interventions that fit the treatment manual.

Never		Sometimes		Aways
1	2	3	4	5

Relationship Between Supervision and Therapist Compliance

Our final impression of the videotaped model of supervision is that, within particular parameters, this model can be an efficient and effective alternative to the more classical model of sit-down, face-to-face style of supervision, particularly in a large multiple-site psychotherapy study. We confirmed, through our own internal quality assurance survey, that the guidelines we adhered to increased therapist compliance and appeared to reduce resistance to the particular treatments and improved therapist-supervisor congruence during supervision.

We established that compliance-resistance could be managed in four ways: by using the manual, using videotapes, providing immediate feedback on ratings, and by developing rapport and empathy in the telephone supervision.

Our final conclusion is that a videotape-based type of supervision can work provided that it is frequent, focused on the manual, and uses the above guidelines to increase compliance and deal with therapist resistance. Supervision delivered in this way may also contribute to client compliance and improvement in retention in psychotherapy studies.

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