Fam Proc 37:107-121, 1998

Evaluating Therapist Competency and Adherence to Behavioral Family Management with Bipolar Patients

AMY G. WEISMAN, Ph.D.[a]

SUMIE OKAZAKI, Ph.D.[b]

JENNIFER GREGORY, M.A.[c]

MICHAEL J. GOLDSTIEN, Ph.D.[c]

MARTHA C. TOMPSON, Ph.D.[c]

MARGARET REA, Ph.D.[c]

DAVIS J. MIKLOWITZ, Ph.D.[d]

[a]Send correspondence to Amy G. Weisman, Ph.D., Department of Psychology University of Massachusetts-Boston, 100 Morrissey Boulevard, Boston MA 02125-3393; e-mail: weisman@umbsky.cc.umb-edu.

[b]University of Wisconson-Madison

[c]University of California, Los Angeles

[d]University of Colorado, Boulder

The present study assessed fidelity to the behavioral family management (BFM) model for treating bipolar disorder patients and their families. The BFM Therapist Competency/Adherence Scale (BFM-TCAS) was developed to evaluate clinicians' competency and adherence to BFM, as outlined by Miklowitz' (1989) BFMManual for use with bipolar patients. Therapist competency and treatment adherence was also evaluated with regard to two family characteristics: overall level of family difficulty and family expressed emotion (EE) status. The BFM-TCAS was used to code 78 videotaped sessions of 26 families with a bipolar member, selected from a larger treatment study of bipolar disorder patients. The findings suggest that, overall, clinicians adhered closely to the BFM manual. Specific areas in which there was high competency and treatment adherence were (a) skill in conveying factual information about bipolar illness, (b) establishment of a therapeutic environment, and (c) ability to take command of therapy sessions. The one area in which there was less compotency and relatively weak adherence to the manual was the use of between-session homework assignments to assist families in mastering the BFM exercises. Results of this study also suggest that, for the most part, therapist competency and adherence ratings were not related to overall level of difficulty or to family EE status.

The advent of treatment manuals has greatly improved efforts to differentiate various approaches to psychotherapy. Manuals provide explicit guidelines for therapists to follow, including those components of behavior that are prescribed by the treatment and those that should be avoided. These guidelines help to insure that the therapies being compared are indeed distinct (Vallis, Shaw, & Dobson,1986). Waltz, Addis, Koerner, and Jacobson (1993), however, caution that the use of manuals is not sufficient to guarantee adherence or purity of treatments. Psychotherapy researchers also need to "document that their efforts to achieve purity have been successful" (Waltz et al., p. 620). Without evidence of adherence, the presence or absence of therapeutic progress cannot be attributed to therapy-specific aspects of treatment (Startup & Shapiro, 1993).

The present study was designed to evaluate clinicians' competency and adherence to a specific form of family treatment for patients with bipolar disorder. This treatment approach, entitled Behavioral Family Management (BFM), combines educational and social learning principles to improve family functioning and course of illness for patients with psychiatric disorders (Mueser & Glynn, 1995). Falloon, Boyd, and McGill (1984) were among the first to specify the essential components of BFM—which they called BFT (therapy)—and to develop a treatment manual for working with families with a schizophrenic member. The treatment was later modified by Goldstein and associates (see Goldstein & Miklowitz, 1994) and manualized by Miklowitz (1989) to better meet the needs of families with a bipolar member.

In the present study, the *BFM therapist Competency/Adherence Scale* (BFM-TCAS; Weisman, Okazaki, Gregory, & Goldstein) was developed to evaluate clinicians' competence and adherence to BFM in a sample of families with a bipolar member. The BFM-TCAS requires trained raters to use Miklowitz' (1989) *Manual for behavioral family management with bipolar patients* as the standard for assessing competence in and adherence to BFM.

This study also assessed how an independently rated measure of the level of family difficulty may be related to ratings on the BFM-TCAS. Difficult clients can prevent even the most competent therapists from successfully using strategies

prescribed by a treatment manual (Waltz et al., 1993). There is some evidence in the literature that supervisors (and clinicians themselves) tend to rate the clinicians who work with angry, hostile, or otherwise difficult clients as less competent than those who work with less difficult clients (Foley, O'Malley, Rounsaville, et al., 1987). The BFM-TCAS was designed to discourage raters from assigning lower competency/adherence scores to clinicians working with families who are resistant or unable to cooperate in treatment, provided that therapists had attempted to deal with these difficulties in the manner prescribed in the BFM manual. In this study the BFM-TCAS rater's ability to evaluate therapists' competency and adherence to BFM independently of overall family difficulty was assessed. The BFM-TCAS measure of family difficulty takes into account both family capacity to understand the treatment exercises, and overall willingness to cooperate in therapy.

Finally, this study evaluated how a family factor termed expressed emotion (EE) related to therapists' ability to adhere to the BFM model. EE is a measure of relatives' attitudes toward a mentally ill family member, and it has been shown to be predictive of the course of psychiatric illness for patients with a range of disorders, including schizophrenia (Vaughn & Leff, 1976), depression (Hooley & Teasdale, 1989), and bipolar disorder (Miklowitz, Goldstein, Nuechterlein, et al., 1986). Research demonstrates that, after psychiatric hospitalization, patients who return to live with relatives rated as high-EE—critical, hostile, and/or emotionally overinvolved—have higher 9-month relapse rates than do patients whose relatives are ratedas low-EE—do not express many negative or emotionally charged attitudes (see Kavanagh, 1992, for a review). In Foley et al.'s (1987) study on the relationship of patient difficulty to therapist performance in interpersonal psychotherapy for depression, patient characteristics were found to influence independent raters' view of skill level in clinicians. In the present study, it was hypothesized that clinicians working with critical, hostile, or emotionally overinvolved relatives (high-EE) might be less successful at establishing rapport, engaging the family in treatment, and carrying out BFM exercises, and may therefore be rated as less competent and adherent on the BFM-TCAS.

In summary, then, the three primary questions examined in this study were:

1. How competent and adherent to the BFM manual were clinicians in the UCLA Bipolar Disorder project (Goldstein, Rea, & Miklowitz, 1996)?
2. Were BFM-TCAS raters able to evaluate therapist competency and adherence to BFM independently of family difficulty?
3. How did family EE status relate to BFM-TCAS ratings?

METHOD

Participants

Participants in this study were drawn from a larger project entitled Lithium and Family Management of Bipolar Disorder (see Goldstein et al., 1996). This project was designed to assess the efficacy of a psychoeducational intervention program used in conjunction with mood-stabilizing medications in the treatment of bipolar disorder. In the larger study, patients and their families were recruited from three inpatient psychiatric facilities serving Los Angeles County. All patients met the DSM-III-R (American Psychiatric Association, 1987) criteria for a manic episode at the time of index hospitalization. Diagnoses were made based on the Present State Examination (PSE; Wing, Cooper, & Sartorius, 1974), supplemented by selected items from the Structured Clinical Interview for the DSM-III-R (SCID; Spitzer, Williams, Gibbon, & First, 1990) to assess manic symptoms. For inclusion in the larger study, patients were also required to be living with or to have at least 4 hours of weekly, face-to-face interaction with a family member for a minimum of one of the 3 months prior to the index hospital admission. Patients with significant alcohol or drug abuse, evidence of mental retardation, and/or a diagnosed central nervous system disorder were excluded from the study. All patients participating in the project received individual medication management sessions with a staff psychiatrist for one year and were required to take mood-stabilizing medications during their participation in the study. In the larger study, patients were randomly assigned to receive either BFM or an individual patient management treatment with one or two family education sessions.

Participants selected for the present analyses included the first 26 families assigned to the behavioral family intervention (BFM) condition. Patients in this sample ranged in age from 18 to 46 ($M = 27.19$) and had an average of 2 years post-high school education. Sixty-four percent of subjects resided with their relatives. Sixty-two percent of participants were Caucasian, 24% were African American, and 4% were Asian American. Relatives participating in the treatment included 15 mothers, 13 fathers, 6 spouses, 2 siblings, and one aunt.

Overview of Treatment

In the present study, family intervention was led by pairs of clinicians trainedin BFM, who were unaware of the family EE status. Each family received 21 BFM sessions over a period of approximately 9 months. Treatment occurred weekly for the first 3 months, biweekly for the second 3 months, and once a month for the final three sessions. All sessions were videotaped.

BFM has three core components, each lasting between 2-9 sessions, depending on the individual needs of the family. The first segment is *Family Education.* The primary objective of this phase is to encourage a thorough understanding of bipolar illness, including the nature of the disorder, its causes, course, and treatment. This segment is presented didactically and uses a series of handouts that outline the major concepts and factual information. Factors that increase risk of relapse (for example, irregular sleeping patterns, drug use) and factors that protect against relapse (for example, medication, family support) are reviewed, and a stress-vulnerability model of bipolar illness is presented. Readings are assigned as homework to facilitate the families' learning of this material.

The second module is called *Communication Training.* The primary objective of this segment is to reduce family stress by improving family communication. Modeling and role-playing are used to teach communication techniques such as listening reflectively, giving feedback, and making positive and negative requests to one another. Families are given structured homework assignments that encourage them to practice the communication techniques between sessions.

The third component of BFM is *Problem Solving.* The underlying rationale for this segment is that knowledge of the right steps involved in solving problems, in combination with good communication skills, will reduce familial tension that often develops in response to stressful life events. Families are presented with a series of steps to follow when solving conflicts: for example, brainstorming, evaluation of ideas, and implementation of solutions. In this phase a "relapse drill" is also conducted in which families use problem-solving techniques to develop a plan of action should the patient's symptoms return.

Measures

Competency/Adherence Ratings

The *BFM Therapist Competency/Adherence Scale* (BFM-TCAS; Weisman et al., 1996) was developed in this study to assess the three specific components of BFM and several other nonspecific aspects of the treatment. The BFM-TCAS was patterned after Harpin, McGill, and Falloon's (1983) *Therapist Competency Rating Scale for Behavioral Family Therapy,* and Miklowitz's (1990) supplement to the Harpin et al. scale, *Additional Items: Therapist Competency Scale.* Items from the Harpin and Miklowitz scales were modified to enhance reliability and validity. Specifically, in the BFM-TCAS, scoring instructions were greatly elaborated; items with low interrater reliability were eliminated (for example, assessment of therapist skill in "trouble shooting"); and a few new items not included in the previous scales were added (for example, therapist cooperation and interaction).

The final BFM-TCAS has thirteen 7-point Likert scale items distributed among six major categories. The first category, education, has one item assessing competence in accurately conveying factual information about bipolar disorder in language understandable to the family. The second category, communication training, includes 3 items that evaluate competence in giving instructions and laying out the communication techniques, directing role-plays, and giving family members feedback about their performance in carrying out the exercises. The third category includes one item assessing competence in directing brainstorming, evaluation of ideas, and implementation of solutions that occur in the problem-solving phase of treatment. The fourth category is entitled general skills and includes 6 items tapping areas such as ability to establish rapport, pacing and efficient use of time, and competence in assigning relevant homework assignments. The fifth category includes one item designed to evaluate co-therapists' skill at working together to provide a safe and effective therapeutic environment. A final, one-item category was also included to assess the level of difficulty each family posed in the session. The rating on this item was based on factors such as family members' ability to grasp and carry out the BFM exercises and their willingness to cooperate with the therapists.

Three raters, 2 Ph.D.-level psychologists (A.W. and S.O.) and one psychology graduate student (J.G.) trained in BFM, each rated one videotape per family using the BFM-TCAS. The first videotaped session in each segment of BFM treatment (education, communication training, and problem solving) was rated for each of 26 families, yielding a total of 78 session ratings. The education, communication training, and problem-solving sessions were distributed approximately equally among the coders. The two Ph.D.-level raters had also served as treating clinicians for one family each. In no case did the raters rate their own therapy sessions.

For each family, scores on family difficulty, therapist cooperation, and all six general items were based on the average rating across the three sessions. Scores on communication training, problem solving, and education for each family were based on the first session in which this segment of treatment occurred. To assess interrater reliability of the BFM-TCAS ratings, all coders rated 9 of the same videotaped sessions (3 of each treatment segment with 9 separate families). As shown in Table 1, intraclass correlation coefficients for each of the 13 items on the BFM-TCAS were good, ranging from .74 for problem specification to .98 for homework. Thus, although the sample (N = 9) for interrater reliability was somewhat small, we were able to demonstrate adequate levels of rater agreement on all 13 items. (See Appendix 1, pp. 566-569, for complete BFM-TCAS scale.)

Table 1
Intraclass Correlation Coefficients for Adherence/Competency Ratings (N = 9)

Education	.92
Communication Training	
Instructions	.90
Role-play	.86
Feedback	.88
Problem Solving	.75
General Skills	
Rapport	.84
Efficiency	.80
Prob. specification	.74
Homework	.98
Session command	.79
Therapists overall	.83
Fam. Difficulty Level	.84
Therapist Cooperation	.85

Expressed Emotion

EE was coded by an independent rater (not a treating clinician or a BFM-TCAS rater) who was unaware of the purpose of this study. EE ratings were obtained approximately 1-2 weeks after the patient's discharge from the index hospitalization, using the abbreviated version of the Camberwell Family Interview (CFI; Vaughn & Leff, 1976). The CFI is a semi-structured interview about familyattitudes toward the patient and the effect that the patient's illness has on the life of the family. The interview focuses on the 3 months prior to hospitalization. The abbreviated version of the CFI requires approximately one-half to 2 hours to administer. Family members who had been living with the patient during the 3 months before the index hospitalization, or who had been in at least 4 hours of weekly contact with the patient were invited to participate in this interview. Relatives who made 6 or more critical comments, who expressed any hostility, or who scored 3 or more on a 5-point scale on emotional overinvolvement (EOI) were rated as showing high-EE attitudes toward the patient. All other relatives were designated as showing low-EE attitudes.

In most cases, EE data were available from more than one relative of the same patient. According to the operational guidelines for rating EE (Vaughn & Leff, 1976), a household is defined as high-EE if one or more relatives receives a high-EE rating and is defined as low-EE only if all relatives receive a low-EE rating. In line with these guidelines, data from only one relative was randomly selected for the analyses in households in which two or more family members had identical EE ratings (either all high-EE or all low-EE). In instances where two or more relatives had identical high-EE ratings (two high-EE/critical relatives or two EOI relatives), and one or more relatives had low-EE ratings, data from one high-EE relative was randomly selected for the analyses, and data from low-EE relatives were systematically dropped. A few households had one or more high-EE relatives based on critical comments and one or more EOI relatives. In these instances a high-EE-critical relative was randomly selected and the data from relatives with EOI ratings were systematically dropped from the analyses. This was done because, in most studies, criticism has been found to be a better predictor of relapse than has EOI (Kavanagh, 1992).

Based on the criteria outlined above, the present study included data from 11 relatives rated as having low-EE attitudes and 15 rated as having high-EE attitudes. Of the high-EE relatives, 5 received this rating because six or more critical comments, 1 for hostility, and 9 for emotional overinvolvement. Reliability ratings for EE using the CFI were adequate (kappa = .68).

RESULTS

Competency/Adherence Ratings

As indicated by mean competence ratings shown in Table 2, therapists had very good overall adherence to the Miklowitz (1989) BFM Manual. Greatest competence and adherence to the treatment model fell in the areas of education ($M = 6.12$) and rapport ($M = 6.05$). In other words, therapists were judged to have "very good" competency/adherence in imparting relevant information about bipolar disorder, and were rated as "very good" in interacting with patients in a warm and

empathic manner. Therapists also had very high ratings ($M = 5.92$) in their overall command of the session. That is, clinicians tended to be skillful in directing the sessions and maintaining the focus on topics related to BFM.

Table 2
Mean Adherence/Competency Ratings[a] and Level of Family Difficulty[b]

Variable	Mean	SD
Education	.73	
6.12		
Communication Training		
Instructions	5.77	1.18
Role-play	5.39	1.13
Feedback	5.46	1.30
Problem Solving	5.08	1.44
General Skills		
Rapport	6.05	.75
Efficiency	5.76	.71
Prob. Specification	5.89	.64
Homework	4.15	1.14
Session command	5.92	.70
Therapists overall	5.87	.65
Therapist Cooperation	5.88	.70
Fam. Difficulty Level	2.44	1.17

[a] BFM rating scale: 0 = not applicable; 1 = very poor; 2 = poor; 3 = fair; 4 = competent; 5 = good; 6 = very good; 7 = excellent.
[b] Family difficulty rating scale: 1 = always cooperative; 3 = generally cooperative; 5 = moderately difficult; 7 = extremely difficult.

Competency and adherence to BFM was rated lowest in assigning homework to families. The mean score of 4.15 reflects an overall rating that therapists were generally "competent" in assigning homework to families. However, this moderate-range rating suggests that therapists occasionally failed to give assignments when appropriate and/or did not fully explain their relevance to the treatment goals.

As indicated in Table 2, clinicians were judged to be competent and/or have "good" adherence for all of the remaining items in the domains of general skills, communication training, and problem solving. Thus, clinicians in the Lithium and Family Management of Bipolar Disorder project appear to follow BFM closely, as prescribed by Miklowitz's (1989) treatment manual.

Family Difficulty

To assess whether BFM-TCAS raters were actually able to rate therapist adherence/competency independently of their own rating of family difficulty, Pearson correlation coefficients were computed between the family difficulty item and the 12 items of the BFM-TCAS. The family difficulty rating was negatively correlated with the session command rating. That is, the more difficult that the family was rated to work with, the less in control clinicians were rated to be of the sessions ($r = -.51$, $p < .01$). Family difficulty was uncorrelated with all other areas assessed by the BFM-TCAS ($p > .05$ for all).

Expressed Emotion

A series of *t*-tests were conducted to assess the relationship of EE and therapist competency/adherence to the BFM-TCAS items. Analyses were first run combining critical-hostile and EOI relatives as one "high-EE" group and comparing them to low-EE families. A Bonferoni t' (correcting for the number of analyses performed) revealed that therapists working with high-EE families ($M = 4.87$, $SD = .76$) were rated as significantly more adherent to the BFM instructions for assigning homework than were therapists working with low-EE families ($M = 3.43$; $SD = 1.02$), $t(18) = -3.57$, $p < .05$.[1] Results did not indicate a significant association between EE and therapist competency/adherence to any other area of BFM ($p > .05$ for all).

It is conceivable that therapists' ability to adhere to the BFM model might vary depending on the subtype of high-EE relatives with whom they are interacting. For example, relatives who were rated as high-EE because they expressed critical and hostile feelings toward the patient may be more difficult to engage in treatment than relatives rated as high-EE because

they expressed excessive amounts of concern or worry about the patient (EOI). To assess this possibility, a series of one-way analyses of variance (ANOVAS) were conducted in which relatives rated as high-EE due to EOI and relatives rated as high-EE due to criticism-hostility were evaluated separately. ANOVAS with three levels of EE (low, critical-hostile, and EOI) yielded essentially the same results as the earlier *t*-tests in which relatives rated as EOI and relatives rated as critical-hostile were combined to form one high-EE group.In other words, in these analyses, EE level again predicted therapists' ability to adhere to the manual in assigning homework, $F(1, 17) = 6.03$, $p < .01$. Results of a Newman-Keuls post hoc comparison indicated that therapists more frequently and/or competently assigned homework to high-EE/EOI ($M = 4.89$, $SD = .69$) and high-EE/critical-hostile ($M = 4.83$, $SD = .96$) families as compared to low-EE families ($M = 3.43$; $SD = 1.02$). A Dunnet's post hoc test revealed no mean differences in the therapist competency for assigning homework to high-EE critical and high-EOI families, $t_d (8) = -.11$, $p > .05$. EE did not predict competency/adherence to BFM for any other area assessed by the BFM-TCAS ($p > .05$ for all).

DISCUSSION

Overall, the results of the present study are very encouraging. Clinicians in the Lithium and Family Management of Bipolar Disorder project appear to follow the BFM treatment manual closely. With respect to the three core components of BFM, therapists' performance ratings were highest for the education segment of treatment. That is, clinicians appear to be particularly skillful in imparting factual information about bipolar disorder to families, and in helping them to recognize important signs and symptoms that might indicate a manic or depressive relapse. Clinicians also have good overall competency/adherence in the communication and problem-solving phases of treatment. In other words, clinicians effectively use techniques such as role-playing and modeling to help enhance familial communication. Similarly, clinicians appear to follow closely the treatment manual in teaching families specific strategies to solve family problems, such as brainstorming, evaluation of ideas, and selection and implementation of solutions.

Results of this study also suggest that clinicians in this project are quite competent in general areas such as establishing rapport with families, using session time efficiently, and recognizing salient issues to be addressed in treatment. Adequate ratings regarding the use of homework assignments were somewhat lower. Ratings in this area suggest that, on occasion, clinicians failed to give homework when it clearly could have been useful, and/or insufficiently emphasized the importance of the assignments. It is widely believed, though the issue is somewhat controversial, that the success of behavioral family therapy hinges on families incorporating more efficient communication and problem-solving skills into their everyday lives (Falloon, LaPorta, Fadden, & Graham-Hole, 1993). It is sometimes challenging to get patients to comply with assignments since homework is often viewed unfavorably by patients (much as it is by pupils in school). However, by increasing the frequency and quality of homework assignments, clinicians in this project (and elsewhere) may better enable families to generalize skills learned in sessions to the home context. Of course, as outcome data becomes available, it will also be necessary to assess whether homework is an essential ingredient in the effectiveness of BFM.

Results of this study indicate that, with the exception of perceived overall command of the session, BFM-TCAS raters were able to assess therapists' competency/adherence to BFM independently of their assessment of how difficult the family was to work with. That is, therapists' performance ratings on the core components of BFM and on most of the general skills were not biased by working with especially resistant clients and families, nor were the ratings enhanced by working with cooperative ones. This is important in that the BFM-TCAS was designed to focus on therapist factors rather than onfamily variables. Thus, overall, raters appeared capable of following the BFM-TCAS guidelines to rate clinicians' competency/adherence independently of family difficulty.

We did find, however, that ratings of session command were negatively correlated with level of family difficulty, as assessed by the BFM-TCAS rater. In other words, the more difficult that families were rated to work with (for example, resistant, incapable of understanding the point of the BFM exercises), the less in charge of the session and less active the clinicians were rated.[2] In a limited way, this finding supports Foley et al.'s (1987) observation that greater client difficulty predicts lower therapist performance ratings by independent observers.[3] It is unclear whether therapists in the present study actually were more passive, less focused, and less competent in working with difficult clients (perhaps due to increased stress, frustration, and so on). An alternative possibility is that the difficulty of working with resistant families was such that any clinician, regardless of experience or clinical skill, would have been prevented from maintaining the direction and control over the sessions that is prescribed in the BFM treatment manual. The latter explanation raises the possibility that the BFM-TCAS guidelines, as presently written, are insufficient to insure that raters take level of family difficulty into account when evaluating clinicians' skill in commanding the BFM sessions. This issue warrants further investigation.

Similar to the results presented above for family difficulty, adherence/competency ratings were also relatively unaffected by level of family expressed emotion. Counter to our hypothesis, therapists working with critical, hostile, or emotionally overinvolved family members (high-EE) did not receive lower ratings on most of the BFM-TCAS items than did therapists working with low-EE families. There was one interesting exception, however. We did find that clinicians working with families with one or more high-EE members, tended to give more effective and more frequent homework assignments than

did clinicians working with low-EE families. It is possible that the therapists assigned at-home practice of BFM techniques—such as reflective listening, expressing positive feelings, and constructive problem solving of family issues—more frequently to high-EE families in order to modify critical, hostile, and emotionally intrusive attitudes. Previous researchers have found high-EE attitudes to predict poorer course of illness for mentally ill patients (Kavanagh, 1992). Given that low-EE families are likely to talk to one another in a low-key manner already, therapists may be less inclined to feel the need to assign at-home exercises to alter their emotional attitudes.

One limitation of the present study is that competency and adherence were not rated as separate dimensions of skill, despite the fact that they reflect somewhat different concepts. Adherence has been defined as the extent to which therapists use interventions and approaches prescribed or encouraged by a treatment, while competency reflects the level of skill and judgment shown by clinicians in delivering the therapy (Waltz et al., 1993). In the present study BFM-TCAS ratings were based on combined judgments regarding clinicians' overall fidelity to the techniques and strategies outlined in the BFM manual, as well as on their level of skill in carrying out specific and nonspecific aspects of the treatment. It is conceivable, ofcourse, that therapists sometimes might be adherent without being particularly competent, or vice versa. For example, an experienced therapist who occasionally just "chats" in session because she or he believes this is necessary to maintain a therapeutic alliance for some clients, may be showing good judgment and competence, yet poor adherence to BFM. Rating competency and adherence as separate dimensions in future studies would allow us to assess more precisely clinicians' specific strengths and areas of weakness.

A second potential limitation of this study is that we used clinicians' case notes to select the first session in which each of the three core segments of BFM occurred. Thus, by design of this study, we rated therapist competency and adherence for the sessions in which they had documented actually having engaged in BFM. It is important to point out that, had sessions been randomly selected, it is possible that competency and adherence ratings would be considerably lower. Rating all sessions or random sessions in future studies could help clarify this issue.

Another important area to investigate in future research is the relationship of competency and adherence in conducting BFM to patient outcome at the end of treatment.[4] We would expect that increasing therapist skill and adherence to the treatment manual would be associated with fewer relapses and a better course of illness for bipolar patients. It will also be important for future investigations to examine which specific clinical skills and aspects of BFM (for example, rapport, communication training) are most effective in helping bipolar patients recover and remain clinically stable. As discussed above, rating the dimensions of competency and adherence separately would allow us to evaluate this issue further. It would be important to know, for instance, whether the patients of competent (directive and caring) therapists who also adhere to the three core components of BFM recover above and beyond those whose therapists are merely competent yet stray from the specific guidelines of the BFM manual. Results of such a study could help strengthen treatment programs by emphasizing techniques and skills found to be most effective in working with bipolar families, and eliminating those that have little or no clinical utility.

CONCLUSIONS

The results of this study are promising. Clinicians in the Lithium and Family Management of Bipolar Disorder study (Goldstein et al., 1996) appear to be skillful and to adhere closely to the techniques and exercises prescribed by BFM. Having a manual with detailed instructions to follow likely contributed to the high performance ratings observed for therapists in that project, which further supports the use of treatment manuals in any structured therapy program. Results of the present study also suggest that, to a large degree, it is possible for researchers to evaluate a therapist's skill without being unduly influenced by family factors like EE, and client difficulty. It is important to establish that therapist evaluations can be separated from client characteristics in evaluating therapy programs, otherwise skill ratings become little more than a description of the therapeutic relationship or a reflection of how far clients have progressed in treatment. We do not intend to imply that therapists are not influenced by client characteristics because this is clearly not the case. However, results of the present study suggest that it is possible to evaluate therapists—based on how well they attempt to follow a treatment protocol—independently of the outcome of these attempts, that is, whether or not clients successfully engage in the exercises, improve skills, and so forth.

REFERENCES

1. American Psychiatric Association, (1987) *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington DC: Author.
2. Falloon, I. R.H., Boyd, J. L. and McGill, C. W., (1984) *Family care of schizophrenia: A problem-solving approach to the treatment of mental illness.* New York: Guilford Press.
3. Falloon, I. R.H., Laporta, M., Fadden, G. and Graham-Hole, V., (1993) *Managing stress in families: Cognitive*

and behavioral strategies for enhancing coping skills. New York: Routledge.
4. Foley, S. H., O'Malley, S., Rounsaville, B.J., Prussoff, B.A. and Weissman, M.M., (1987) The relationship of patient difficulty to therapist performance in interpersonal psychotherapy of depression. *Journal of Affective Disorders, 12*, 207-217.
5. Goldstein, M. J. and Miklowitz, D.J., (1994) Family intervention for persons with bipolar disorder (pp. 23-35). In A.B. Hatfield (ed.), *Family interventions in mental illness.* San Francisco: Jossey-Bass.
6. Goldstein, M. J., Rea, M. and Miklowitz, D.J., (1996) Family factors related to the course and outcome of bipolar disorder (pp. 193-203). In C. Mundt, M.J. Goldstein, & K. Hahlweg (eds.), *Interpersonal factors in affective disorders.* London: Royal College of Psychiatrists Book Series.
7. Harpin, R. E., McGill, C.W. and Falloon, I.R.H., (1983) *Therapist competency rating scale for behavioral family therapy.* Unpublished manuscript.
8. Hooley, J. M. and Teasdale, J.D., (1989) Predictors of relapse in unipolar depressives: Expressed emotion, marital distress, and perceived criticism. *Journal of Abnormal Psychology, 98,* 229-235.
9. Kavanagh, D. J., (1992) Recent developments in expressed emotion and schizophrenia. *British Journal of Psychiatry, 160,* 601-620.
10. Miklowitz, D. J., (1989) *Manual for behavioral family management with bipolar patients.* Unpublished manuscript.
11. Miklowitz, D. J., (1990) *Additional items: Therapist competency scale.* Unpublished manuscript.
12. Miklowitz, D. J., Goldstein, M.J., Nuechterlein, K.H., Snyder, K.S. and Doane, J.A., (1986) Expressed emotion, affective style, lithium compliance, and relapse in recent onset mania. *Psychopharmacology Bulletin, 22,* 628-632.
13. Mueser, K. T. and Glynn, S.M., (1995) *Behavioral family therapy for psychiatric disorders.* Boston: Allyn and Bacon.
14. Spitzer, R. L., Williams, J.B.W., Gibbon, M. and First, M.B., (1990) *User's guide for the structured clinical interview for DSM-III-R (SCID).* Washington DC: American Psychiatric Press.
15. Startup, M. and Shapiro, D. A., (1993) Therapist treatment fidelity in prescriptive vs. exploratory psychotherapy. *British Journal of Clinical Psychology, 32,* 443-456.
16. Vallis, T. M., Shaw, B.F. and Dobson, K.S., (1986) The cognitive therapy scale: Psychometric properties. *Journal of Consulting and Clinical Psychology, 54,* 381-385.
17. Vaughn, C. E. and Leff, J.P., (1976) The measurement of expressed emotion in the families of psychiatric patients. *British Journal of Social and Clinical Psychology, 15,* 157-165.
18. Waltz, J., Addis, M. E., Koerner, K. and Jacobson, N. S., (1993) Testing the integrity of a psychotherapy protocol: Assessment of adherence and competence. *Journal of Consulting and Clinical Psychology, 61,* 620-630.
19. Wing, J. K., Cooper, J.E. and Sartorius, N., (1974) *The description and classification of psychiatric symptoms: An instructional manual for the use of the PSE and the CATEGO system.* Cambridge, England: Cambridge University Press.

Manuscript received June 2, 1997; Revisions submitted June 2, 1997; Accepted October 22, 1997.

APPENDIX

BFM Therapist Competency/Adherence Scale

Instructions: Assess the skill of the therapy team on each item and record the rating on the scoring sheet. Take into account the difficulty and cognitive capacity of the family. That is, therapists should *not* be penalized if the family has difficulty grasping a task or is resistant to carrying out an exercise, provided that the task has been competently explained. Anchor points are described for odd-numbered scale points. Use even numbers for skill levels falling between two anchor points. Use 0 for items that are (appropriately) not applied in the session being assessed (e.g., education during a communication training session). However, a rating should be lowered by a minimum of one scale point if a technique prescribed by BFM, which would likely enhance the therapy, is overlooked.

0	1	2	3	4	5	6	7
Not Applicable	Very Poor	Poor	Fair	Competent	Good	Very Good	Excellent

EDUCATION

1. Therapists convey incorrect factual information or use outdated or stereotyped explanations that perpetuate misconceptions and may cause therapeutic harm.

3. Explanations contain some major inaccuracies, though more than 50% of content is accurate. Material communicated in a dry, technical way that does not hold the interests of the family members.

5. Explanations generally correct though there may be one or two significant deletions or inaccuracies. Communicated in lay language with opportunity for questions throughout as well as frequent checks for understanding. Some inappropriate use of technical terms and/or occasions where lay concepts are not checked for understanding.

7. Explanations completely accurate with no significant deletions or inaccuracies. Communicated in lay language with any technical terms checked for understanding. Questions actively solicited throughout.

Communication Training

1. Instructions convey little information about what the clients are to do. Instructions are global and vague without specification of behaviors to be carried out.

3. Instructions convey some specific behaviors to be carried out but are sometimes vague, incomplete, overly complicated, or expressed in a demanding manner.

5. Instructions convey what to do but are not specific enough or request too many behaviors to practice at one time.

7. Instructions stipulate exactly and clearly what behaviors to practice. Clients are requested to practice only behaviors they possess the ability to perform.

B. Role-Play:

1. Little skill at directing role-plays. Role-plays too long. Role-plays are not stopped when bad habits are being practiced. Minimal coaching employed or poorly performed. Therapists do not use modeling when appropriate, or modeling is poorly demonstrated.

3. Some skill at directing role-plays. Therapists occasionally interrupt when bad habits are practiced. Coaching lacks specificity. Modeling used but instructions regarding behaviors to be observed for learning purposes somewhat unclear or behaviors to be modeled inadequately demonstrated.

5. Therapists competently direct role-plays. Role-plays almost always stopped when bad habits are practiced. Adequate coaching for the most part. Modeling reasonably well demonstrated.

7. Role-plays optimally directed. Skillful coaching throughout. Optimal modeling of behaviors.

C. Giving and Soliciting Feedback:

1. Little skill at giving or soliciting feedback (e.g., too much or too little given). Negative feedback given first and predominates. Little attention to what was done competently.

3. Some skill at giving and soliciting feedback. Some positive feedback but negative feedback predominates. Feedback has behavioral elements but is generally rather global and vague.

5. Satisfactory skill at giving and soliciting feedback. Positive feedback predominates though the atmosphere may be somewhat critical.

7. Skillful at giving and soliciting feedback. Quantity and quality of feedback maximally enhances learning. Positive feedback and rewarding atmosphere clearly predominate.

PROBLEM SOLVING

1. Training wholly inconsistent with this approach. Therapists do not employ any specific behavioral strategies for coping with management problems when appropriate.

3. Therapists employ specific behavioral strategies but inefficiently (e.g., confusing instructions, overly direct the session, generate and choose many solutions, make plans without maximizing family involvement).

5. Training essentially consistent with approach. Therapists employ specific behavioral strategies reasonably efficiently. Occasional errors in technique or content. Therapists allow family to identify problems, generate and choose solutions, plan implementation, review, etc.

7. Training wholly consistent with approach. Therapists optimally employ specific behavioral strategies. Treatment team facilitates patient and family problem identification, and encourage all family members to generate and choose solutions and plan and review in a manner that maximizes learning as well as independence from therapists.

GENERAL SKILLS

A. Rapport and Therapeutic Alliance-Building Skills:

1. Therapists lack rapport-building skills. Disrespectful or negative toward clients. Act in a therapeutically harmful manner.

3. Abrupt, cool, or disingenuous with clients. Appear disinterested (e.g., fail to make eye contact).

5. A reasonable level of empathy and genuineness displayed throughout.

7. A polished ability to convey empathy, warmth, and genuineness.

B. Pacing and Efficient Use of Time:

1. Session seems aimless. Therapists make no attempt to structure therapy time.

3. Session has some direction. Significant problems structuring and pacing (e.g., too little structure, inflexible about structure, too slowly paced, too rapidly paced).

5. Reasonably efficient structuring. Appropriate control over flow of discussion and pacing. At times therapists let the family go on too long, or may occasionally interrupt, or inappropriately cut off family members' discussions.

7. Very efficient structuring. Tactful limiting of peripheral and unproductive discussion. Pacing of session is optimal.

C. Problem Specification:

1. Therapists fail to identify any functionally relevant problems or goals during session.

3. Identify some functionally relevant goals but miss other important goals or problems.

5. Identify all functionally relevant goals or problems. Problems adequately defined but lack some clarity.

7. Identify all functionally relevant problems/goals very efficiently. Problems clearly defined.

D. Homework:

1. Homework is not given (with no apparent reason for the omission), is described in a confusing manner, or is given in an offhanded manner.

3. Homework is given (or followed up), but therapists do not convey the importance of the assignment or treatment; or, it is not clear whether the family understood the assignment.

5. Homework described satisfactorily but there may be some doubt that the family has fully understood the assignment. Therapists adequately stress importance of homework and convey expectation of compliance.

7. Homework assignments optimally identified and described. Therapists request that clients repeat assignments. The relevance and importance of assignments are clear and/or are emphasized by the therapists.

[**Note**: Ratings should take into account any discussion pertaining to assignments from previous sessions. However, ratings should not be lowered for failing to follow up on assignments. This is because an assignment may or may not have been given during the previous appointment, and competency and adherence are to be based primarily on what occurs during the session presently being evaluated.]

E. Session Command:

1. Therapists are extremely passive. The family is in almost total control of the session, and "runs over" the therapists (e.g., family interrupts the therapists and therapists make no attempt to restructure the discussion).

3. Therapists are moderately directive. The family seems to lead most of the discussion but therapists make some attempt to follow a stated agenda.

5. Therapists are generally directive and follow their agenda, but the plan occasionally "gets lost" over the course of the session due to derailment by the family.

7. Therapists are directive and follow their own plan for the session. While they may respond to issues raised by the family that may or may not be relevant, they always bring the session back on task.

F. Overall Rating of Therapy Team:

1. Therapists did a very poor job overall. Their approach was inconsistent with BFM. They were rude to clients and/or

appeared disinterested in the treatment. You definitely would *not* select this treatment team if you were doing an outcome treatment study in BFM.

3. The therapists did a fair job overall. The session appeared to lack some direction and the BFM skills used were employed fairly. General skills, such as pacing and therapeutic alliance building, were somewhat lacking.

5. The therapists did a reasonably good job overall. No glaring errors in employing BFM or in other general areas, but skills somewhat less than polished. You would probably select this treatment team if you were conducting an outcome treatment study in BFM.

7. Therapists displayed excellent BFM and general skills. You would definitely select this treatment team if you were doing an outcome treatment study on BFM.

THERAPIST COOPERATION AND INTERACTION

1. Therapists do not work well together. They argue openly and frequently and appear to have separate agendas.

3. Therapists undermine and/or contradict one another at times, but do not blatantly argue. They sometimes appear to have different agendas.

5. Therapists work reasonably well together. They may occasionally disagree, but they resolve conflicts quickly. Their overall goals for the session appear to be similar.

7. Therapists work extremely well together. They appear to have similar aims for the session. They interact in a cooperative and complementary fashion.

LEVEL OF FAMILY DIFFICULTY

1. The family is very cooperative and not difficult. Assignments are done on time. Role-plays are undertaken with relative ease. Family has little or no difficulty learning the skills. Family listens and tries to incorporate didactic material.

3. The family is generally cooperative. May voice occasional complaints about exercises but always goes along with suggested tasks. Some derailment of the therapists' attempts to present didacticmaterial. May have some difficulty understanding or learning new skills.

5. The family is moderately difficult and/or uncooperative. Needs a great deal of urging to carry out exercises. Irrelevant issues are frequently raised. Discussions are often derailed by family members. Family often disagrees with the validity of the educational material or the rationales offered. The family may have considerable difficulty grasping the skills. However, they eventually "get" and go along with the suggested tasks, even if reluctantly.

7. The family is extremely difficult and/or uncooperative. They refuse to engage in exercises and/or constantly question their utility. Members are easily distracted by external stimuli and are disruptive during the session (e.g., may leave the room; constantly derail the discussion). Family is not a "partner" with the therapists. Family members may altogether ignore the therapists or may constantly question their competence.

[1]Six cases had missing data for this analysis because of family sessions that were not conducive to giving homework (for example, completing a phase of treatment at the end of the session; family going on vacation between sessions).

[2]Of course, there is also the possibility that when therapists lost control of the session, the raters rated the family as more difficult, rather than vice versa.

[3]The independent observers were supervisors in the Foley et al. study.

[4]It is still too early to assess outcome for patients in the Lithium and Family Management of Bipolar Disorder study because not all of them have fully completed their participation in the project.