

Regular article

## Assessing fidelity in individual and family therapy for adolescent substance abuse

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### Abstract

This study introduces an observational measure of fidelity in evidence-based practices for adolescent substance abuse treatment. The Therapist Behavior Rating Scale—Competence (TBRS-C) measures adherence and competence in individual cognitive-behavioral therapy and multidimensional family therapy for adolescent substance abuse. The TBRS-C assesses fidelity to the core therapeutic goals of each approach and also contains global ratings of therapist competence. Study participants were 136 clinically referred adolescents and their families observed in 437 treatment sessions. The TBRS-C demonstrated strong interrater reliability for goal-specific ratings of treatment adherence, and modest reliability for goal-specific and global ratings of therapist competence, evidence of construct validity, and discriminant validity with an observational measure of therapeutic alliance. The utility of the TBRS-C for evaluating treatment fidelity in field settings is discussed. © 2008 Elsevier Inc. All rights reserved.

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### 1. Introduction

Evaluating the feasibility and effectiveness of research-developed treatments for substance use disorders in usual care settings has become a national health care priority (Institute of Medicine, 2006). Substance abuse treatment programs are facing increased stakeholder demands for adherence to empirically based practice guidelines (Hayes,

Barlow, & Nelson-Gray, 1999), and many programs describe their efforts to implement evidence-based practices as a cornerstone of quality care (e.g., Henderson et al., 2007; Mark et al., 2006). In addition, emerging research indicates that strong fidelity is critical for successful transportation of research-based protocols (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997; Henggeler, Pickrel, & Brondino, 1999). Reliable, brief, and cost-efficient evaluation tools are therefore needed to assess fidelity to multicomponent treatments that stand ready for dissemination to clinical settings (Carroll et al., 2000; Garland, Hurlburt, & Hawley, 2006).

There has been a recent surge in the number of empirically supported treatments for adolescent substance

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abuse (for reviews, see Muck et al., 2001; Williams, Chang, & Addiction Centre Adolescent Research Group, 2000). However, only a handful of fidelity instruments have been developed to measure the implementation of evidence-based practices with adolescent drug users (e.g., Henggeler et al., 1999; Hogue et al., 1998), and these assess treatment adherence but not therapist competence. Treatment adherence generally refers to the quantity or extent of specific treatment techniques used in session, whereas therapist competence refers to the quality or skill with which interventions are delivered (Waltz, Addis, Koerner, & Jacobson, 1993). Elements of therapist competence include knowledge of client issues, appropriateness and timing of interventions, and degree of responsiveness to client in-session behaviors (Stiles, Honos-Webb, & Surko, 1998). This study introduces a measure of therapist competence for adolescent drug treatments that incorporates these important elements.

Competence ratings are typically based on observer reports, inasmuch as therapist reports of their own clinical proficiency do not match observer accounts (Levin, Owen, Stinchfield, Rabinowitz, & Pace, 1999; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004) and clients do not have sufficient expertise to judge treatment quality per se. In research studies with adult clinical populations, two methods have been commonly used to measure competence. In the global rating method, a single item (“How competent was the therapist in this session?”) or a few interrelated items (e.g., therapist skill, empathy, and nonverbal behavior; Carroll, Connors, et al., 1998) are used to rate the observed portion of treatment. Advantages of this method include high face validity and relative ease in training judges; drawbacks include a lack of specificity in describing components of the particular model being assessed. In the discrete technique method, multiple intervention techniques considered to be signature therapeutic ingredients of a particular model are rated separately. In discrete technique fidelity scales, two separate ratings are given for each technique: a “quantity” score to capture adherence and a “quality” score to capture competence. Fidelity studies of adults with depression (Barber, Crits-Christoph, & Luborsky, 1996; Shaw et al., 1999) and substance use disorders (Barber, Foltz, Crits-Christoph, & Chittams, 2004; Carroll et al., 2000) have used this method. Advantages include the ability to discriminate adherence from competence and the high degree of specificity in assessing model components.

There are two limitations to using either the global rating method or the discrete technique method for measuring competence. First, these approaches do not closely approximate the theory-driven processes of case formulation and treatment planning that guide clinical practice, training, and supervision. Case formulation and treatment planning tend to revolve around molar therapeutic goals that embody the model’s underlying principles of change and provide structure in clinical decision making for each client (Kazdin,

1999; Stiles et al., 1998). Therapeutic goals themselves comprise multiple integrated intervention techniques that extend across several sessions (Diamond & Diamond, 2002). Therapeutic goals are the clinical blueprint of a treatment model, whereas discrete techniques are the clinical tools. Second, global and discrete measures tend to focus on the behavior of the therapist. In clinical practice, however, competence is largely determined by the therapist’s ability to adapt continually to developments in clients’ lives as they occur in and out of session, while still adhering to the specified clinical framework (Stiles et al., 1998). Therapist responsiveness to client behaviors in time-referral problems, interpersonal manner, amenability to intervention efforts, and so forth is central to competent model delivery (Waltz et al., 1993).

To address these two limitations in competence assessment, we developed the Therapist Behavior Rating Scale—Competence (TBRSC), an observational measure of adherence and competence in individual and family-based therapy for adolescent substance abuse. The TBRSC focuses on molar therapeutic goals, rather than on specific techniques, and includes both goal-specific and global ratings of therapist competence. The TBRSC also contains separate global ratings of therapist skill, responsiveness, and overall competence.

The TBRSC was initially developed as a discrete technique adherence scale to assess fidelity in the same randomized trial of individual cognitive-behavioral therapy (CBT) versus multidimensional family therapy (MDFT) from which this study sample was drawn. Hogue et al. (1998) used the original TBRSC to confirm basic treatment adherence and differentiation in the trial: CBT focused on antecedents and consequences of drug use and behavioral skills building, whereas MDFT focused on family interactions and systemic interventions. The current study expands upon Hogue et al. in two important ways. First, it examines fidelity to the core therapeutic goals of each model (five in CBT, four in MDFT) in lieu of 26 discrete techniques contained in the original TBRSC. The molar therapeutic goals contained in the TBRSC each comprise multiple discrete treatment techniques, including all those in the original TBRSC and others. Second, this study includes a multidimensional assessment of therapist competence in addition to treatment adherence.

The primary aim of this study was to examine the interrater reliability, construct validity, and discriminant validity of the TBRSC in measuring adherence and competence in CBT and MDFT for adolescent substance abuse. This study is among the first to assess competence and adherence in evidence-based treatments for adolescent drug problems. Because specific clinical expertise is needed to make valid assessments of competence in model delivery (Waltz et al., 1993), separate coding groups were recruited for each treatment condition (as in Barber et al., 2004): CBT-knowledgeable judges rated CBT sessions, and family-therapy-knowledgeable judges rated MDFT sessions. Interrater reliability and variance components (therapist, client,

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