

STUDY NAME _____
 ID NO. _____ SITE _____ THERAPIST(S) _____
 TREATMENT: _____ SESSION No. _____ DATE _____
 FAMILY MEMBERS PRESENT (circle): M F PT Sib 1 Sib 2 Other
 RATED BY _____ DATE _____

THERAPIST COMPETENCY AND ADHERENCE SCALE, REVISED (TCAS)

Rate all of the following items. If the content did not occur, rate a 0. Reference the rating guidelines at the end of this document.

1. PHASE: This was a session of:

- ___ Psychoeducation (1)
 ___ Communication Enhancement Training (2)
 ___ Problem-solving (3)
 ___ Crisis intervention (4)

2. EDUCATION	0	1	2	3	4	5	6	7
3. COMMUNICATION TRAINING	0	1	2	3	4	5	6	7
4. ROLE-PLAY	0	1	2	3	4	5	6	7
5. GIVING/SOLICITING FEEDBACK	0	1	2	3	4	5	6	7
6. PROBLEM-SOLVING	0	1	2	3	4	5	6	7
7. PROBLEM SPECIFICATION	0	1	2	3	4	5	6	7

GENERAL SKILLS (Rate all of the following; 0 is not an option):

8. RAPPORT/ALLIANCE	1	2	3	4	5	6	7
9. PACING/EFFIC. USE	1	2	3	4	5	6	7
10. HOMEWORK	1	2	3	4	5	6	7
11. SESSION COMMAND	1	2	3	4	5	6	7
12. OVERALL RATING	1	2	3	4	5	6	7

LEVEL OF FAMILY DIFFICULTY (1= easy, 2 = moderately difficult, 3 = difficult):

	family. Therapist explains skills that will be taught during FFT treatment and format and expectations of the program. Therapist makes connections between individual goals that have been articulated and skills taught during FFT sessions that may support achievement of those goals. Throughout the session, therapist engages family members in the discussions, answers questions, and tries to generate interest in the treatment.				
Content Item	Examples	Occurred ? Y/N	1 (not acceptable)	2 (suboptimal)	3 (optimal)
2. Discussion of symptoms of the prodrome	Therapist presents information about relevant symptoms clearly and accurately, and elicits examples from patient and family about their experiences with, perceptions of and/or reactions to symptoms. Therapist is able to keep the process moving along so that they touch upon a broad range of symptoms. Emotional reactions are acknowledged, but therapist does not allow them to completely overwhelm the agenda.				
3. Introduction of the vulnerability-stress model	Therapist presents model clearly and accurately and asks a variety of family members what they think about the model, and whether the goals of reducing stress and fortifying coping skills in order to keep symptoms manageable makes sense to them.				
4. Identifying and evaluating stress	Therapist provides information about a variety of sources of stress. Therapist helps family members to identify stress in their own lives, and creates a written record of individual's stressors to use in later sessions. Therapist helps family members to identify their own reactions to stress and to fill out their own stress thermometers.				
5. Medications and adherence	Therapist discusses importance of adherence in an informational way; discusses ways to improve consistency (if relevant). May address the following as needed: reasons for nonadherence; the patient's and relatives beliefs, attitudes toward, and feelings about medications in general and specific medications in the regimen; addresses conflicts and disagreements about medications. Therapist encourages patient and family to form a real working relationship with the psychiatrist and to discuss their concerns with him/her.				
6. Regulating sleep	Helps patient develop adaptive, regulated daily and nightly routines				
7. Behavioral activation or pleasant event	Therapist explains rationale for this by making some connection between patient's or family's problems and lack of				

scheduling	pleasant events or patient's goals and the need to increase participation in pleasant events. Therapist engages family members in the process by having them take turns reading 10 events on the list while everyone circles events they would consider adding to their lives. Therapist helps family members to generate specific plans for engaging in some of the events they have identified.				
8. Prevention action plan	Therapist explains the prevention action plan to the family clearly and helps the patient to develop a plan involving a summary of stress triggers, early warning signs, and preventative actions. The therapist tries to engage family members in generating ideas about preventative actions, although the focus is on the patient's plan..				
9. Crisis Management	Therapist handles a crisis (such as suicide assessment, child abuse assessment, assessment of need for hospitalization, etc.) calmly and professionally. Therapist addresses crises primarily through advice-giving, giving examples of other persons in similar situations; serves as a conduit to other treatment providers; takes authoritative stance				
	STYLE AND ORIENTATION	Little or None	Suboptimal	Optimal	
10. Hopefulness and Enthusiasm	Communicates positive attitude toward the future; communicates genuine belief that if patient and family members work at skill implementation, the patient will have a better symptom course and quality of life; conveys enthusiasm for session content, clearly not "going through the motions"				
11. Didactic focus	Therapist takes a teaching stance; authoritative, agenda-focused. The clinician may need to do a lot of teaching in a session to catch up, but the family may make it difficult to do this; nonetheless, rate "absent" if the clinician is not doing any teaching				
12. Socratic focus	Therapist tries to individualize psychoeducational material wherever possible; elicits examples from various family members to personalize didactic material; adjusts material to the presenting problems; communicates that "patient is expert"				
13. Addresses emotional reactions	Spends time validating patients' or family members' affective reactions to the educational materials or skill-training tasks; discusses resistances and ambivalences				

	PROSCRIBED INTERVENTIONS (rate as present versus absent in the given session)			
		Absent	Present	
14. Psychodynamic Interpretation	Therapist interprets individual behavior in terms of past familial relationships, or connects the family members' feelings about the therapist to feelings about past figures, with no apparent behavioral plan to address the individual behavior			
15. Unfocused exploration	Therapist spends a significant amount of time exploring feelings of individuals in family without any clear focus or connection to psychoeducation, communication training or problem-solving. <i>The family may be driving the lack of focus and the therapist may be finding a way to get back to the agenda; take these factors into consideration</i>			
16. Individual orientation	The orientation of the therapist is clearly focused on individual dynamics and little attempt is made to explore bidirectional relationships or interactions			
17. Cognitive restructuring	Therapist breaks from agenda to introduce cognitive restructuring in the form of structured thought records and homework assignments focused on cognition tracking and rehearsal of new cognitions			

FFT Items _____
 EC items _____

Frequently asked questions:

To what extent are we rating whether the manualized treatment was delivered in step by step fashion? For example, if the manual says that in session 2 “x” will be covered and the therapist doesn’t cover “x” do you rate the therapist lower? Alternatively, do you just rate on adherence to that topic (or module) of treatment, no matter what session the therapist is on?

Generally, we do not rate therapists lower if the session content is out of sequence. There may be good reasons why the clinician chose to introduce education later and communication training earlier (e.g., the patient had a worsening of symptoms and many of the early sessions involved treatment planning regarding the worsening). If the clinician is still covering education in session 8, or the family is covering communication or problem solving in session 2, it is likely that the treatment has gone off course. Nonetheless, rate the adherence and competence of the sessions even if the content is out of order. In such cases it will probably be useful to go back to earlier sessions and rate them according to adherence with the manual. It may be that early sessions will be rated lower than later sessions. If the clinician actually mentions why he or she has strayed from the agenda (e.g., we spent the first five sessions dealing with the fact that he was cutting school), then factor in these reasons into your rating.

Is there a helpful guide to separate out competence as a therapist from adherence to the manual?

Adherence is “sticking to the manual.” Competence is “doing it with skill, within the context of the treatment manual.” The initial items on page 1 about education and skill training are about adherence to the manual, whereas the items that cover skills like pacing or efficient use of time, or ability to convey empathy really reflect competence. Competence should only be rated high if the therapist is generally adhering to the manual. That is, if he or she is doing good therapy, but is not at all doing FFT, then “General skills” should be rated lower.

Competence is generally rated lower if the therapist is way off protocol. For example, if s/he is doing very competent psychodynamic therapy, the rating for competence with FFT would be lower, since FFT is a more active, directive, and psychoeducational approach.

For the content and skill checklist: If an item could have been addressed but wasn’t, what score do you give it? What if the therapist says during the session (or during supervision) that the item didn’t need to be addressed in the family?

Simply rate a ‘No.’ The clinician may have had good reasons for not addressing a certain topic. It is very difficult for an observer who is only rating a subset of sessions to make a judgment that X or Y issue should have been addressed; the clinician may have addressed these issues in an earlier session.

APPENDIX (From Weisman et al., 1998)**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. There are items for assessing family difficulty.

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).

0	1	2	3	4	5	6	7
NA	Very Poor	Poor	Fair	Competent	Good	Very Good	Excellent

1. PHASE OF TREATMENT (self-explanatory)**2. EDUCATION**

Consider the following: (a) clarity and accuracy of delivery; (b) interactive manner allowing for questions; (c) addresses emotional reactions to the didactic material but doesn't allow these reactions to overwhelm and sidetrack the session; (d) helping patient and family to put the information into practice and develop a plan. NOTE: Most FFT sessions contain some psychoeducation. So, it is very rare for this item to be rated a 0. However, you can use 0 if introducing psychoeducational material would have been inappropriate given the other content in the session.

Rating criteria:

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. It is not made clear what the material has to do with them.
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. The material is "personalized" but not to the extent that it could be.
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. The family is clear on how the didactic material is relevant to them.

3. Communication Training

0. This was not a communication training session.

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. Clinician does not do any active skill training but instead talks about communication in the abstract (e.g., "it's good to listen to each other").

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 the participants are being asked to do but could be explained with more specificity. Therapist may 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.

4. Role-Play:

0. This was not a communication training session.

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, although the clinician neglects to have the participants rehearse the skill a second or third time. Modeling reasonably well demonstrated.

7. Role-plays optimally directed. Skillful coaching throughout. Optimal modeling of behaviors, with rehearsal of skills in same scenarios.

5. Giving and Soliciting Feedback:

0. This was not a communication training session.

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.

6. PROBLEM SOLVING

0. This was not a problem-solving session.
1. Training wholly inconsistent with this approach. Therapists do not employ any specific behavioral strategies for coping with problems when appropriate.
3. Therapists attempt to employ problem-solving strategies but do so inefficiently (e.g., instructions are confusing, therapist is overly directive, too many solutions are chosen without plans for implementation, family members are not adequately involved in this process).
5. Training essentially consistent with problem-solving approach. Therapists employ specific behavioral strategies reasonably efficiently. Occasional errors in technique or content. Therapists help family to identify problems, generate and choose solutions, and plan implementation, but the process ends before adequate resolution is reached.
7. Training wholly consistent with approach. Therapists optimally employ specific behavioral strategies. Therapist 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 therapist.

7. PROBLEM SPECIFICATION

Problem specification refers to the clinicians efforts to define a joint focus; identify goals; and define problems. It need not be a problem-solving session for the clinician to have defined areas of focus. Look for examples of statements such as “So, you’d like to think through how to manage your finances as a family,” or “you want to make sure we address his going off his medications.”

1. Therapists fail to identify any functionally relevant problems or goals during session.
3. The therapist identifies some functionally relevant problems or goals, but these are poorly defined or overly broad (e.g., “you want to improve your communication”).
5. Therapist focuses on a subset of key problems and facilitates the process of defining these problems from each person’s perspective. Problem definitions lack some clarity.
7. Therapist focuses on a subset of key problems and facilitates the process of defining these problems from each person’s perspective. Problems are clearly defined, even if no solutions or agreements are reached. The process of problem definition is efficient and succinct.

GENERAL SKILLS

8. 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.

9. 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.

Point(s) are subtracted for:

- Therapist digressing with examples from own life or self disclosures that drag on too long
- Therapist allowing self to get drawn into details of medications and turning session into a psychiatry session w/out appropriately redirected patient to talk with psychiatrist and returning to psycho-educational material within a reasonable amount of time.

10. 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. Although homework was assigned in the prior session, it is not discussed.

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. Therapist does not check to see if the family has understood the assignment.

7. Homework assignments optimally identified and described. Therapists request that clients repeat assignments or say them in their own words. 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, keep in mind that 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.]

11. 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.

12. Overall Rating of Therapist:

1. Therapist did a very poor job overall. Their approach was inconsistent with FFT. 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 FFT.
3. The therapist did a fair job overall. The session appeared to lack some direction and the FFT skills used were employed fairly. General skills, such as pacing and therapeutic alliance building, were somewhat lacking.
5. The therapist did a reasonably good job overall. No glaring errors in employing FFT 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 FFT.
7. Therapist displayed excellent FFT and general skills. You would definitely select this treatment team if you were doing an outcome treatment study on FFT.

LEVEL OF FAMILY DIFFICULTY

The three items in this subscale ask the rater to evaluate whether the family was difficult to treat because of high levels of criticism and conflict (13), resistance by the patient (14), or resistance from family members (15).

1. Family is cooperative. Role-plays are undertaken with relative ease. Family has little or no difficulty learning the skills. Family listens and tries to incorporate didactic material. The patient appears to be trying hard, even if s/he does not always appreciate what is being suggested. The family members do not fight or attack each other, and generally do not derail the skill training or educational process. There is a sense of a "partnership" between therapist, patient, and family. Therapist does not have to work hard to stick with the agenda.
2. The family is moderately difficult and/or occasionally uncooperative. Voices complaints about exercises (e.g., "this will never work at home" or "this is pointless"). 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. The patient may appear annoyed by the session, but goes along with tasks reluctantly. Discussions may be derailed from time to time by verbal attacks and counter-attacks, criticisms, or other disruptive behavior. Therapist has to work hard to keep to the agenda.

3. The family or patient 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). Members openly attack each other verbally, criticize each other frequently, swear, or hurl insults. Family is not a "partner" with the therapists. Family members may altogether ignore the therapist or question his or her competence. Patient is highly resistant and uncooperative. The therapist cannot develop a shared agenda despite good efforts.