

Therapists' Attitudes about and Preferences to Use Relationship Focused Interventions: New Tools to Measure a Critical Component of Functional Analytic Psychotherapy (FAP)

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Abstract

The primary study aims were to create reliable measures of therapists' attitudes about and preferences to use Relationship Focused Interventions (RFIs), and investigate factors that influence them. Explicit and implicit measures of therapists' attitudes and preferences were administered to a national sample of mental health trainees and FAP practitioners. The measures demonstrated acceptable reliability (α 's < .70). FAP practitioners reported more positive explicit and implicit attitudes about RFIs than trainees ($p < .05$). Client diagnosis did not appear to influence practitioners' preferences to use RFIs ($p > .05$). Therapist training may affect preferences to use RFIs.

Keywords

Functional Analytic Psychotherapy, Therapeutic Relationship, Measures to Assess Therapeutic Relationship, Implicit Measurement of Therapy Processes

The role of the therapeutic relationship is emphasized as an important factor across several therapies, including newer contextual behavioral therapies such as Functional Analytic Psychotherapy (FAP). FAP exclusively focuses on the use of the therapeutic relationship as a primary mechanism of therapeutic change. FAP requires that therapists assess for and consequate in-session behaviors that are characteristic of the client's presenting problems and approximations of behaviors related to their treatment goals. The focus on in-session behavior and the use of behavioral techniques to consequate in-session behaviors is termed in-vivo (Kohlenberg & Tsai, 1991). In-vivo interventions, briefly defined as the use of moment-to-moment therapy interactions (Kanter et al., 2009), are believed to be potent therapeutic interventions because they enable therapeutic change to occur more rapidly or enhance the effectiveness of non-FAP related techniques (e.g., cognitive disputation) (Baruch et al., 2009; Robert J. Kohlenberg, personal communication, March 27, 2007). Currently, there are no published measures of the factors (e.g., beliefs about in-vivo interventions, attitudes about in-vivo interventions) that may promote or inhibit therapists' use of this important class of interventions. The current study was a first step toward improving our understanding of the factors related to therapists' use of in-vivo interventions.

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For the purposes of the paper, the term Relationship Focused Interventions (RFIs) will be used in place of in-vivo interventions. The term relationship-focused intervention better captures the role of the therapeutic relationship in FAP. Also, in-vivo interventions are not unique to FAP and practitioners from other therapies may be more amenable to the term Relationship Focused Interventions. Thus, it may help facilitate research on RFIs by practitioners from other theoretical orientations or therapy approaches.

Relationship Focused Interventions use the "live" moment-to-moment interactions between the client and the therapist (Kanter et al., 2009). Maximal behavior change occurs when a reinforcer is delivered close in time and location to the behavior's occurrence; thus, maximal therapeutic change is thought to occur when behaviors are consequated close in time and location to the behavior's occurrence (i.e., in-session behaviors; R. J. Kohlenberg, personal communication, March 27, 2007; cf. Baruch et al., 2009 for a detailed examination of the empirical literature on basic behavioral principles underlying FAP). Basic behavioral research supports the idea that relationship focused processes are powerful behavior change strategies and many therapies promote the use of these processes (e.g., Beck, Rush, Shaw, & Emery, 1979).

Several empirical studies suggest that RFIs are unique to interpersonally-focused therapies and that their addition may improve outcomes. A study of cognitive therapy for depression showed that the occurrence of RFIs was rare (Bolling, Parker, & Kohlenberg, 2000). This result was replicated in a second study that found that the use of RFIs in both behavioral activation and cognitive therapy was rare (Kanter et al., 2009). A third study (Kohlenberg, Kanter, Bolling, Parker, & Tsai, 2002) suggested

that the addition of RFIs to therapies that do not typically incorporate them might increase their efficacy. In this study, incorporating RFIs into typical cognitive therapy was related to increased satisfaction with social support and increased improvements in outside relationships. Research from Goldfried and colleagues (Goldfried, Castonguay, Hayes, Drozd, & Shapiro, 1997; Goldfried, Raue, & Castonguay, 1998; Wiser & Goldfried, 1998) also supports the idea that RFIs can improve therapy outcomes. In a study of expert psychodynamic therapists and cognitive-behavioral therapists, sessions that were identified as having an in-session impact on the client and that resulted in client change were found to have more in-session focus than lower clinically significant sessions (Goldfried, Raue, & Castonguay, 1998).

Currently, there are no published measures of the factors (e.g., beliefs about RFIs, attitudes about RFIs) that may promote or inhibit therapists' use of this important class of interventions. However, in order to study this area, reliable and valid measures of therapist preferences are needed. The current study represents a first step towards understanding the factors related to therapists' use of Relationship Focused Interventions.

The main focus of this study is the use of both explicit and implicit measurement strategies to examine attitudes about and preferences toward Relationship Focused Interventions. The primary difference between explicit and implicit measures is that explicit measures rely on experiences available to introspection, while implicit experiences, generally, do not. As implicit measurement appears to be less vulnerable to self-presentation biases, we elected to create and use an implicit measure of RFIs because we believed that practitioners may be prone to present more favorable attitudes about RFIs or that it may be difficult for practitioners to reflect on their own preferences for these interventions.

We elected to use the Implicit Association Test (IAT), a method that has substantial support for its use as a reliable and valid method of assessing implicit experiences (Greenwald, Poehlman, Uhlmann, & Banaji, 2009; Lane, Banaji, Nosek, & Greenwald, 2007). The IAT assesses implicit attitudes via asking participants to sort stimuli representative of a concept or attribute and is based on the idea that the sorting task should be easier when the two concepts that are sorted similarly are strongly associated than when they are weakly associated (Nosek et al.). The IAT generally has moderate to high split-half internal consistency, high test-retest reliability, and good convergent, discriminant, and predictive validity (Nosek et al., 2007). Furthermore, the reliability of the IAT appears to be higher than other implicit measures designed to assess the same construct (Nosek et al., 2007). Research also suggests that it is quite difficult to fake (Kim, 2003; Steffens, 2004) and that the IAT may be a better predictor of behavior related to socially sensitive attitudes than of behaviors related to attitudes that are not as socially sensitive.

THE CURRENT STUDY

The study had three aims. The first aim was to create measures of therapist's RFIs preferences (defined as approaching or avoiding RFIs opportunities). The second aim was to explore how FAP training affects participants' responses on RFIs measures. The final aim of the study was to examine whether therapists'

preferences about RFIs were affected by the diagnostic label of the client (Major Depression vs. Cocaine Dependence).

In designing the study, we predicted that mental health care trainees would self-report positive attitudes about RFIs, but would display an implicit bias against RFIs. We also predicted that FAP practitioners would report both explicit and implicit preferences for RFIs. We also examined the effect of client diagnosis on preference for RFIs. Research has shown that practitioners tend to hold more negative attitudes about substance use than depression (Angermeyer & Dietrich, 2006; Corrigan et al., 2000). Therapists' negative attitudes about substance use may impact the therapist's preferences about RFIs in that therapists may be less willing to invest their emotional resources for clients they view negatively. Therefore, we predicted that practitioners who received a client description with the diagnosis of Cocaine Dependence would display a stronger bias against RFIs than practitioners who received a client description that involved a diagnosis of Major Depression.

METHODS

PARTICIPANTS

National Sample of Mental Health Care Trainees (MHTs; n = 144). This national sample of mental health care trainees (MHTs) were individuals enrolled in advanced training programs (Masters, Ph.D., and Psy.D. programs) in clinical psychology, counseling psychology, and social work, as well as interns at sites in clinical psychology, social work, and psychiatry.

Mental Health Practitioners with specialized training in RFIs (termed FAP community members, n = 49). FAP community members were researchers, therapists, and graduate students who either identified their primary focus of research/therapy as FAP, or who had received training in FAP.

MEASURES

Demographics. The demographics questionnaire included questions focused on participants' therapy practice (e.g., caseload, theoretical orientation) and basic identifying information.

Preference for using Relationship Focused Interventions (RFIs) IAT. This measure was created for the study to measure a therapist's preference to use RFIs. The RFIs IAT is very similar to the IAT in its structure, but differs in that the participants are sorting stimuli about therapeutic situations rather than race, gender, or political affiliation. A second difference between the RFIs IAT and IATs that assess socially constructed attitudes (e.g., race) is that the RFIs IAT includes the use of a storyboard (the storyboard is described below) in which the stimuli used in the IAT were introduced prior to the IAT measure.

RFIs Storyboard. The first screen of the storyboard task included: 1.) a brief description of the task; 2.) a request that the participants imagine themselves as the therapists of the fictional clients they were about to read about; 3.) a statement that the pictures in the storyboard would be used in later tasks and were designed to help them remember the client statement associated with the picture; 4.) the diagnosis of the clients. Based on the participant's randomization, he/she read a description of the client that varied only in the diagnosis of the client: Major De-

pression, Cocaine Dependence, or no Axis I diagnosis (control condition).

The participants were then presented a picture of Caucasian female client (gender and race were held constant to reduce their effects as confounds) with a statement made by the client directly under the picture (see Figure 1 in appendix). The client's name (the names of the clients were "Client X" or "Client Y") was displayed above the picture. Eight pictures (4 pictures per client) with their associated client statements were shown to the participants.

The eight client pictures were taken from Ekman's Japanese and Caucasian Facial Expression of Emotions (JACFEE; Matsumoto & Ekman, 1988). All pictures in the JACFEE set have undergone empirical testing to ensure the validity and reliability of the emotions being displayed in each picture (Matsumoto & Ekman, 1988). Based on the content of the four statements pictures displaying sadness, anger, and happiness were selected. To minimize the influence of factors such as the women's attractiveness we pre-tested the pictures of the Caucasian women in the JACFEE set. Pictures without any identified concerns about their use were used in the RFIs storyboard and subsequently, as the stimuli in the RFIs IAT.

Eight statements were created for the study (1 statement per picture) and were pre-tested for their clarity and face validity. Four of the statements discussed an important person in the client's life who was *not* the therapist (termed daily life statements). Client Y always offered daily life statements. The other four statements were identical to the statements about the important person, but were about the *therapist* (termed relationship-focused statements). Client X always offered relationship-focused statements (see Figure 1 in the appendix for a storyboard that was used in the study)¹. The pictures, through their associations with the statements, were believed to be representative of daily life or relationship-focused opportunities.

Relationship-Focused Interventions (RFIs) IAT. After viewing the storyboard, participants completed the RFIs IAT. The RFIs IAT was designed to assess implicit preferences to approach RFIs relative to avoiding RFIs. The pictures from the RFIs storyboard were used as the target stimuli and synonyms for approach or avoid were used as the attribute stimuli (see Ostafin, Marlatt, & Grenwald, 2008 for another study with the same approach/avoid stimuli; see Figures 2 and 3 in the appendix for the stimuli used in the RFIs IAT and for a schematic of the RFIs IAT procedure). The target categories of "Client X" (the name of the client representing RFIs opportunities) and "Client Y" (the name of the client representing daily life opportunities), as well as the terms "approach" and "avoid," were displayed in the appropriate upper corners of the screen throughout all of the tasks. Participants were required to correct errors to continue with the task (the response latency was recorded throughout the error correction process).

The structure and procedure of the RFIs IAT is similar to other seven block IATs (e.g., Teachman, Wilson, & Komarovskaya, 2006). The IAT is a response time task that requires participants to categorize stimuli that belong to the category (i.e., Client X,

Client Y) or attribute (i.e., approach, avoid). In the RFIs IAT, participants were required to sort pictures of the clients from the RFIs storyboard. Additionally, participants sorted terms belonging to each of the attribute categories (i.e., approach or avoid; see Figure 3 in the appendix for a schematic of the RFIs IAT). The critical portions of the IAT are the trials where the attributes and concepts are assigned to the same key (i.e., combined trials). The differences between the response latencies of the combined trials comprise the IAT effect, a measure of relative strength of associations of categories with attributes. Positive scores on the RFIs IAT indicated preferences to use RFIs relative to avoid RFIs. Negative scores on the RFIs IAT indicated preferences to avoid RFIs relative to approach RFIs. Analyses indicated the RFIs IAT had acceptable internal consistency ($\alpha = .71$ for the practice block and $\alpha = .77$ for the test blocks) and were within the range of reliability estimates found in IATs of other implicit experiences (Nosek et al., 2007).

Therapeutic Relationship Measure (TRM). The TRM was created specifically for the study to assess explicit attitudes and beliefs about RFIs. Participants were asked to rate their level of agreement with using the therapy relationship as a therapeutic technique on a Likert scale from -7 (very negative feelings/strongly disagree) to +7 (very positive feelings about/strongly agree) (0 represented a neutral attitude or neither agree/disagree). Based on the analyses of the reliability of the TRM one item (a question about the ethics of RFIs) was removed because it did not correlate with the other items on the measure and the removal of the item substantially improved the reliability of the measure. The internal consistency of the measure was good ($\alpha = 0.90$). The final version of the TRM consisted of 6 items (scored -7 to +7), resulting in a range of total possible scores of -42 to +42 with negative scores indicating increasingly negative attitudes and beliefs about RFIs and positive scores indicating increasingly positive attitudes and beliefs about RFIs.

Explicit RFIs Thermometers. Thermometer measures are typically used in IAT research to assess explicit attitudes. Thermometers were created for the study to assess explicit attitudes and preferences about RFIs interventions. The scales on both thermometers range from -3 (very coldly/not at all likely to use the therapeutic relationship) to +3 (very warmly/very likely to use the therapeutic relationship) with 0 as the mid-point (neither cold nor warm/neither unlikely nor likely to use the therapeutic relationship). Two RFIs Thermometers were created: 1.) the RFIs Warm/Cold Intervention Thermometer, designed to measure explicit ratings of warmth or coolness toward RFIs; 2.) the RFIs Approach/Avoid Thermometer designed to measure how likely an individual is to use the therapeutic relationship (RFIs) as a therapy technique. Positive scores on the thermometers indicate positive feelings or preferences to approach RFIs. Negative scores on these measures were representative of negative feelings or preferences to avoid RFIs.

PROCEDURE

Participants for the Mental Health Trainees sample (MHT) were recruited via postings on student listservs of professional organizations. Directors of Clinical Training and Graduate Program Coordinators from training programs and internships in psychology, psychiatry, and social work and colleagues of the

¹ The assignment of the woman to Client X and the woman to Client Y was counterbalanced. The presentation order of Client X (RFI opportunities) of Client Y (daily life opportunities) was also counterbalanced.

researchers were also emailed to solicit participation of eligible participants. FAP community members were recruited through the FAP listserv and through contacts with professional colleagues. All individuals who participated in the study were eligible to enter a drawing to win one of four \$50.00 gift certificates.

All study assessments and documents were located on a website programmed using Web Inquisit (Inquisit 3.0.3.1.0). After reviewing the description of the study and the procedure for entering the drawing for the gift certificate, participants completed the measures described above and other measures from a study on stigmatizing attitudes about mental illness. The presentation order of the study measures and tasks were counterbalanced.

IAT Effect (the D Measure). The D measure is the preferred algorithm to calculate the IAT effect, a measure of the relative strength of associations of the concepts with attributes (Greenwald et al., 2003). In this study a positive D score on the RFIs IAT indicated a greater preference to approach RFIs opportunities relative to avoiding RFIs opportunities.

DATA ANALYSIS

Hypothesis Testing. Hierarchical (sequential) regressions and Pearson product-moment correlations were conducted to examine the hypotheses of the study. For all hierarchical regressions, group membership (MHTs vs. FAP community members) was entered first. The order of entry for the remaining predictor variables was determined by theoretical considerations. The regression model that produced the best fit of the data is reported.

RESULTS

EXCLUSION OF SUBJECTS

A total of 164 MHTs and 56 FAP community members completed the study. Based on recommendations from previous IAT researchers (Greenwald et al., 2003; Nosek et al., 2007), individuals with IAT data that contained an error rate of greater than 35%, those whose data included extremely long latencies (greater than 3,000 ms), and those with 10% or more of their latencies faster than 300 ms were omitted from the study. Twenty-seven participants were excluded (20 were MHTs, 7 were FAP community members) due to incomplete data (defined as 20% or more of data missing across study measures), or because their data were duplicated and recorded multiple times, or because IAT performance did not meet the criteria outlined above.

DEMOGRAPHICS

Demographics: National Sample of Mental Health Care Trainees (MHTs) ($n = 144$). The mean age in the MHT sample was 29.6 years ($SD = 6.0$, range 19 - 57). Approximately 80% (81.3%) of the sample identified as female and 18.7% as male. The sample was predominately Caucasian (87.5%) with other races and ethnicities identified by less than 5% of the sample. Most (52.8%) reported a highest level of education as a Master's Degree, with 45.1% reporting a Bachelor's Degree, and 2.1% reporting a Doctorate Degree. Over half of the participants in this sample identified their theoretical orientation as Cognitive-Behavioral followed by eclectic/integrative. The average caseload of the participants was 12 ($SD = 18.7$, range 1 - 200). Approximately half of MHTs

endorsed knowing a friend or family member suffering from depression (43.8%) or a substance use disorder (41.0%).

Demographics: FAP Community Members ($n = 49$). Due to concerns about the possibility of identifying a FAP community member based on their age, categorical response options for age were used (e.g., age 20 - 25). The most frequently occurring age group in the sample was 26 - 30 years old (32.7%) followed by 50 years or older (22.4%). Approximately 65% of FAP members identified as female and 35% identified as male. Caucasian was the most frequently identified race/ethnicity by FAP participants (84.0%) with other race/ethnicities identified by less than 6% of the sample. FAP community members tended to be well-educated with 49.0% having a Doctorate's degree, 42.9% with a Master's Degree, and 2.0% with a Medical Degree. Of the FAP participants who were currently in graduate school, the majority were in their 4th year of graduate school or beyond (34.7%). The theoretical orientation identified by a majority of the sample was behavioral (57.1%) with cognitive-behavioral the second most frequently endorsed theoretical orientation (20.4%). The mean caseload for FAP participants was 18.2 ($SD = 30.6$, range 1 - 200). A substantial portion of participants reported having a friend or family member suffering from depression (57.1%) or substance use (34.7%).

In regards to training in FAP, unfortunately 43.1% of the sample did not provide a response to this specific question. Of the participants who responded 17.5% stated that they had received training in FAP for less than 1 year, 14.0% stated that they had been practicing/learning FAP for 5 - 10 years, and 9.2% stated that they had between 3-5 years of training. Less than 10% of the sample responded that they had received 2-3 years or had over 10 years of training. The sample varied widely in number of years practicing FAP with 38.6% stating they have been practicing for over 3 years and 12.3% stating they have been practicing for less than 1 year.

EXPLICIT ATTITUDES ABOUT AND PREFERENCES TO USE RFIS

On average, mental health care trainees endorsed very positive attitudes and beliefs about RFIs. The mean score on the TRM for the mental health care trainee sample was 28.55 ($SD = 9.95$) with a range of 2.00 to 42.00. Overall, FAP community members endorsed extremely positive attitudes and beliefs about RFIs. The mean score on the TRM for the FAP community member sample was 37.28 ($SD = 5.32$) and mean scores ranged from 21.00 to 42.00.

RFIs Thermometers. On average, FAP community members had higher scores on RFIs Warm Cold thermometer ($M = 2.84$, $SD = 0.37$) than MHTs ($M = 1.67$, $SD = 1.16$). Similar to the means on the RFIs Warm Cold Thermometer, the mean of the FAP sample on the RFIs Approach Avoid Thermometer ($M = 2.52$, $SD = 0.51$) was higher than the mean of the MHT sample ($M = 1.61$, $SD = 0.99$).

IDENTIFICATION OF POTENTIAL PREDICTOR VARIABLES

No demographic variables (e.g., race, gender) had a significant impact on the study measures (all p 's > .05). Variables related to participants' training, theoretical orientation, caseload, and current treatment of a client with depression or substance use disorder had significant effects on study measures, although the

Table 1. Correlations Between Variables Relating to Explicit Attitudes about Relationship Focused Interventions ($n=193$).

Measure	1	2	3	4	5	6
1. Therapeutic Relationship Measure	—	-.377**	-.330**	.642**	.728**	-.163
2. Group membership (MHT vs. FAP)		—	.196	-.444**	-.397**	.008
3. Theoretical orientation (CBT vs. Other)			—	-.128	-.179	.002
4. Warm Cold Thermometer				—	.710**	-.177
5. Approach –Avoid Thermometer					—	-.142
6. RFIs IAT D Score						—

n 's for many of these demographic questions were not sufficient to conduct the appropriate inferential statistical tests (i.e., n 's < 30; the exception was the theoretical orientation variable in which there was sufficient n to conduct the analyses).

Mental Health Trainees. Results with MHTs were contrary to our expectation. The mean score on the TRM (the explicit measure of attitudes about RFIs) for MHTs was $M = 28.58$, ($SD = 9.75$) with a range of 2.00 to 42.00 indicating positive attitudes about RFIs. The mean D score on the RFIs IAT (the implicit measure of preferences to use RFIs) for MHTs was also positive, $M = 0.10$ ($SD = 0.38$), indicating a preference to approach RFIs opportunities relative to avoid RFIs opportunities. The relationship between implicit and explicit attitudes about RFIs interventions in mental health care trainees was positive, but not significant, $r = .18$, $p = .08$. To facilitate comparison between the implicit and explicit measure, Cohen's d effect sizes were calculated using the difference between the mean on each measure and the score indicating "no preference" on each measure (a score of 0 on each measure). The effect size of the RFIs IAT was 0.28, a small effect (Cohen, 1988). The effect size of the explicit preference to use RFIs was 1.62, a large effect (Cohen).

Between group comparisons. Average scores on the TRM were significantly higher for FAP participants ($M=37.43$, $SD = 5.42$) compared to MHTs ($M = 28.58$, $SD = 9.75$), $t(155) = 5.69$, $p < .001$, $d = 1.12$. In addition to group membership, the influence of other potential predictor variables (identified by theory and review of the empirical literature on RFIs) on TRM scores was examined by conducting a hierarchical regression. After entering the group membership, potential predictor variables were entered in the following order: theoretical orientation², RFIs thermometer measures, and RFIs IAT D scores (see Table 1).

Group membership was a significant predictor of explicit attitudes about RFIs, $F(1, 73) = 12.07$, $p = .001$, $R^2 = .14$. The second step of the model (entry of the theoretical orientation variable into the regression model) resulted in a significant change in R^2 , $F(2, 72) = 9.58$, $p = .02$. Entry of the explicit RFIs thermometer measures (the third step of the regression model) resulted in a significant change in R^2 , $F(4, 70) = 26.62$, $p < .001$. The final step of the model (entry of the RFIs IAT D scores) did not result in a significant change in R^2 , $F(5, 69) = 21.19$, $p = 0.53$. Based on the results of the hierarchical regression, the third model that

included group membership, theoretical orientation, and the explicit RFIs thermometer measures was the best predictor of explicit attitudes about RFIs, $F(4, 70) = 26.62$, $p < 0.001$, $R^2 = 0.60$. These results suggest that explicit attitudes about RFIs interventions are likely to be influenced by group membership, an individual's theoretical orientation, and an individual's reported level of warmth towards RFIs (Warm Cold RFIs Thermometer) and their explicit preference to use RFIs (Approach Avoid RFIs Thermometer).

The difference between FAP ($D = 0.16$, $SD = 0.46$) and MHT ($D = 0.11$, $SD = 0.39$) groups on the implicit RFIs preference measure approached significance, $t(102) = -1.79$, $p = .08$. A hierarchical regression was conducted to examine if group membership (MHT vs. FAP) and other study variables (selected for theoretical reasons or based on the empirical literature on RFIs) significantly predicted RFIs IAT D scores (implicit RFIs preference). The potential predictors selected and the order they were entered into the model were: theoretical orientation, the explicit RFIs thermometer measures (entered simultaneously), and explicit attitudes about RFIs (TRM). The regression model predicted approximately 4% of the variance in RFIs IAT D scores and was not significant ($p = .53$).

Effect of patient diagnosis. An ANCOVA was conducted to examine the influence of client description (cocaine vs. other diagnoses) on RFIs IAT D scores while controlling for the effect of group membership (MHT vs. FAP). The covariate, group membership, did not significantly affect RFIs IAT D scores, $F(1, 104) = 0.16$, $p = .686$. Because group membership did not influence RFI IAT D scores, the groups were combined and an ANOVA was conducted to examine the influence of client description on RFIs IAT D scores. The ANOVA was not significant, $F(2, 104) = 1.78$, $p = .173$. A hierarchical regression was done to examine if other study variables (selected for theoretical reasons) predicted implicit preference to use RFIs. With the exception of the correlation between the explicit attitudes about RFIs (TRM) and RFIs IAT, correlations between the predictor variables and RFIs IAT D scores were not significant ($p > .05$). The regression models predicted less than 3% of the variance in RFIs IAT D scores and were not significant ($p = .20$). Based on these results, a client's diagnosis or a practitioner's theoretical orientation does not appear to influence a therapist's implicit preferences toward RFIs.

DISCUSSION

The study was a preliminary attempt to examine attitudes about and preferences to use an important technique in FAP, the Relationship Focused Intervention (RFIs). Additionally, we sought

² We selected theoretical orientation as a potential predictor variable because we believed that there may be differential emphasis on the use of the RFI dependent on an individual's theoretical orientation. Additionally, published research has revealed that practitioners trained in Cognitive Therapy for Depression or Behavioral Activation do not tend to use RFIs (Bolling et al., 2002; Kohlenberg et al., 2002; Kanter et al., 2009).

to examine how therapist and client factors might influence explicit and implicit attitudes and preferences to use RFIs. No published measures on RFIs attitudes or preferences could be located therefore one of the critical tasks of the study was to create reliable and viable measures of therapists' attitudes about and preferences to use RFIs. The measures created for the study, including the implicit measure (the RFIs IAT) appear to be reliable and viable, although further research on their reliability and validity are needed.

We believed that MHTs would display an implicit preference to avoid RFIs; however, both MHTs and FAP community members displayed implicit preferences to approach RFIs. Discrepancies between explicit and implicit preferences to approach RFIs were discovered, suggesting that implicit preferences may be less subject to self-presentation biases or an individual's awareness of his/her preferences. Specialized training in RFIs influenced individuals' explicit and implicit preferences to use RFIs, as well as their attitudes about RFIs. Individuals with specialized training in RFIs (i.e., FAP community members) had higher scores (indicating greater likelihood to use RFIs or more positive attitudes about RFIs) on implicit and explicit measures about RFIs. For practitioners interested in using RFIs and for practitioners interested in training other mental health professionals to use RFIs, results from this research indicate that training may influence practitioners' attitudes and preferences to use RFIs. Future studies should examine how the amount of training and types of trainings in RFIs affect explicit and implicit preferences and attitudes about RFIs. Additionally, within subject studies of how these preferences and attitudes change across time with training would be helpful in describing and understanding how training affects RFIs preferences and attitudes, and subsequently may lead to improvements in training practitioners to use RFIs.

In addition to specialized training in RFIs, theoretical orientation appeared to affect preference for RFIs. Practitioners identifying with a CBT orientation had significantly lower scores on the explicit measure of attitudes about RFIs than MHTs who endorsed a non-CBT orientation. This finding is consistent with results in published empirical studies about the low occurrence of RFIs in therapists trained in Cognitive Therapy and Behavioral Activation for Depression (Bolling et al., 2000; Kohlenberg et al., 2002; Kanter et al., 2009). The reason for this difference in preferences is uncertain. While training in CBT does not prohibit the use of RFIs, it may be that the lack of specialized training in RFIs prevents the development of positive attitudes and preferences to use of RFIs.

RELATIONSHIP OF CLIENT DIAGNOSIS AND PREFERENCES TO USE RFIS

To our surprise, a client's diagnosis of Cocaine Dependence did not influence practitioners' implicit or explicit preferences to use RFIs. We believed that practitioners' beliefs or attitudes about substance use would have influenced practitioners to avoid using therapeutic interventions that require interpersonal closeness on the part of the therapist. However, the results from the study suggest that a client diagnosis of a substance use disorder does not significantly impact practitioners' preferences to use RFIs. The results should be interpreted with caution because

of the small n of practitioners assigned to each of the conditions (Cocaine Condition $n = 29$; Major Depression $n = 37$; No Diagnosis $n = 38$).³ Because of the small n 's in each condition there may be insufficient power to detect small, but potentially important differences between the groups. Future research should further examine if client diagnosis or other client characteristics impact preferences toward and actual use of RFIs.

The discrepancy between self-reported preferences and implicit preferences to use RFIs is consistent with other studies of constructs that are subject to self-presentation biases or that may be difficult to introspect about (Greenwald, Poehlman, Uhlmann, & Banaji, 2009; Nosek et al., 2007). It is important to note that the discrepancy between explicit attitudes about/preferences for RFIs and implicit preferences to use RFIs was not just found in therapists without specialized training in RFIs. Results from this study suggest that therapists with specialized training in RFIs also display these discrepancies. One interpretation of these findings is that social desirability influences explicit attitudes/preferences for RFIs (i.e., practitioners report increased positive feelings about and likelihood to use RFIs), but is less likely to influence implicit preferences for RFIs. Another interpretation is that practitioners may have more difficulty accessing and reflecting upon their preferences to use RFIs. Because research on the IAT has shown that implicit and explicit measures of the same attitude differentially impact behavioral outcomes, future studies should examine which therapeutic outcomes are best predicted by explicit measures of RFIs and which outcomes are best predicted by implicit measures of RFIs.

LIMITATIONS AND FUTURE DIRECTIONS

An important limitation of the research was the small sample size of FAP practitioners and the MHTs assigned to the Cocaine Diagnosis condition of the RFIs IAT task. Future studies should attempt to replicate the findings of the current study by using a larger sample of practitioners. Some potential predictor variables (e.g., training in FAP, identification of a psychodynamic theoretical orientation) were not entered into the regression models because of insufficient sample size to warrant their inclusion in the models. It is also relevant to note that this study examined preferences to use RFIs rather than actual reported use of RFIs. It awaits further research to determine the extent to which preferences predict actual use of RFIs.

CONCLUSION

The study was an attempt to create reliable and viable measures of practitioners' attitudes about and preferences to use an important FAP technique, Relationship Focused Interventions (RFIs). Additionally, we attempted to examine the influence of therapist and client variables on practitioners' attitudes and preferences to use RFIs. Results from the study indicate that we were successful in creating reliable and usable measures. Furthermore, results suggest the importance of assessing both implicit and explicit attitudes and preferences. Finally, we showed that therapist training in RFIs may influence attitudes and preferences for RFIs. We hope that researchers interested in RFIs

³ We conducted several analyses to determine if there were any significant differences among the participants in the conditions and no significant differences on any of the study measures were discovered.

will continue to investigate the use of RFIs and the factors that influence therapists' use of RFIs.

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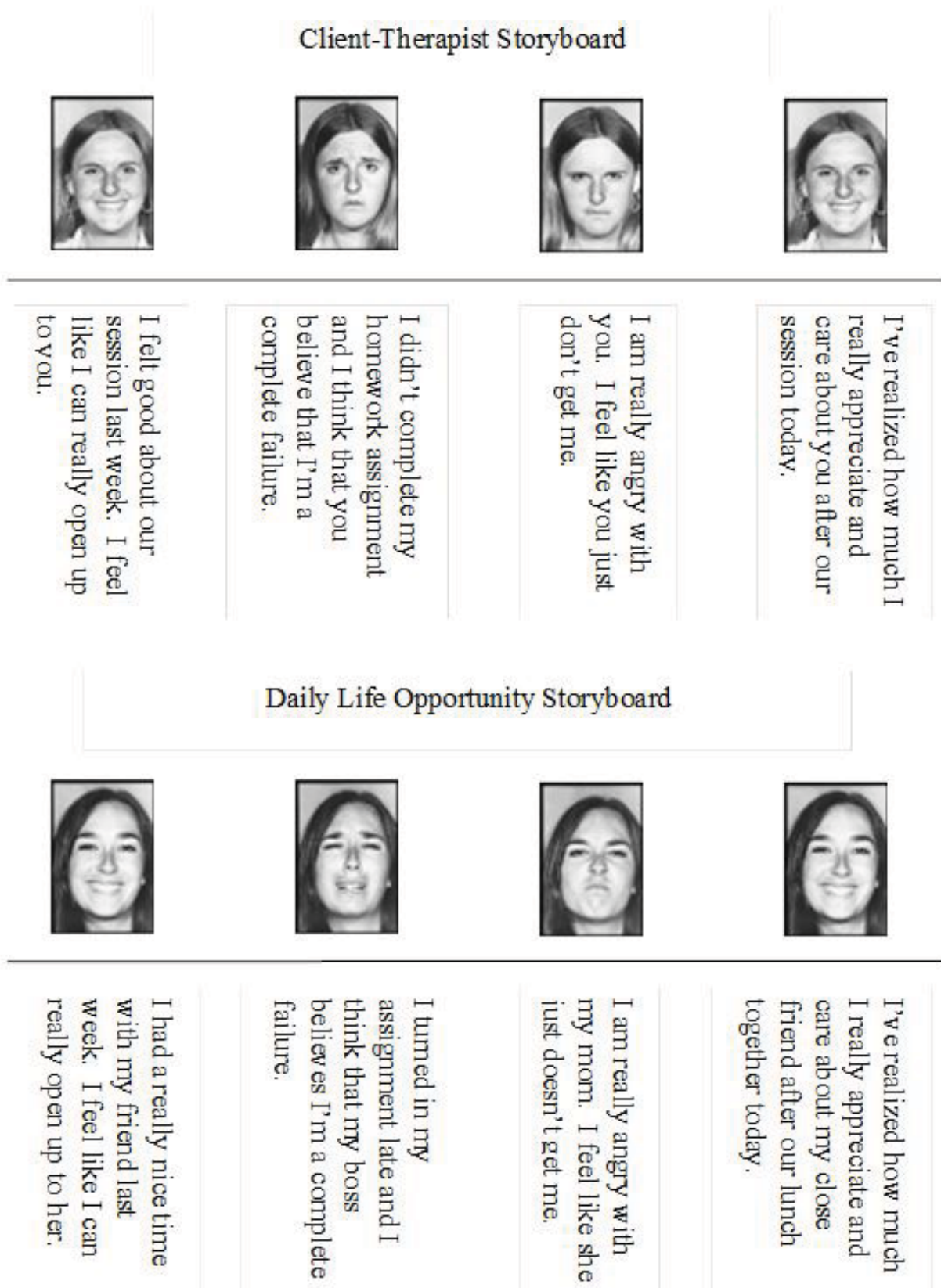
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■ APPENDIX



Note: Pictures taken from Ekman's Japanese and Caucasian Facial Expression of Emotions (JACFEE; Matsumoto & Ekman, 1988). Pictures published with permission.
 Figure 1. Example of Client-Therapist and Client-Important Other Storyboards.









CONCEPT CONTRASTS FOR IVI IAT

		Relationship Focused Statements versus Daily Life Statements		Avoid versus Approach	
Concepts		Client X (Relationship Focused Statements)	Client Y (Daily Life Statements)	Avoid ("E" key)	Approach ("I" key)
Items				Leave Away Withdraw Escape	Closer Advance Forward Toward

Note: Pictures were taken from Ekman's Japanese and Caucasian Facial Expression of Emotions (JACFEE; Matsumoto & Ekman, 1988). Pictures are published with permission.

Figure 2. Relationship-Focused Interventions (RFIs) Implicit Association Test (IAT) Concept Categories and Attributes.

SEQUENCE OF TASKS FOR RFIS IAT

Sequence	1	2	3	4	5
Task Description	<i>Initial target-concept discrimination</i>	<i>Associated attribute discrimination</i>	<i>Initial combined task</i>	<i>Reversed target-concept task</i>	<i>Reversed combined task</i>
Task Instructions	● Client X (Relationship Focused) Client Y (Daily Life) ●	● Avoid Approach ●	● Client X (Relationship Focused) ● Avoid Client Y (Daily Life) ● Approach ●	Client X ● (Relationship Focused) ● Client Y (Daily Life)	Client X ● (Relationship Focused) Approach ● ● Client Y (Daily Life) ● Avoid
Sample Stimuli	 ○ ○ 	○ Leave ○ Away Closer ○ Advance ○	 ○ Closer ○  ○ Leave ○	 ○  ○	 ○ Advance ○  ○ Away ○

Note: The table is based on the IAT figure published in Greenwald, McGhee, & Schwartz (1998). Categories for target-concept discriminations are assigned a right or left response, indicated by the black circles in the third row. These are combined in the third step and then recombined in the fifth step, after reversing response assignments (in the fourth step) for the target-concept discrimination. Correct responses are indicated as open circles.

Figure 3. Example of Client-Therapist and Client-Important Other Storyboards.