RUPTURE RESOLUTION QUESTIONNAIRE –
THERAPIST VERSION (RRQ-T)
Development of a Therapist-Rated Measure of Rupture Resolution

by

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ABSTRACT

The Rupture Resolution Questionnaire – Therapist Version

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The last several decades of psychotherapy research have consistently pointed to the therapeutic alliance as one of the most robust predictors of outcome. Some argue that the strength of the alliance is the variable most important to a successful treatment. A new generation of alliance research has begun to focus on more specific and often subtle psychotherapeutic processes thought to have strong implications for treatment success. Several researchers have begun to emphasize fluctuations in the alliance as important therapeutic events in need of further study. Initial research suggests that working through strains in the alliance has a positive effect on the strength of the alliance, thus promoting therapeutic change.

This study aims to examine the relationship between therapist resolution processes, particularly the presence of optimal therapist states thought to be conducive to resolution, and other measures of therapeutic process and outcome. This was assessed over the course of multiple 30-session psychotherapy treatments at the Brief Psychotherapy Research Project at Beth Israel Medical Center. Therapist resolution processes are measured by the Rupture Resolution Questionnaire – Therapist version (RRQ-T), developed and validated initially as a patient self-report inventory and later revised for use by therapists. This study expected to demonstrate the reliability of this scale, in addition to its concurrent and predictive validity in relation to several well-established process and outcome measures. Subjects included 49 patient-therapist dyads that completed a set of questionnaires after each therapy session and also at the time of intake and termination of treatment.

The RRQ-T was shown to be a highly reliable measure, with strong levels of internal consistency for the total scale and all but one subscale. Concurrent validity analyses also yielded largely significant results, suggesting that the presence of therapist resolution processes is strongly related to strength of the therapeutic alliance in addition to other measure of psychotherapy process. Predictive validity was not as firmly established and determined to be in need of further analysis. Overall, the RRQ-T was demonstrated to be a useful measure of psychotherapy process, and more specifically of the negotiation of the therapeutic relationship. It is hoped that it will prove to be a valuable tool in future investigations into this complex process.
DEDICATION

This dissertation is dedicated to the memory of my mother, Claire Hanning, for all of her support, encouragement, and love throughout the years. She had a special gift for resolving any troubles or issues that came our way in the most sensitive and admirable of ways, and I owe any talent that I possess in this domain to her, and so much more...
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Chapter I

Introduction and Literature Review

Psychotherapy research consistently demonstrates the robust nature of the therapeutic alliance as a predictor of outcome. Research over the past twenty years has worked to clarify the common factors involved in therapeutic change, and has established a stable and positive relationship between a strong alliance and good psychotherapy outcome. Given the importance of this construct, much of the relevant research has focused on developing tools to measure the alliance. These measures have worked to dramatically improve our understanding of the underlying dimensions of the alliance, and have also shed light on the relation of the alliance to other process and outcome variables.

More recently, research in this domain has begun to focus on fluctuations in the strength or quality of the alliance. Many researchers have demonstrated the importance of studying these alliance fluctuations, or ruptures, in order to better understand the process of therapeutic change (Bordin, 1994; Frieswyk, S. H., Allen, J. G., Colson, L., Gabbard, G. O., Horwitz, L., & Newsom, G., 1986; Safran, J. D., Crocker, P. McMain, S., & Murray, P., 1990). It has been argued that rupture events may capture patients' core issues and act as a window into maladaptive interpersonal schemas (Muran, 2002; Safran et al., 1990). It has been further stated that working through a rupture in the alliance leads to positive therapeutic change, and initial research findings are consistent with this claim.

The following review of the literature begins with a broad overview of the theoretical and empirical contributions pertaining to the construct of the therapeutic alliance. Measurement of the alliance and its established relationship with psychotherapy
outcome is discussed, as is the emergence of the alliance as a process variable. Particular
attention is given to the recent focus on fluctuations in the alliance as markers of
important therapy events. This review concludes with a summary of the existing
literature, a statement of purpose, and list of hypotheses specific to the current study.

This dissertation has as its aim the validation of a recently developed therapist-
rated self-report measure, the Rupture Resolution Questionnaire – Therapist version
(RRQ-T). This measure was originally developed by Winkelman, Safran, & Muran
(1996) to assess the constructive negotiation of conflict within the therapeutic
relationship from the patient perspective. A therapist-rated measure was recently
designed at Beth Israel’s Brief Psychotherapy Research Program and the purpose of this
study is to obtain initial findings concerning the measure’s reliability, concurrent, and
predictive validity.

Theory and Research on the Therapeutic Alliance

Conceptualization of the therapeutic alliance. The concept of the therapeutic
alliance has its roots in early psychoanalytic theory. Freud (1958), as early as 1913,
considered the difference between the transference or neurotic aspects of the client’s
attachment to the therapist and the positive and friendly (reality-based) elements of the
relationship.

Many other early analysts also offered insight into this construct and broadened
our understanding of the therapeutic relationship and its implications. Sandor Ferenczi
(1932) was an early proponent of considering the role of the analyst’s personality in the
therapeutic interaction. He highlighted the “real” nature of the therapist’s contribution to
the analytic situation. Sterba (1934, 1940) stressed the importance of the analyst allying with the patient's ego against unconscious impulses. He also emphasized the import of having the patient positively ally with the therapist in order for them to work toward common therapeutic goals. In other words, Sterba encouraged the alliance of the therapist with the reality-based component of the ego (observing ego). Notably, neither Freud nor Sterba clearly differentiated the alliance from the more general tenets of transference. Elizabeth Zetzel (1956, 1966) was the first to distinguish the therapeutic alliance from constructs such as resistance and “transference neurosis,” and considered the alliance to be a central element of successful psychotherapy. Zetzel conceptualized the alliance as the emotional bond or rapport between analyst and analysand that is not rooted in transference distortions. She also stressed the idea that it is the therapist's obligation to provide an environment supportive enough to facilitate the development of this alliance, particularly in patients who lacked the basic capacity to form trusting relationships. Carl Rogers (1957) understood the positive value of the therapeutic relationship in terms of the therapist's ability to be empathic and maintain unconditional positive regard toward a client. It was this stance, according to Rogers, that provided the patient with the optimal environment to effect change. Some argue that these conditions alone are rarely enough and that the success of psychotherapy is much more complex, but Rogers' focus on therapist factors was nonetheless vastly influential and contributive.

Greenon (1967, 1971) broadened and revised previous conceptualizations of the alliance and was the first to use the term working alliance. Greenon used this term to make explicit the delineation between the reasonable, non-distorted elements of the
patient’s attachment to the therapist, and the more transference bound elements of the relationship. The primary aim of Greenson’s “working alliance” was for the patient to be able to work purposely in the therapy. He emphasized the importance of dynamic and explicit collaboration in the sharing and negotiation of tasks. This is assumed to be distinct from transference and is seen as a joint effort to overcome patient’s difficulties. The real relationship, according to Greenson, consists of genuine and mutual feelings of fondness, trust, and respect and it is this real relationship and its features that constitute the essential quality of the alliance.

Luborsky (1976) also expanded on the alliance construct suggesting that it is a dynamic rather than fixed entity that responds to the changing demands of the therapeutic situation. He distinguished between two types of alliance. Type I, which refers to the quality of the therapeutic relationship or how able the patient is to experience the therapist as amiable, helpful, and supportive. Type II is similar to Greenson’s working alliance and refers more to the collaborative elements of the relationship, in which the patient and therapist are able to share in the responsibility and work of the therapy. Luborsky argued that the intensity of both alliance types were positively related to change in psychodynamic therapy.

Bordin (1979) further refined the alliance concept providing a broader and more transtheoretical model of the therapeutic alliance. He argued that the alliance is a universally applicable concept, the strength of which depends on the “closeness of fit” between the personal characteristics of the patient and therapist in addition to the demands of a particular type of working alliance. He also stated that the alliance
“substitutes the idea (that the relationship is therapeutic in itself) for the belief that the alliance makes it possible for the patient to accept and follow the treatment faithfully” (p. 2). Bordin also stressed the idea that a strong alliance is a necessary component for change in all therapeutic modalities.

Bordin’s tripartate model views the alliance as the “common change factor,” the quality of which is determined by agreement on goals and tasks, and the relational bond. These three components can be defined as follows: Goals refer to the overall objectives of the therapy and tasks designate the specific methods or means by which the goals will be achieved. The bond dimension represents the attachment shared between therapist and patient including mutual affinity, confidence, and trust. This captures and integrates Luborsky’s conceptualization of the two types of alliance while at the same time offering an operationalized understanding of the alliance construct. This will be given further attention in the discussion of the various measurements of the alliance. Bordin states that the degree of agreement between patient and therapist regarding tasks and goals is crucial, as is the quality of the relational bond. It is important to note that these elements are interdependent, each having an impact on and mediating the development and maintenance of the other. (Safran, et al., 1990). Another valuable contribution of Bordin’s conceptualization of the alliance is the importance with which he understands the mutual nature of the therapeutic relationship. This view works to further integrate the role of the therapist, thus encouraging and allowing for further examination of therapist contribution to and understanding of the alliance construct.
Gaston’s (1990) review of the alliance literature indicated that it is comprised of four complementary dimensions (1) the patient’s affective relationship to the therapist; (2) the patient’s capacity to work purposefully in therapy; (3) the therapist’s empathic understanding and involvement; and (4) patient-therapist agreement on goals and tasks of treatment. While understood in a variety of ways, the collaborative nature of the relationship appears to be the primary component of the alliance (Horvath & Symonds, 1991; Horvath & Greenburg, 1994). Differences in therapeutic skillfulness also appear to play a role, in that the degree of therapist helpfulness seems to directly impact the development of the therapeutic alliance (Safran & Muran, 2000). The conceptualization of the therapeutic relationship as an ongoing process, initially put forth by Luborsky, also allows room for therapist failure and an evolution in the understanding of the concept (Safran & Muran, 2000).

**Measurement of the therapeutic alliance.** The therapeutic alliance has increasingly become a central concept in the psychotherapy research community (Horvath & Greenburg, 1994; Horvath & Luborsky, 1993; Martin, Garske & Davis, 2000; Safran & Muran, 2000). According to Safran et al. (1990), it was Bordin’s “integrative conceptualization of the alliance which gave impetus to the current flurry of research interest” (p. 154). The last 25 years have produced a large body of research, including the development and validation of several measures that attest to the predictive validity of the therapeutic alliance (Gaston, 1990; Harty, 1985; Horvath & Symonds, 1991). There are five “families” of measures that make up the most widely used today. These instruments, which are all considered to have acceptable levels of reliability and adequate
psychometric properties (Horvath, 1994), evaluate the quality of the alliance over varying spans of time (segments of therapy sessions, complete therapy sessions, or over several sessions) and from various perspectives (therapist, patient, and observer) (Horvath & Luborsky, 1993; Horvath & Symonds, 1991). These five measures are as follows: (1) Working Alliance Inventory (Horvath & Greenburg, 1986, 1989), WAI-12 (Tracey & Kokotovic, 1989); (2) Vanderbilt Psychotherapy Process Scale/Vanderbilt Therapeutic Alliance Scale (Hartly & Strupp, 1983); (3) California Psychotherapy Alliance Scales (Gaston & Marmar, 1994; Marmar, Horowitz, Weiss & Marziali, 1986); (4) Therapeutic Alliance Scales (Marziali, 1984); and (5) Penn Helping Alliance Scales (Alexander & Luborsky, 1986). It is notable that Martin and colleagues (2000) also listed the Therapeutic Bond Scales (Saunders, Howard & Orlinsky, 1989) as one of the most widely used alliance measures in their recent meta-analytic review.

Several researchers have demonstrated the various measures of alliance assessment to be highly correlated (Hatcher & Barends, 1996; Safran & Wallner, 1991; Tichenor & Hill, 1989). This broad and comprehensive overlap suggests that the various scales are all measuring the same fundamental construct (Horvath, 1994). The strength of the association between measures does, however, appear to vary considerably (Henry, Strupp, Schacht & Gaston, 1994; Horvath, 1994) and may reflect differences in the conceptualization of the alliance construct.

Horvath (1994), consistent with Bordin's conceptualization of the alliance, delineates two components that are either explicitly or implicitly accounted for in each of
the contemporary alliance measures, although generally afforded different weights: (1) personal attachment or bond and (2) collaboration in the therapy process.

The Henry et al. (1994) review of the validation research, which looks at the fundamental dimensions of the therapeutic alliance, found some variation based on statistical techniques applied. Correlational studies (subject to methodological criticisms) failed to provide significant support that the alliance construct has distinct underlying dimensions. Exploratory factor analyses provided more substantial evidence in support of underlying dimensions, although with inconsistent results. Confirmatory factor analyses (designed to verify a preconceived theory) provided support for the existence of a larger alliance factor with several underlying and fundamental dimensions. One such study confirmed Bordin’s conceptualization of the alliance as having three components (bonds, tasks and goals) as measured by the WAI-12 (Tracey & Kokotovic, 1989). Exploratory and confirmatory studies have also demonstrated some evidence to support Gaston’s (1990) four alliance dimensions: patients’ affective and working collaboration, therapists’ empathic understanding, and patient-therapist agreement on tasks and goals.

Horvath (1994) calls for researchers to aim to reach consensus on the finer distinctions of the alliance construct. To meet that aim, most contemporary alliance measures incorporate therapist and patient self-report ratings, in addition to observer-rated coding, although there has been some discrepancy based on the source of alliance report. Martin and colleagues (2000) found that all ratings had adequate reliability, and while therapist ratings tended to be less consistent than those of patients or observers, they remained within the acceptable range. Martin and his colleagues further determined that
patients rated alliance more consistently than either therapists or observers, underlining the importance of developing a good alliance early in treatment. As suggested by Harty (1985), it is important to continue to study this construct from all three sources (therapist, patient, and observer) in order to gain the most comprehensive understanding of the process.

The therapeutic alliance and outcome. The importance of the relationship between the therapeutic alliance and psychotherapy outcome has been established repeatedly over the course of the last 25 years of research (Frieswyk et al., 1986; Henry et al., 1994; Horvath, 1994; Horvath & Symonds, 1991; Luborsky, 1994; Martin, et al., 2000).

The search for common change factors has intensified as a result of the consistent finding of similar efficacy rates across various psychotherapeutic modalities (Safran & Muran, 1995). The therapeutic alliance continues to emerge as the best predictor of positive psychotherapy outcome (Safran, et al., 1990). Safran and Muran (1995), among others, have argued that the quality of the alliance may be more important in terms of treatment success than modality.

Horvath and Symonds (1991) conducted a meta-analytic review of 24 alliance-outcome studies and found a highly significant overall effect size of .26. They determined the therapeutic alliance to be a moderately robust predictor of psychotherapy outcome and further concluded that the strength of this association is independent of treatment length and/or modality.
Luborsky (1994) also conducted a review of 18 alliance-outcome studies (including 24 patient samples) and found alliance strength to be positively related to treatment outcome. The strength of the alliance predicted outcome in 19 of 24 cases, with a level of prediction primarily in the range of .20 to .45.

Martin, et al. (2000) published a more recent and comprehensive meta-analytic review of 79 relevant studies using the same inclusion criteria as the Horvath and Symonds (1991) review. They too found a consistent and moderate relationship between alliance and outcome, with an overall effect size of .22.

There have been several variables posited as potential moderators of the association between the alliance and outcome. Martin, et al. (2000) concluded that none of these variables had any impact on the alliance-outcome relation, while Horvath and Symonds (1991) did find some moderating relationships. Horvath and Symonds (1991) suggest that alliance measures may “overlap equally, but with different aspects of therapy outcome” or that there may be an additional variable, as yet undetermined, causally linking positive alliance to success in therapy. These potential moderating variables are discussed below.

Type of treatment does not appear to impact this relationship as the strength of the alliance predicts positive outcome across a wide range of therapeutic modalities (Horvath & Symonds, 1991; Martin, et al., 2000), including psychodynamic, cognitive-behavioral, and gestalt therapies (see Horvath & Luborsky, 1993 for review and citations). The alliance-outcome association also appears to be predictive independent of treatment length (Horvath & Symonds, 1991).
According to Martin and colleagues (2000), source of alliance rating also fails to have a significant impact on the alliance-outcome association. In contrast, Horvath and Symonds (1991) found the therapeutic alliance to be more predictive of outcome based on client and observer assessment than that of therapist. Horvath and Symonds (1991) do note, however, that one small study with negative therapist-reported alliance/outcome correlations had a considerable impact on the effect size in their meta-analysis. Horvath and Symonds (1991) also reported that the therapist-based measures have the most stability, while the observer-rated measured were the least reliable. Horvath and Symonds (1991) offer the following potential explanations for low therapist predictability: (1) they state that therapists who tend to overestimate the strength of the alliance, particularly early in treatment, are increasingly likely to have poor outcomes. They call this “overoptimism” and suggest that potential counter-transferential reactions, or therapists mistaking overcompliant behavior for genuine collaboration may be to blame; and (2) while patients are asked to indicate their own feelings and beliefs regarding their experience, therapists are often asked to deduce the experience of the patient. In fact, according to Horvath and Luborsky (1993), several therapist scales are simply direct rewordings of the patient scales. Differences based on source of report suggest that these three viewpoints are not entirely compatible and may represent diverse views of psychotherapy process (Winkelman, et al., 1996).

Time of alliance assessment was not found to impact the alliance-outcome relation by Martin and colleagues (2000), but Horvath and Symonds (1991) found early alliance ratings to be most predictive of outcome. Horvath and Symonds (1991) suggest
that fluctuations in therapeutic alliance caused by a rupture-repair cycle may explain these findings. Safran et al. (1990) suggest that the practice of averaging alliance scores over the course of treatment may result in too modest a relation between alliance and outcome.

Martin and colleagues (2000) deny that type of outcome measure has a moderating effect on the alliance-outcome relation. Horvath (1994) suggests, however, that the alliance may be most positively associated with outcomes tailored to the individual patient as opposed to those measuring global symptomatic change. Horvath and Luborsky (1993), for example, found that alliance measures appear to be better able to predict outcome as measured by client-specific tools, i.e., Target Complaints (TC; Battle, C. C., Imbar, S. D., Hoehn-Saric, R., Stone, A.R., Nash, E. R., & Frank, J. D., 1966), and less successful in predicting more global change such as is measured by Symptom Distress Check List-90 (SCL-90; Derogatis, Rickels, & Rock, 1976). Henry et al. (1994) also determined that while the ability of the alliance construct to predict outcome has been demonstrated across several measures (symptomotolgy, interpersonal functioning and target complaints), measures assessing other aspects of functioning, such as self-concept and social functioning, have not enjoyed the same success. Generally speaking, the use of multiple outcome measures, capturing the diverse nature of psychiatric disorders, and tapping into several dimensions of therapeutic change, allows for the most comprehensive assessment of the relationship between alliance and outcome.

There have been some methodological issues raised concerning the measurement of the relationship between alliance and outcome (Horvath & Luborsky, 1993). The possibility that measures of alliance and measures of outcome may overlap has been one
such concern. Luborsky, Crits-Cristophe, Mintz, and Auerbach (1988), however, have found minimal overlap between various alliance and outcome measures. Another methodological concern has centered on potential overlap between the quality of the alliance and prior improvement in therapy. It has been posited that as patients improve over the course of therapy, they may as a consequence begin to develop more positive feelings toward the therapist and the treatment. It has been demonstrated, however, that the alliance predicts outcome aside from in-treatment symptomatic change (Gaston, Marmet, Gallagher & Thompson, 1991). These findings provide additional support for the alliance construct as a casual factor in psychotherapy (Henry et al., 1994).

**The therapeutic alliance as a process variable.** Along with being a significant indicator of positive psychotherapy outcome, the construct of the therapeutic alliance is also valuable as a process variable. Research on psychotherapy process has become increasingly central in recent years (Bergin & Garfield, 1994; Garfield & Bergin, 1994). Psychotherapy process research examines the inner workings of individual psychotherapy sessions (Lambert & Hill, 1994) and generally looks at the individual variables that promote therapeutic change (Garfield & Bergin, 1994).

While process research has become increasingly sophisticated it also remains quite complex, with a variety of measures, hypothesized variables, and methodologies, and it is often difficult to bridge the gap between process and outcome research in practical terms. This may be due in part to the different levels of analysis involved in each (Orlinsky, Grawe & Parks, 1994). Analysis of outcome can range from the investigation of “micro-outcomes,” i.e., at the end of each session, to the level of ultimate
outcome, which is measured at the termination of treatment. Analysis of process can range from “microanalysis” of speech turns or behavior to “macroanalysis” of various phases of therapy. In other words, process refers to fluctuations or changes within therapy sessions whereas outcome is often reflected by changes outside of the therapeutic relationship (e.g., improvement in social or emotional functioning).

The various methodological approaches used to link process and outcome may also serve to complicate the issue. According to Lambert and Hill (1994), the three primary approaches applied are correlational approaches, sequential analyses, and analysis of patterns (e.g., task analysis). In their discussion of the advantages and disadvantages of each, Lambert and Hill (1994) determined that while some advances have been made, particularly with sequential and pattern analyses, an adequate method for evaluating the association between process and outcome remains slightly out of our reach.

Process and outcome research are not independent, nor is the distinction between them entirely clear. In fact, the two are complimentary and both are fundamental in the study of therapeutic change (Strupp, 1993). Some have argued that the construct of the therapeutic alliance works to bridge the gap between the traditional dichotomy of process and outcome (Greenburg, 1986; Safran, et al., 1990). According to Lambert and Hill (1994), process and outcome may overlap to the extent that shifts in process can be regarded as early indications of outcome. That the therapeutic alliance is both transtheoretical, and linked to psychotherapy outcome makes it particularly appealing as a process variable.
Theory and Research on Alliance Ruptures and Resolution in the Therapeutic Alliance

**Conceptualization of alliance ruptures and the resolution process.** Building on the understanding that a positive alliance is an integral component of therapeutic change, researchers have begun to focus more specifically on the phenomena believed to promote the development and maintenance of the alliance. The last decade has seen what Safran, Muran, Samstag, and Stevens (2002) referred to as the “second generation of alliance research,” in which psychotherapy researchers have placed increasing emphasis on fluctuations, or ruptures, in the therapeutic alliance as an important phenomena in psychotherapy process (Bordin, 1994; Frieswyk et al., 1986; Safran, et al., 1990).

Safran et al. (2002) define a rupture in the therapeutic alliance as “a tension or breakdown in the collaborative relationship between patient and therapist.” Rupture events can vary in “intensity, duration and frequency…” (Safran, et al., 1990). Ruptures can be discrete events with a clear beginning and end, or more pervasive within the context of a particular treatment. Ruptures can also range in severity from minor, scarcely noticeable tensions, to a complete and irreconcilable breakdown of the relationship, often resulting in unilateral termination (Safran et al., 2002). Based on Bordin’s conceptualization of the alliance, Safran and his colleagues (2002) understand ruptures in the alliance to be composed of (1) disagreements about treatment tasks, (2) disagreements about treatment goals, or (3) strains in the bond.

Several researchers have emphasized the importance of investigating strains in the alliance in order to better understand the change process and to prevent unilateral termination (Bordin, 1994; Frieswyk et al., 1986; Safran, et al., 2002). Frieswyk et al.
(1986) also proposed that fluctuations in the alliance be used to study the effectiveness of the diverse types of therapeutic interventions.

Safran et al. (1990) stress the importance of successfully resolving breeches in the alliance in order to effect therapeutic change, suggesting that this process can work to refute a patient’s “dysfunctional interpersonal schema.” Muran (2002) further states that ruptures involve “the unwitting participation of both patient and therapist, and mark critical opportunities to bring dissociative processes into awareness, and to challenge pathogenic beliefs implicit to a maladaptive schema.”

The concept of therapeutic alliance ruptures overlaps to some extent with many earlier understandings of therapeutic impasses including resistance, empathic failure, and transference/countertransference issues (Safran & Muran, 1996). Bordin (1994) suggested that the notion of resistance was the precursor to the idea of alliance ruptures. The concept of ruptures in the alliance is particularly valuable, however, in that it is linked to current psychotherapy research, is transtheoretical, and stresses the interpersonal nature of the relationship and any strains within it (Safran, 1993; Safran & Muran, 1996).

Research and empirical evidence. While initial results are promising, the concept of fluctuations in the alliance is in its early stages as a topic of investigation, and many of the initial studies consist of small samples or qualitative data (Safran et al., 2002). In their extensive review of the literature, Safran and his colleagues (2002) categorized the empirical evidence concerning ruptures in the alliance into four groups: (1) studies aimed at detecting ruptures, (2) qualitative analyses of alliance problems and negative therapist responses, (3) studies aimed at directly addressing and repairing ruptures, and (4) studies
aimed at investigating patterns of alliance development. These studies will be summarized below. Safran, Muran, and their colleagues (Safran, et al., 1990; Safran & Muran, 1996; Safran, Muran & Samstag, 1994) have also made significant progress in furthering the study of ruptures and the resolution process with their development and refinement of a model of the resolution process. This model will also be presented in detail below.

Detecting ruptures. There have been several studies aimed at detecting ruptures in the alliance. This process alone can be a difficult process even for highly experienced clinicians due to the subtle nature of many misunderstanding events. Using qualitative research methodology, Rennie (1994) demonstrated patient deference to be an important and often complicating factor in the negotiation of the therapeutic relationship. As these findings suggest, patients who consider it their job to protect and defer to their therapist will not likely feel comfortable openly discussing problems within the relationship, or the treatment. Safran et al. (2002) observe that these findings highlight the importance that therapists are able to recognize subtle strains in the alliance and are also able to address them in a manner that encourages patient participation in the exploration and resolution of the rupture. As stated, however, the ability to detect this therapeutic process appears to be difficult even for seasoned clinicians.

Regan and Hill (1992), in another qualitative study, discovered that most thoughts and feelings left unexpressed by patients and therapists during treatment were negative in nature and that therapists were only aware of patients’ holding something back 17% of the time.
Rhodes, Hill, Thompson, and Elliot (1994) performed a qualitative analysis of therapists’ recollections of misunderstanding events from their own treatment. They found that patients who did not feel comfortable disclosing treatment concerns were able to conceal these feelings from their therapists. As a consequence, the tension in the relationship went largely unaddressed and often resulted in early termination. Results also indicated that when patients were willing to share negative feelings about the treatment and therapists were able to explore the rupture event nondefensively, the alliance improved.

Hill, Thompson, Cogar, and Denman (1993) provided further evidence that therapists often remain unaware of patients’ negative thoughts and feelings. This study demonstrated that patients tend to conceal their negative reactions from therapists and that even the most experienced clinicians were aware of less than 50% of patients’ unexpressed concerns. In addition, 65% of the patients’ reported having left something, usually negative, unsaid and only 27% of the therapists were aware of what their patients were withholding.

In a later study, Hill, Nutt-Williams, Heaton, Thompson, and Rhodes (1996) asked therapists to recall misunderstanding events that had led to early termination and performed a qualitative analysis of their responses. As in previous studies, patients withheld their dissatisfaction until deciding to terminate the treatment. Notably, therapists were often surprised by patients’ discontent and their decision to end treatment. This provides further evidence that therapists often remain unaware of patients negative reactions to aspects of the relationship and/or the treatment overall. The therapists in the study retrospectively
identified several variables they believed to have contributed to the rupture and subsequent termination including, disagreement on tasks and goals, therapist error, transferral issues, and therapist personal qualities.

Alliance problems and negative therapist reactions. Some researchers have conducted qualitative analyses of alliance problems and negative therapist responses. These studies indicate that even when therapists are able to detect strains in the alliance, it often remains difficult to know how to address the situation in an effective manner.

Castonguay, Goldfried, Wiser, Raue, and Hayes (1996), in a study of the alliance in cognitive therapy, determined that therapists often respond to strains in the alliance by adhering more closely to their preferred treatment model. Therapists in this study often responded to tension in the alliance in a rigid fashion (i.e., by challenging distorted cognitions) rather than flexibly attending to the rupture event. This increased adherence to the cognitive model was found to be inversely related to good outcome.

Piper, Azim, Joyce, and McCallum (1991) investigated the relationship between transference interpretations, alliance, and outcome and found these factors to be negatively correlated. They suggested that therapists may have relied on transference interpretations in an attempt to repair a rupture in the alliance, but results demonstrated this tactic to be counterproductive.

In a later study, Piper, Ogrodniczuk, Joyce, McCallum, Rosie, and O’Kelly (1999) built upon these results by performing qualitative analyses of the last session of 22 dropout cases. These process analyses revealed a pattern of patients beginning the session with an expression of dissatisfaction with the treatment and therapists responding
with transference interpretations. This pattern was often perpetuated throughout the session, and as patients withdrawal and/or resistance increased, so too did therapists reliance on transference interpretations.

Directly addressing and repairing ruptures. Two early studies of the alliance were aimed at directly addressing and repairing ruptures and provided evidence that when therapists are able to respond to a strain in the alliance in a direct, nondefensive, and flexible manner, the alliance is strengthened.

Forman and Marmer (1985), in one of the earliest inquiries into this phenomenon, studied 6 patients who had completed treatment in a brief dynamic therapy and had initially poor alliance scores. Three of these patients reported improvement in alliance strength and were considered to be good to superior outcome cases at termination, while the remaining 3 patients continued to report a weak alliance and were considered poor outcome cases at termination. Forman and Marmer (1985) concluded that directly addressing alliance ruptures improved alliance and that the following therapist interventions had implications for alliance improvement: (1) addressing the patient’s defenses; (2) addressing the patient’s guilt and expectations of punishment; (3) addressing the patient’s problematic feelings in relation to the therapist; and (4) linking the problematic feelings in relation to the therapist with the patient’s defenses.

Another early investigation was conducted by Lansford (1986) and also focused on 6 patients who had completed a brief dynamic therapy treatment. This study demonstrated that the successful resolution of strains in the alliance is positively correlated with psychotherapy outcome. These results also provided confirmation of the importance of
addressing a weakened alliance directly. Lansford (1986) suggested that strains in the alliance often center on the patient’s target complaints (i.e., their “chronic and enduring pain”).

*Patterns of alliance development.* There have been several investigations into the development of the alliance over the course of a treatment. Golden and Robbins (1990) have suggested that patients go through patterns of alliance development, as initially predicted by Mann (1973). They looked at two successful therapy cases and found that despite consistent therapist warmth and interest level, patient alliance ratings increased, dropped, and then increased again during each treatment.

Patton, Kivlighan, and Multzon (1997) also found evidence of this high-low-high pattern of alliance development in their investigation of 16 patient-therapist dyads and concluded this pattern to be positively related to outcome.

In a later study, Kivlighan and Shaughnessy (2000) applied cluster analyses to 79 patient-therapist dyads over 4 therapy sessions. They found three discrete alliance development patterns: quadratic alliance growth, linear alliance growth, and stable alliance. The quadratic pattern of alliance development was associated with the greatest level of therapeutic change. While promising, results from studies of alliance development patterns are hardly definitive. There does seem to be preliminary indication, however, of the potential therapeutic benefits of a pattern of alliance development, rupture, and repair over the course of a treatment.

As Safran et al. (2002) highlight, it is important to distinguish between studies that examine alliance development on a global level and those that look at more molecular
change in the alliance. Nagy, Safran, Muran, and Winston (1998) investigated shifts in the
goodship of the alliance within sessions, as perceived by both patients and therapists, in a
sample of 75 therapeutic dyads. They concluded that: (1) ruptures in the therapeutic
alliance are a relatively common event, (2) that therapists perceive (or report) ruptures
more often than patients (patients report in 11-38% of sessions and therapists report in 25-
53%), (3) that while patients' overall view of the alliance tends to be tenuous early in
treatment, and can fluctuate dramatically based on individual rupture events, this is not the
case once the therapeutic relationship has had a chance to develop, (4) therapists, even
early in treatment, are not likely to allow a discrete rupture event to influence their overall
definition of the alliance, (5) patient and therapist ratings of gross rupture resolution were
predictive of patient-rated alliance, and (6) patient and therapist agreement on the presence
of a rupture was related to positive outcome.

Model of rupture resolution. Safran, Muran and their colleagues have made
considerable contributions in this domain of research with the development of an explicit
model of ruptures and resolutions within the therapeutic alliance (Safran, et al., 1990;
Safran & Muran, 1996; Safran, Muran & Samstag, 1994). Safran and his colleagues were
guided by Rice and Greenburg's (1984) task analytic approach to psychotherapy process
research in the development of this model. This approach applies both discovery and
verification-oriented procedures to identify continual patterns of change-related events.
The task analytic approach is based on rational-empirical principles that oblige
researchers to use theory and empirical evidence interchangeably, and in a
complementary fashion, in order to refine a hypothesized model.
In concordance with the task analytic method, this model of rupture resolution has undergone several refinements. The model captures the sequence involved in rebuilding the alliance after a rupture event, and in its most recent revision consists of the following four stages: (1) Attending to the Rupture Marker; (2) Exploration of Rupture Experience; (3) Exploration of Avoidance; and (4) Emergence of Wish or Need. (see Safran & Muran, 1996; Safran et al., 2002 for more thorough discussions of the model’s development and refinement). These stages include four patient states and three therapist interventions, which were operationalized using a semantic definition technique and the following process measures: the Structural Analysis of Social Behavior (SASB: Benjamin, 1974); the Experiencing Scale (EXP: Klien, Mathieu-Coughlan, Kiesler, 1986); and the Client Vocal Quality Scale (CVQ: Rice & Kerr, 1986).

The first stage (Attending to the Rupture Marker) is divided into two components, a patient state: Patient Rupture Marker, and a therapist intervention: Therapist Focusing Attention. The second stage (Exploration of Rupture Experience) is also broken down into two subcomponents: Patient Expresses Negative Sentiment and Therapist Empathy and/or Acceptance of Responsibility. The third stage (Exploration of Avoidance) is also divided into two components: Patient Discloses Block and Therapist Probes for Block. The fourth stage (Emergence of Wish or Need) consists of a patient state only, in which the patient is able to disclose his thoughts or feelings in a relatively clear and direct fashion. In the most recent revision (Stage-Process Model III), Safran and Muran integrated the Core Conflictual Relationship Theme (CCRT) method in reconceptualizing
the operational criteria of each stage of the model. Employing CCRT terms, stage four can be viewed as the assertion of the underlying wish.

Precursor to the current study. Winkelman, Safran, and Muran (1996) developed the Rupture Resolution Questionnaire – Patient Version (RRQ-P), a patient self-report measure designed to “identify the presence of experiences hypothesized to be associated with the process of alliance rupture resolution.” This measure, unlike typical alliance measures, which attend to patient/therapist agreement, focuses on feelings and experiences related to the constructive negotiation of conflict between patient and therapist (Muran, 2002). As a version of this measure will be used to assess the process of rupture resolution from the therapist perspective in the current study, a detailed account of its development and validation is given in the Instrument Development Section. Initial findings with the RRQ-P demonstrated the scale to have favorable psychometric properties, particularly internal consistency and concurrent validity. This measure was found to be positively related to several well-established measures of psychotherapy process. Winkelman et al. (1996) also demonstrated support for the consistent finding that the strength of the therapeutic alliance is predictive of ultimate outcome in psychotherapy. This study provided further indication that ruptures are prevalent in many treatment modalities (Winkelman et al., 1996). Winkelman et al. (1996) also demonstrated a positive relationship between successful rupture resolution and overall outcome, although these findings are considered to be modest and to require further evaluation. These findings suggest that process of detecting and addressing
ruptures in the therapeutic alliance may have vast implications for successful psychotherapy, and is thus in need of continued investigation.

Summary and conclusions

Psychotherapy research has evolved considerably over the course of the last few decades. Since the establishment of similar efficacy rates among the various therapeutic modalities, researchers have shifted their attention to increasingly specific aspects of psychotherapy process. Research on the relationship between diverse process variables and psychotherapy outcome has yielded the consistent finding that the strength of the therapeutic alliance is the most robust predictor of treatment success.

The concept of the therapeutic alliance itself, with its foundation in early psychodynamic theory, has undergone significant development and refinement since its inception. The contributions of Greenson (1967, 1971), Luborsky (1976), and Bordin (1979) have been vital to our current understanding of the therapeutic relationship. The alliance is especially valuable in that it is transtheoretical and linked to a large body of current empirical research.

As the strength of the relationship between a positive alliance and good psychotherapy outcome has become firmly established in the field, researchers have begun a more detailed examination of the quality of the alliance. Many researchers have identified fluctuations, or ruptures, in the alliance as potentially meaningful change-related events. It has been suggested that alliance ruptures may capture a patient's core issues and that working to resolve these misunderstanding events is an important element of therapeutic change. Much of the initial research on ruptures in the alliance has focused
on identifying these, often subtle, events and addressing them in the most beneficial manner. Alliance ruptures and the resolution process have been tentatively linked to the strength of the alliance and positive psychotherapy outcome. It seems apparent that this line of inquiry may serve to illuminate the process of therapeutic change and work to refine our understanding of the mechanisms by which psychotherapy is effective. Safran, Muran, and their colleagues (2002) have closely examined the rupture resolution process, both in their own investigations, and in their review of the current literature, and it seems clear that further work is needed to clarify and refine our understanding of this complex phenomena. There have been some recent and preliminary attempts to operationalize alliance ruptures and the resolution process. Early empirical studies have offered interesting insights into this process, but this line of inquiry remains in its early stages. Increased focus and attention is essential in order to gain a more comprehensive understanding of the impact of these processes on the therapeutic alliance and the process of change in psychotherapy. The present study was designed with the hope of furthering the research in this area through the modification and empirical validation of a recently developed measure of the rupture resolution process.
Statement of Purpose

The purpose of this study is to better understand the relationship between therapist-rated rupture resolution processes, as defined by optimal therapist internal states and behaviors thought to be conducive to resolution, and several well-established psychotherapy process and outcome variables. The following global research questions are addressed:

1. Does the presence of therapist internal states and behaviors hypothesized to facilitate the rupture resolution process, as reported by clinicians, have implications for other aspects of therapeutic process (i.e., therapeutic alliance)?

2. Does the presence of therapist internal states and behaviors hypothesized to facilitate the rupture resolution process, as reported by clinicians, predict ultimate outcome in psychotherapy?

This study addresses these questions through a clinical field trial of 49 patient-therapist dyads in brief psychotherapy. Based on this data, validity analyses will be performed to assess the relationship between therapist-rated rupture resolution processes and other measures of psychotherapy process, as well as the association between therapist-rated rupture resolution processes and psychotherapy outcome. The current study will attempt to demonstrate that the presence of therapist internal states and behaviors hypothesized to facilitate the resolution of ruptures in the therapeutic alliance, as reported by clinicians, will be strongly related to other therapeutic processes (i.e., strength of the therapeutic alliance) and will also predict positive outcome in psychotherapy. Reliability estimates for the RRQ-T will also be determined.
Research Hypotheses

1. The presence of optimal therapist states hypothesized to be facilitative of the rupture resolution process, as reported by clinicians, will be positively related to the strength of the therapeutic alliance, as rated by therapists and patients.

2. The presence of optimal therapist states hypothesized to be facilitative of the rupture resolution process, as reported by clinicians, will be positively related to depth of individual therapy sessions, as rated by therapists and patients.

3. The presence of optimal therapist states hypothesized to be facilitative of the rupture resolution process, as reported by clinicians, will be negatively related to smoothness of individual therapy sessions, as rated by therapists and patients.

4. The presence of optimal therapist states hypothesized to be facilitative of the rupture resolution process, as reported by clinicians, will be positively related to perception of session helpfulness, as rated by therapists and patients.

5. The presence of optimal therapist states hypothesized to be facilitative of the rupture resolution process, as reported by clinicians, will be positively related to degree of rupture intensity, as rated by therapists and patients.

6. The presence of therapist rupture resolution processes, as reported by clinicians, will be positively related to report of global resolution, as rated by therapists and patients.

7. The presence of optimal therapist states hypothesized to be facilitative of the rupture resolution process, as reported by clinicians, will be associated with improvements in ultimate treatment outcome, as reported by therapists and patients.
8. The presence of optimal therapist states hypothesized to be facilitative of the rupture resolution process, as reported by clinicians, will be more predictive of outcome tailored to individual patients, such as Target Complaints, than more global measures of outcome, i.e., the Symptom Checklist-90.
Chapter II

Instrument Development

The Rupture Resolution Questionnaire – Patient Version (RRQ-P)

Winkleman and colleagues developed the RRQ-P in 1996 as a measure of the constructive negotiation of conflict in the therapeutic relationship, from the patient’s perspective. Items were generated based on a thorough examination of several proposed items and dimensions. These initial proposals were developed by a team of psychotherapy researchers at Beth Israel Medical Center’s Brief Psychotherapy Research Project and included 68 items, with 9 underlying dimensions. To establish construct validity and further refine the scale, a team of 10 highly qualified experts, which consisted of psychologists and psychiatrists representing varied theoretical orientations, then evaluated this pool of items and prospective dimensions. Based on the ratings and recommendations of the team of experts, and after consultation with the research staff, a revised 30-item scale was administered to a group of 60 analog subjects to further assess the reliability of the scale. Item analyses were then performed to shorten the scale and make it more suitable for clinical use.

A 12-item scale representing the following six underlying dimensions was decided upon: (1) affective attunement (the emotional connection between patient and therapist); (2) separation-individuation (recognition of separateness, including the assertion of own needs); (3) patient owns role in interaction (recognition of responsibility to rupture); (4) expansion of self-definition (discovery of dissociated self-states); (5) coming clean (experience of relief resulting from disclosing uncomfortable feelings); and
(6) disconfirmation (experience of implicit fears disconfirmed). An additional
questionnaire was developed from the remaining 18-items (3 per dimension), and were
distributed to patients at the midpoint and after the completion of treatment. At a later
point, the RRQ-P was further refined and six items were added to the post-session version
of the measure, resulting in the current 18-item scale. Items are rated on a 5-point scale,
the lower end of which indicates that the statement reflects the patient’s experience “not
at all”, and the upper end indicating that the statement “definitely” reflects the patient’s
experience.

The Rupture Resolution Questionnaire – Therapist Version (RRQ-T)

A therapist version of this measure was later implemented at the Brief
Psychotherapy Research Project. This modified scale, the Rupture Resolution
Questionnaire – Therapist Version (RRQ-T), is the focus of this study (see Appendix A).
This measure was adapted for use by therapists as a tool to assess their experience of the
rupture resolution process. In modifying the patient-rated scale for clinician use the
research team was guided by theoretical and clinical ideas about the optimal therapist
states of mind and behaviors that would be conducive to working through therapeutic
impasses. Some minor changes in the wording of items, and subtle adjustments to the
subscales were made, in addition to the development of a few new items in order to best
reflect the therapist experience. In making the transition from patient to therapist scale,
however, the research team’s understanding of both scales and the processes being
measured by each underwent some evolution of thought. While it was already clear that
these measures did not directly measure the process of rupture resolution, our thinking
began to better reflect the intrapsychic nature of many of the items. With regard to the therapist scale, we began to think of the scale as tapping into optimal internal states and in some cases behaviors that would likely facilitate the resolution process. In other words, a high score on the RRQ-T suggests that therapists are thinking and acting in a way that will often facilitate the resolution process, but it does not provide concrete information about whether resolution is actually occurring.

The revised therapist scale shares many of the same properties of the patient-rated scale. There are 18 questions, which are rated on the same 5-point scale described above. The RRQ-T also has six subscales, which were intended to essentially reflect the same six dimensions identified for the patient scale (See Appendix B). The overall purpose of this study is to evaluate the psychometric properties of this scale.
Chapter III

Clinical Field Trial

Methods

Design. This study was conducted at the Brief Psychotherapy Research Program at Beth Israel Medical Center in New York City. This program is a long-established research project funded by The National Institute for Mental Health, which was instituted in the 1980s to further the study of psychotherapy process and outcome. The participants in the current study were engaged in individual therapy between 2001 and 2004.

Therapists were all recruited from Beth Israel Medical Center’s Department of Psychiatry. Patients are recruited chiefly through advertisements in the Village Voice, and also through referrals from mental health professionals, and patients who have previously participated in the program. Participation is voluntary and includes informed consent apropos the parameters of the overall research project (see Appendix M). Patients receive brief (30 session), inexpensive psychotherapy, with fees determined on a sliding scale based on their income. Inclusion criteria for participation in the program include: (1) adults between the ages of 18 and 65, and (2) agreement to comply with rigorous research assessment procedures. Exclusion criteria for the program include: (1) organic brain disorders or mental retardation; (2) psychotic symptoms; (3) bipolar disorder; (4) active substance use disorder; (5) active Axis III medical diagnosis; (6) history of violent behavior or impulse control problems; (7) active suicidal ideation and/or behavior and (8) inconsistent use of psychotropic medication within the last year.
Patients are screened for exclusion criteria during a comprehensive intake procedure that includes an initial phone interview, the completion of a packet of intake questionnaires (see Measures section below), two structured diagnostic interviews (SCID-II: Spitzer, Williams & Gibbon, 1987) and an abbreviated Adult Attachment Interview (George, Kaplan & Main, 1985).

Until September of 2002, subjects were randomly assigned to a therapist and one of three treatment modalities: cognitive-behavioral (CBT), dynamic (BAP), and interpersonal-experiential (BRT). A new design was introduced in September 2002, in which each patient is assigned to a CBT treatment and therapists are introduced to relational, rupture-related concepts at various points of the treatment. The timing of this introduction is assigned randomly and therapists enter into supervision groups at either session #1, session #8, or session #16.

Participants. The subjects in this study were 49 therapist-patient dyads who participated in short-term treatment between 2001 and 2004 at Beth Israel Medical Center’s Brief Psychotherapy Research Project. The 49 dyads included 49 patients treated by 45 therapists (4 therapists treated 2 patients). Patients in this study ranged in age from 23 to 60 (X = 36.18; SD = 9.62) and included 18 males and 31 females. Thirty-six of the patients were currently employed. Many of the patients had attended some college, 22 completed a bachelor’s degree, 2 had completed some post-graduate work, and 15 held graduate degrees. Five of the patients were married, 11 divorced, 1 widowed, and 32 never married. Thirty-seven patients were White, 7 were Black, 2 were Hispanic, and 3 were of Asian descent. Of the 49 patients, 24 completed the 30-session protocol, 3
terminated 3-5 sessions early due to external events, 13 dropped out of treatment prematurely, and 9 were still in treatment at the time of data collection. Patients carried a broad range of Axis I psychiatric diagnoses including 20 patients (41%) diagnosed with depressive disorders, 12 patients (25%) diagnosed with anxiety disorders, 11 patients (22%) diagnosed with a Relational V-code, 3 patients (6%) diagnosed with adjustment disorders, and 1 patient (2%) diagnosed with a somatoform disorder. Two patients carried no Axis I diagnosis. Of these subjects, 25 (51%) also carried a DSM-IV Axis II personality disorder diagnosis including 9 patients (18%) diagnosed with Obsessive Compulsive Personality Disorder, 8 patients (16%) diagnosed with Personality Disorder NOS, 4 patients (8%) with Avoidant Personality Disorder, 3 patients (6%) with Depressive Personality Disorder, and 1 patient (2%) with Narcissistic Personality Disorder (%). Twenty-four patients (49%) carried no Axis II personality disorder.

Forty-five different therapists provided treatment in the current study. Six were licensed clinical psychologists, 13 were advanced psychiatry residents and 26 were doctoral candidates in clinical psychology. This group of therapists consisted of 32 women and 13 men, ranging in age from 25 to 50 ($X = 34.30; SD = 6.37$). Thirty-nine therapists were White, 1 was Black, 1 was Hispanic, 2 were Asian, and 2 characterized themselves as Other. Therapists also provided written consent to have their information used for research and training purposes (see Appendix L).

Measures and Procedure. Several measures were used in this study in order to attain the most comprehensive and valid understanding of therapeutic change. Patients and therapists were required to complete a packet of assessment measures upon intake, at
the midpoint of treatment, and at the termination of the therapy. The questionnaires completed by the patient included the Target Complaint Index, the Inventory of Interpersonal Problems-64, and the Symptom Check List-90. The therapist questionnaire packet included the Target Complaint Index, the Inventory of Interpersonal Problems-32, and the Global Assessment Scale. These measures will be discussed further below.

In addition to the various outcome measures, therapist and patients were also asked to complete parallel versions of the Post-Session Questionnaire (PSQ) after each psychotherapy session (see Appendices D & E). The PSQ is comprised of various measures concerning the nature and strength of the therapeutic relationship, including the Working Alliance Inventory and the Session Evaluation Questionnaire. The PSQ also has six questions that provide a gross assessment of rupture and resolution within each session. These questions, which appear directly before and provide a context for responding to the rupture resolution items (RRQ), assess the following: (1) whether there was the perception of any problem or tension in the relationship during the session, (2) where in the session the tension was located, (3) the highest degree of felt tension, (4) the extent to which the problem was addressed, (5) the degree to which the problem was resolved and (6) a brief description of the problem. For the purposes of this study, we will be concerned only with questions three and five.

*Process measures.* The Working Alliance Inventory (WAI: Horvath & Greenberg, 1989; WAI-12: Tracey & Kokotovic, 1989) captures Bordin’s transtheoretical perspective in measuring the strength of the alliance. The Inventory consists of twelve items (WAI-12) that evaluate diverse aspects of the therapeutic relationship and was
completed by both patient and therapist after each session. Each item is rated on a 7-point scale where 1 = "never" and 7 = "always." This measure has well-established psychometric properties.

The Session Evaluation Questionnaire (SEQ: Stiles, 1980; Stiles, W. B., Shapiro, D. A., & Firth-Cozens, J. A., 1990; Stiles & Snow, 1984) measures the tone of psychotherapy sessions with regard to smoothness and depth. Patients and therapists rate each session on 12 bipolar adjective scales, presented in 7-point semantic differential format. The SEQ has been demonstrated to reliably assess depth and smoothness, which are discrete and independent components of the overall impact of individual psychotherapy sessions.

**Outcome measures.** The Global Assessment Scale (Endicott, Spitzer, Fleiss & Cohen, 1976) is a clinician-rated single item scale, ranging from 1-100, which evaluates gross mental health, or the overall adaptive functioning, of a patient. This inventory has demonstrated both validity and inter-rater reliability. See Appendix J.

The Symptom Checklist List-90-Revised (Derogatis, 1977; Derogatis, 1983) is a self-report inventory designed to assess general psychiatric symptomatology. Patients rate, on a Likert-type 5-point scale, the degree of distress they experience from each of 90 psychiatric symptoms. This inventory has established validity, internal consistency and test-retest reliability. The present study will focus on the Global Severity Index (GSI), an overall score derived from the SCL-90-R. See Appendix K.

The Target Complaints Questionnaire (Battle, et al., 1966) is an idiographic instrument developed to assess three of patients' presenting problems as identified by the
patient at the outset of treatment. This scale is rated independently by both patient and therapist on a Likert-type scale measuring degree of severity. See Appendices F & G.

The Inventory of Interpersonal Problems (Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureno, G., & Villasenor, V. S., 1988) is a self-report inventory developed to assess interpersonal functioning with regard to social problems often encountered and the distress associated with them (social adjustment and interpersonal difficulties). The degree of distress is assessed by a 5-point scale. This inventory has established validity, internal consistency and test-retest reliability. There is a 32-item therapist-rated version (see Appendix H) and a 64-item patient-rated version (see Appendix I), both with the same properties.

Outcome was determined by calculating residual gain scores between Intake (time one) and Termination (time two) on the SCL-90, the GAS, the TC, and the IIP-64/32. Residual gain scores are statistical calculations employed to assess the degree to which patients demonstrate relative change over the course of a treatment. This method is more suitable than using the alternative, and simpler method, of subtracting intake from termination scores. Residual gain scores exclude from the analyses the variance attributable to regression to the mean, or the amount of change that would be expected based solely on intake scores (Fiske, Hunt, & Luborsky, 1970).

Case and session selection. The 49 dyads chosen for the current study were selected based on their participation in the project since the inception of the therapist-rated Rupture Resolution Questionnaire (RRQ-T) in 2001. These subjects were all consecutive admissions to the research project between 2001 and 2004. Complete data
was not available for all subjects for various reasons including subjects terminating
treatment prematurely, failing to submit certain questionnaires, or being only partway
through treatment at the time the analyses were computed. As a result, the number of
subjects included in each analysis may vary considerably based on the data available.
Cases with less than three therapist PSQs were not included in this study as this was
considered to be an insufficient amount of data.

Sessions were selected based on the availability of data. All sessions for which
the therapist PSQs were available were used in the analyses. A generalized estimating
equations (GEE) approach, developed by Liang and Zeger (1986), will be applied to the
collected data. GEE is a type of multiple regression designed for use with repeated
measures and nested data sets. It is calculated on the basis of all data points and
accommodates dependence among the repeated measures and missing data. This was
particularly helpful due to the design of this study and the inevitability of missing data.
So for each of the 49 dyads, all completed process measures (up to 30 for each patient and
therapist) were included in the analyses.
Results

A sequence of analyses was conducted in order to assess the psychometric properties of the RRQ-T. First, the reliability of the RRQ-T and each of its subscales was estimated based on internal consistency data. Next, to assess the concurrent and predictive validity of the RRQ-T in relation to several well-established process and outcome measures, a series of regression analyses of repeated measures was performed.

Reliability. Both the RRQ-T and five of its six subscales were found to have acceptable levels of reliability. Reliability was assessed by computing coefficient alpha for the items and subscales so as to determine the degree of internal consistency. Internal consistency information provides an initial indication of the measure’s validity. It is a form of item analysis that recognizes patterns of ratings and assesses the degree to which items hang together. Reliability analyses were performed at session #3 for all dyads in which RRQ-T data was available. Session #3 was chosen as the point of analysis based on the selection criteria of the overall study. Dyads with less than three sessions of submitted data were not included in this study. As illustrated in Table 1, reliability estimates were quite strong at .93 (N = 43) for the RRQ-T total scale and also significant for all but one subscale. Standardized item alpha levels for each subscale ranged from .54 to .86. These reliability estimates, with the exception of one subscale, are well above the range (.7 to .8), which is generally considered to be adequate (Goldstein & Hersen, 1990). It should be noted that each of the six subscales are made up of only three items, which may have impacted the reliability analyses. See Appendix C for RRQ-T mean, standard deviation, corrected item-total correlations, and alpha if item deleted data.
Table 1
Cronbach’s Alpha Data for Rupture Resolution Questionnaire – Therapist Version (RRO-T) and each subscale at session #3

<table>
<thead>
<tr>
<th></th>
<th>Number of items</th>
<th>N</th>
<th>Standardized Item Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRQ-T total scale</td>
<td>18</td>
<td>43</td>
<td>.93</td>
</tr>
<tr>
<td>Affective Attunement</td>
<td>3</td>
<td>45</td>
<td>.76</td>
</tr>
<tr>
<td>Separation-Individuation</td>
<td>3</td>
<td>45</td>
<td>.54</td>
</tr>
<tr>
<td>Therapist Owns Role</td>
<td>3</td>
<td>44</td>
<td>.77</td>
</tr>
<tr>
<td>Expansion of Self-Definition</td>
<td>3</td>
<td>45</td>
<td>.85</td>
</tr>
<tr>
<td>Coming Clean</td>
<td>3</td>
<td>45</td>
<td>.83</td>
</tr>
<tr>
<td>Disconfirmation</td>
<td>3</td>
<td>44</td>
<td>.86</td>
</tr>
</tbody>
</table>

Regression analyses with process variables. A series of regression analyses were conducted to assess the concurrent validity of the RRQ-T in relation to several well-established process measures. A generalized estimating equations (GEE) approach developed by Liang and Zeger (1986; Zeger & Liang, 1986) was applied. This approach was developed for measurements that are obtained at multiple time points for each participant within a group of participants, and unlike traditional approaches to longitudinal data analysis, accommodates dependence among the repeated measures and missing data; it does require, however, independence across participants and has been shown to consistently estimate the variance of the proposed estimators even when the assumed correlational structure of the repeated measures is incorrect. The FORTRAN program RMGEE (Davis, 1993) was used to implement this approach.

Several regression analyses were performed between the RRQ-T and the previously described therapist and patient-rated measures of process and outcome. The results of these analyses are presented below.
Patient-rated process variables. The first set of regression analyses was a simple bivariate analysis of the RRQ-T and each patient-rated process variable. For each session that RRQ-T data was available, regression analyses were performed in order to assess the strength of the relationship between the RRQ-T and each of the following patient-rated process variables: working alliance (WAI), session depth (SEQ-depth), session smoothness (SEQ-smoothness), and rupture resolution (RRQ-P). The relationship between the RRQ-T and the following patient-rated variables were also examined: session helpfulness, rupture intensity, and degree of global rupture resolution. As illustrated in Table 2, the RRQ-T demonstrates high levels of concurrent validity with nearly all patient-rated process measures. As expected, the RRQ-T was significantly and positively correlated with patient-rated WAI ($z = 2.46$, $p = 0.0138$, $\overline{N} = 48$), RRQ-P ($z = 3.74$, $p = 0.0002$, $\overline{N} = 48$) and SEQ-depth ($z = 3.16$, $p = 0.0016$, $\overline{N} = 48$). The relationship between the RRQ-T and patient-rated SEQ-smoothness ($z = -1.76$, $p = 0.0779$, $\overline{N} = 48$) also approached significance in the expected direction. The RRQ-T was also significantly and positively correlated with patient-rated session helpfulness ($z = 2.62$, $p = 0.0087$, $\overline{N} = 48$), rupture intensity ($z = 2.58$, $p = 0.0099$, $\overline{N} = 48$), and degree of global rupture resolution ($z = 2.37$, $p = 0.0179$, $\overline{N} = 37$).

Table 2
$z$ Scores From Regression Analyses Using Generalized Estimating Equations of the RRQ-T and Patient-Rated Process Measures

<table>
<thead>
<tr>
<th></th>
<th>WAI</th>
<th>SEQ-d</th>
<th>SEQ-s</th>
<th>RRQ-P</th>
<th>SHI</th>
<th>RII</th>
<th>GRI</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRQ-T</td>
<td>2.46*</td>
<td>3.16**</td>
<td>-1.76^</td>
<td>3.74***</td>
<td>2.62**</td>
<td>2.58**</td>
<td>2.37*</td>
</tr>
<tr>
<td>$n$</td>
<td>48</td>
<td>48</td>
<td>48</td>
<td>48</td>
<td>48</td>
<td>48</td>
<td>37</td>
</tr>
</tbody>
</table>
Note. WAI = Working Alliance Inventory; SEQ-d = Session Evaluation Questionnaire –
depth dimension; SEQ-s = Session Evaluation Questionnaire – smoothness dimension;
RRQ-P = Rupture Resolution Questionnaire – Patient version; SHI = Session helpfulness
index; RII = Rupture intensity index; GRI = Global resolution index.
\^ p < .10   * p < .05   ** p < .01   *** p < .001

Therapist-rated process variables. The next set of regression analyses assessed
the relationship between the RRQ-T and each therapist-rated process variable. For each
session that RRQ-T data was available, regression analyses were performed in order to
evaluate the strength of the relationship between the RRQ-T and each of the following
therapist-rated process variables: working alliance (WAI), session depth (SEQ-depth),
and session smoothness (SEQ-smoothness). The relationships between the RRQ-T and
the following therapist-rated variables were also examined: session helpfulness, rupture
intensity, and degree of global resolution. As illustrated in Table 3, the RRQ-T
demonstrates high levels of concurrent validity with nearly all therapist-rated process
measures. As expected, the RRQ-T was significantly and positively correlated with
therapist-rated WAI (z = 7.98, p < 0.0001, N = 49) and SEQ-depth (z = 5.30, p < 0.0001,
N = 49). The relationship between the RRQ-T and therapist-rated SEQ-smoothness (z =
2.94, p = 0.0033, N = 49) was also significant, but not in the expected direction. The
RRQ-T was also significantly and positively correlated with therapist-rated session
helpfulness (z = 4.87, p < 0.0001, N = 49), and degree of global rupture resolution (z =
9.60, p < 0.0001, N = 49). The relationship between the RRQ-T and therapist-rated
rupture intensity (z = 0.56, p = 0.5729, N = 49), was in the expected direction, but not
significant.
Table 3

<table>
<thead>
<tr>
<th>Therapist-Rated Process Measures</th>
<th>WAI</th>
<th>SEQ-d</th>
<th>SEQ-s</th>
<th>SHI</th>
<th>RII</th>
<th>GRI</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRQ-T</td>
<td>7.98***</td>
<td>5.30***</td>
<td>2.94**</td>
<td>4.87***</td>
<td>0.56</td>
<td>9.60***</td>
</tr>
<tr>
<td>n</td>
<td>49</td>
<td>49</td>
<td>49</td>
<td>49</td>
<td>49</td>
<td>49</td>
</tr>
</tbody>
</table>

Note. WAI = Working Alliance Inventory; SEQ-d = Session Evaluation Questionnaire – depth dimension; SEQ-s = Session Evaluation Questionnaire – smoothness dimension; RRQ-p = Rupture Resolution Questionnaire – patient version; SHI = Session helpfulness index; RII = Rupture intensity index; GRI = Global resolution index.
* p < .05  ** p < .01  *** p < .001

Regression analyses with outcome variables. A series of regression analyses was conducted to assess the predictive validity of the RRQ-T in relation to several well-established outcome measures. Recall that residual gain scores were computed and used for all outcome analyses and note that Liang and Zeger’s (1996) GEE approach was also applied to predictive validity data.

Patient-rated outcome variables. The first set of predictive validity analyses was a simple bivariate analysis of the RRQ-T and each patient-rated outcome variable. For each session that RRQ-T data was available, regression analyses were performed in order to assess the strength of the relationship between the RRQ-T and each of the following patient-rated outcome variables: Symptoms Checklist – 90 (SCL-90), Inventory of Interpersonal Problems – 64 (IIP–64), and the Target Complaints Index (TC). As illustrated in Table 4, the relationship between the RRQ-T and the patient-rated TC (z = -1.90, p = 0.0575, N = 19) approached significance in the expected direction. The relationship between the RRQ-T and SCL-90 (z = -0.14, p = 0.8879, N = 18) was not
significant. The relationship between the RRQ-T and IIP-64 \((z = 0.56, p = 0.5756, N = 18)\) was not significant, nor was it in the expected direction.

Table 4

<table>
<thead>
<tr>
<th>Patient-Rated Outcome Measures</th>
<th>SCL-90</th>
<th>IIP-64</th>
<th>PTC</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRQ-T</td>
<td>-0.14</td>
<td>0.56</td>
<td>-1.90^</td>
</tr>
<tr>
<td>(n)</td>
<td>18</td>
<td>18</td>
<td>19</td>
</tr>
</tbody>
</table>

Note. SCL-90 = Symptom Checklist -90 (Global severity Index); IIP-64 = Inventory of Interpersonal Problems – 64; PTC = Patient Target Complaints.

\(^{^\wedge}p < .10\)  \(*\ p < .05\)  \(**\ p < .01\)  \(***\ p < .001\)

*Therapist-rated outcome variables.* The final set of regression analyses assessed the relationship between the RRQ-T and each therapist-rated outcome variable. For each session that RRQ-T data was available, regression analyses were performed in order to evaluate the strength of the relationship between the RRQ-T and each of the following therapist-rated outcome variables: Global Assessment Scale (GAS), Inventory of Interpersonal Problems – 32 (IIP-32), and the Target Complaints Index (TC). As illustrated in Table 5, the RRQ-T was not significantly correlated with any of the therapist outcome variables. The relationship between the RRQ-T and the GAS \((z = 0.30, p = 0.7671, N = 21)\) was in the expected direction, but not significant. The relationship between the RRQ-T and the IIP-32 \((z = 1.28, p = 0.1990, N = 20)\), and the therapist-rated TC \((z = 1.12, p = 0.2647, N = 21)\) were not significant, nor were they in the expected direction.
Table 5

<table>
<thead>
<tr>
<th>z Scores From Regression Analyses Using Generalized Estimating Equations of the RRQ-T and Therapist-Rated Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist-Rated Outcome Measures</td>
</tr>
<tr>
<td>GAS</td>
</tr>
<tr>
<td>RRQ-T</td>
</tr>
<tr>
<td>n</td>
</tr>
</tbody>
</table>

Note. SCL-90 = GAS = Global Assessment Scale; IIP-32 = Inventory of Interpersonal Problems – 32; TTC = Therapist Target Complaints.

* p < .05  ** p < .01  *** p < .001

Supplementary Analyses. Due partially to the lack of significant findings in the predictive validity analyses of the RRQ-T, a small number of supplementary analyses were performed. An Analysis of Variance (ANOVA) was conducted to assess possible differences in RRQ-T ratings by patients who completed therapy as opposed to those who dropped out of treatment prematurely. The data was divided into two groups, those who completed the treatment protocol and those who did not, and the mean scores of these groups on the RRQ-T and each subscale were compared. As illustrated in Table 6, there were few statistically significant differences in how patients rated this measure based on whether or not they completed the treatment protocol. The only statistically significant difference between these groups was on the Separation-Individuation subscale (F=5.34, p=0.026). The only other subtest to approach a statistically significant difference between these groups was the Expansion of Self-Definition subscale (F=3.86, p=0.057). There were no significant differences between the total scale scores (F=.864, p=0.358) or any of the remaining four subscales: Affective Attunement (F=.437, p=0.513), Therapist Owns
Role (F=.306, p=0.583, Coming Clean (F=.583, p=0.450), and Disconfirmation (F=2.24, p=0.143).

Table 6
Analysis of Variance comparing mean RRQ-T scores of patients who completed treatment and those who dropped out prematurely.

<table>
<thead>
<tr>
<th>Total Scale &amp; Subscales</th>
<th>TS</th>
<th>AA</th>
<th>SI</th>
<th>OR</th>
<th>SD</th>
<th>CC</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>F-values</td>
<td>.864</td>
<td>.437</td>
<td>5.34*</td>
<td>.306</td>
<td>3.86^</td>
<td>.583</td>
<td>2.24</td>
</tr>
</tbody>
</table>

*Note.* TS = Total Scale; AA = Affective Attunement subscale; SI = Separation-Individuation subscale; OR = Therapist Owns Role subscale; SD = Expansion of Self-Definition subscale; CC = Coming Clean subscale; D = Disconfirmation subscale.

^ p < .10  * p < .05  ** p < .01  *** p < .001
Chapter IV

General Discussion

The current study was designed to assess the overall psychometric properties of a newly developed measure of therapist rupture resolution processes, the Rupture Resolution Questionnaire – Therapist version (RRQ-T). The relationship between therapist resolution processes and established measures of psychotherapy process and outcome were examined. It was expected that the presence of optimal therapist states and behaviors hypothesized to facilitate the rupture resolution process, would have positive implications for other dimensions of psychotherapy process (i.e., therapeutic alliance) and outcome. Several analyses were run to test these assumptions, the results of which are discussed below. For simplicity, the following two statements are used interchangeably throughout this discussion: “therapist internal states and behaviors thought to facilitate rupture resolution” and “therapist resolution states”.

Reliability of the instrument

The reliability of the RRQ-T was examined through an assessment of the measure’s internal consistency. Reliability estimates were found to be quite strong for the total scale, suggesting that the items of the RRQ-T hang together well. In addition, all but one subscale were found to have acceptable levels of reliability. The Separation-Individuation subscale did not yield an adequate level of internal consistency, which suggests that this subscale may be in need of further attention and refinement. Upon consideration, it is not clear that this subscale measures one cohesive dimension of the process of therapist rupture resolution. The individual items do not seem to be tapping
into one larger overarching factor, and it may be the case that the items, or our understanding of the subscale, did not transition well from Winkelman and colleagues’ (1996) patient-rated measure (RRQ-P). Additional modification of the RRQ-T subscales seems to be in order so as to ensure that the measure most effectively captures the therapist experience of the rupture resolution process.

Validity of the instrument

The overall results of this study with regard to the validity of the RRQ-T are encouraging. By and large, concurrent validity was strong, and substantiated our formal hypotheses concerning the relationship of the RRQ-T and other dimensions of psychotherapy process. As expected, the presence of optimal therapist states and behaviors hypothesized to facilitate the rupture resolution process, were significantly associated with the majority of our other measures of therapeutic process. In contrast, evidence of the measure’s predictive validity was uncertain. Although our findings do suggest that the presence of optimal therapist resolution processes is related to some aspects of psychotherapy outcome, these findings were less impressive overall. There are several potential reasons for the lack of findings in this domain of the current study, which will be discussed in detail below.

Overall, these results provide firm support for the reliability and concurrent validity of the RRQ-T, and suggest that this measure may prove to be a useful tool in future investigations of psychotherapy process. Findings concerning a therapist resolution processes-outcome association, while less impressive, provide some degree of encouragement and ideas for future directions of study.
**Concurrent validity.** A series of regression analyses were conducted to assess the concurrent validity of the RRQ-T in relation to the following patient and therapist variables: working alliance (WAI), session depth (SEQ-d), session smoothness (SEQ-s), patient-rated rupture resolution (RRQ-P), session helpfulness, rupture intensity, and global degree of resolution.

**Patient variables.** Hypotheses concerning the relationship between the presence of optimal therapist internal states and behaviors conducive to rupture resolution, and dimensions of patient-rated therapeutic process, were largely supported. The results pertaining to these analyses are as follows. As expected, when therapists reported the presence, in a given session, of these optimal therapist resolution states, patients experienced that session as helpful. This suggests that when therapists assume an authentic, sincere, and non-defensive approach to the negotiation of conflict within the therapeutic relationship, patients respond by feeling helped in some way. There are several potential reasons for this finding. It may be that patients feel more understood or connected with their therapist, or that they experience their therapist as more genuine. It may also be that patient’s are reassured by being offered the opportunity to be honest themselves in talking about tensions, concerns, or dissatisfactions within the therapy.

The presence of therapist internal states and behaviors hypothesized to facilitate the rupture resolution process is also related to an increase in patient-rated alliance strength (WAI). This finding provides evidence for the theoretical assumption that attending to and resolving conflict in the manner previously described, works to enhance the therapeutic relationship. These results are consistent with the results and conclusions
reached by Forman & Marmer (1985), and Lansford (1986), regarding the importance of directly addressing alliance ruptures in order to strengthen the therapeutic alliance. This finding is also consistent with results found by Winkelman et al. (1996), who demonstrated a similarly strong relationship between patient conflict resolution processes (RRQ-P) and alliance strength (WAI).

Psychotherapy sessions in which the presence of these optimal therapist states were reported, were perceived by the patient as having a high level of depth (SEQ-d). This finding makes intuitive sense if we think of a patient’s experience of their therapist attending to, and exploring tension or conflict in a direct manner. In thinking about this finding one might also consider Safran, Muran, and colleague’s (Safran et al., 1990; Muran, 2002) suggestion that alliance ruptures may provide a window into a patient’s core interpersonal schema. In view of this supposition, it would follow that attention to the rupture event and a focus on resolution would be a particularly deep experience for a patient. This finding is also consistent with Winkelman et al. (1996), who demonstrated a positive relationship between the patient resolution processes (RRQ-P) and the patient experience of session depth (SEQ-d).

The presence of therapist internal states and behaviors hypothesized to facilitate the rupture resolution process was not significantly related to patient report of degree of session smoothness. While we did see the expected direction, namely that sessions evidencing therapist resolution processes would be experienced by patients as somewhat uncomfortable or difficult, this finding only approached significance. It is unclear why this was so, but encouraging that the relationship appears to be of the nature we expected.
Not surprisingly, the presence of optimal therapist resolution states was firmly associated with patient report of resolution processes (RRQ-P). As these two measures tap into comparable processes, this suggests that there was some level of agreement between patient and therapist about what was happening during the session. This evidence of a shared experience, in that both patient and therapist are reporting the presence of very similar internal processes, may be the consequence of the therapist directly addressing any tension, and assuming an encouraging stance in the negotiation process.

The presence of optimal therapist resolution processes was also firmly associated with patient perception of rupture intensity. This finding is not surprising as it seems intuitive that as degree of felt tension increases, so to would the presence of therapist states and behaviors conducive to negotiating strains or conflict within the relationship. One possible construal of this finding is that therapists in this study were well able to detect and respond to patient cues suggestive of a rupture event, particularly as intensity of the rupture increased. It may also be the case that patients’ perceive the beginning stages of the repair process as a continuation of the rupture event due to the ongoing focus on conflict or tension.

Psychotherapy sessions in which the presence of these optimal therapist states were reported, were also perceived by patients as having a high level of global resolution. This finding again supports the intuitive notion that when therapists’ are reporting the presence of processes conducive to resolution, patients will experience any conflict or tension as having been, at least in some part, resolved.
Therapist variables. Hypotheses concerning the relationship between the presence of optimal therapist internal states and behaviors conducive to rupture resolution, and other dimensions of therapist-rated therapeutic process were largely supported. As expected, when therapists reported the presence, in a given session, of these optimal therapist resolution states, they also experienced that session as having been helpful to the patient. Considering the finding of a positive relationship between the therapist resolution processes and patient-ratings of session helpfulness, one possible explanation for this association is that therapists are picking up on the patient’s experience of being helped. The therapists’ experience of being honest and open with their patients and approaching the negotiation of tension in a non-defensive manner, also may contribute to their perception of the session as helpful to their patient. Finally, it is tempting to consider the therapist’s potential feelings of satisfaction and relief, particularly if the patient is able to engage with them in a constructive and collaborative negotiation process, and recognition of the positive impact of this potentially new experience for the patient.

The presence of therapist internal states and behaviors hypothesized to facilitate the rupture resolution process is also positively related to therapist reports of alliance strength (WAI). This provides evidence for the theoretical assumption that attending to and resolving conflict in the manner previously described, works to strengthen and enhance the therapeutic relationship.

As expected, when therapists reported the presence of these optimal therapist states, these sessions were also perceived by therapists as having a high level of depth
(SEQ-d). There are several possible explanations for this finding. First, remember that many of the items on the RRQ-T reflect very meaningful internal processes (i.e., coming to terms with your own feelings of vulnerability), and that therapists attending to and working within the context of their own internal and emotional sphere will likely experience this process as both deep and intense. Secondly, it is often the case that patients will respond to their therapist focusing on tense or meaningful moments in a powerful way. It may be that they become initially more resistant or perhaps increasingly emotional, be it with anger, sadness, or any number of powerful affects. Whatever the case may be, a therapist faced with this level of response is not likely to experience it as shallow in nature, but rather as deep and consequential.

Interestingly, psychotherapy sessions in which the presence of these optimal therapist states was reported were also experienced as smooth by therapists. Although this relationship was significant, it was not in the expected direction. Having given considerable thought to this finding, it does not seem overly surprising that our hypothesis was not supported. Recall that this finding did approach significance in the expected direction from the patient perspective. Although this result was not significant, we did see the expected trend, namely that patient’s will experience the resolution process as a bit of a “bumpy ride.” As opposed to patients engaged in resolution, however, therapists may not perceive these moments as rocky or discomfiting, in that they are likely viewing the process as the beginning of the repair or resolution. It may also be the case that relative to the initial rupture event, the resolution process is perceived as more smooth by therapists. This was a particularly interesting finding in that, although it failed
to support our hypothesis, it does provide potentially important information regarding the way in which patient and therapist perceptions differ with regard to the repair process.

Also interesting, the presence of these optimal therapist resolution processes was not related to therapist report of rupture intensity. While initially surprising and somewhat troublesome, upon further consideration, there is at least one potential reason for the lack of association between these variables. Recall that this was a significant finding for patients, who are more likely to experience some of these therapist states and actions as tense, and potentially as some sort of continuation of the rupture experience. Therapists, on the other hand, and similar to previous comments about session smoothness, are talking about these issues in the service of resolution, and may therefore not be rating these moments as highly tense. Further, one must consider the possibility that on a global level, therapists are not experiencing or reporting ruptures as intensely as patients, which would also have a potential impact on this relationship.

Psychotherapy sessions in which the presence of these optimal therapist states were reported were also perceived by therapists as having a high level of global resolution. As these therapist states are all perceived as being in the service of resolution, it is hardly surprising that therapists are also rating a high level of global resolution for these sessions.

Predictive validity.

A series of regression analyses were conducted to assess the predictive validity of the RRQ-T in relation to several patient and therapist-rated measures of psychotherapy outcome. These results were mixed, providing only limited support for the hypotheses
concerning the relationship of the presence of therapist resolution process and psychotherapy outcome. In general, patient-rated outcome was more firmly associated with the presence of therapist resolution processes, than was therapist-rated outcome. On a global level, one possible reason for the lack of expected results may stem from the methodological limitations of this study, namely the small sample size for outcome data. This will be discussed in more detail in the general limitations section that follows.

**Patient variables.** Hypotheses concerning the relationship between the presence of optimal therapist internal states and behaviors conducive to rupture resolution and dimensions of patient-rated psychotherapy outcome received mixed support. The first set of predictive validity analyses assessed the association between the presence of optimal therapist resolution processes and the following patient-rated outcome measures: Symptom Checklist – 90 (SCL-90), Inventory of Interpersonal Problems – 64 (IIP-64), and the Target Complaints Index (PTC). The only relationship to approach significance was between the presence of therapist resolution processes and patient report of improvement in presenting problems (PTC). While this is consistent with our hypothesis that the RRQ-T would be most predictive of outcome tailored to the patient, as opposed to more global measures of outcome (i.e., SCL-90), this finding was not ultimately significant. There was no significant relationship found between the presence of therapist states assumed to be conducive to the resolution process and patient ratings of symptomatic relief (SCL-90). It is not clear why this was so. Our findings also failed to support a relationship between the presence of therapist resolution processes and improvement in interpersonal functioning. This finding is particularly problematic in that
the resolution process has at its core the negotiation of conflict. One would intuitively think that successfully resolving conflict would lead to a healthier and more adaptive interpersonal stance.

*Therapist variables.* Hypotheses concerning the relationship between the presence of optimal therapist internal states and behaviors conducive to rupture resolution and dimensions of therapist-rated psychotherapy outcome were completely unsupported. The final set of predictive validity analyses assessed the association between the presence of optimal therapist resolution processes and the following therapist-rated outcome measures: Global Assessment Scale (GAS), Inventory of Interpersonal Problems – 32 (IIP-32), and the Target Complaints Index (TTC). These analyses yielded no significant associations. It is not clear why this was so. It is possible that the lack of findings in this area were due to the small sample size with regard to therapist outcome data (N = 20-21). Recall that initial analyses with patient data also failed to yield significant results.

**Supplementary Findings**

A post-hoc set of analyses was run so as to determine whether there was a significant difference between the mean RRQ-T ratings of patients who completed treatment and those who did not. There was some evidence of a difference in rating style between these two groups, namely with regard to the Separation- Individuation and the Expansion of Self-Definition subscales. This suggests that therapists are reporting differences in their internal states in response to patients who complete treatment than those who do not. More specifically, therapists appear to experience a significant difference on the Separation-Individuation subscale, suggesting that they are more apt to
have felt self-accepting with patients who completed treatment than those who did not. It must be noted, however, that this particular subscale was the only one that did not demonstrate an acceptable level of internal consistency. This makes the current finding more difficult to interpret. The only other difference to approach significance between these two groups was on the Expansion of Self-Definition subscale. Although this finding did not achieve statistical significance it does suggests that therapists were somewhat more likely to develop an expanded concept of themselves during sessions with patients who would go on to complete the treatment than with those who would not. There were no significant findings between these two groups on any of the remaining four subscales or on the total scale, which was the variable used in all other analyses is the current study. This indicates that patients who completed the treatment did not rate the RRQ-T total scale in a significantly different manner than did those who failed to complete the treatment.

**General implications of the findings.** The findings of the present study are considered to be a valuable contribution to the literature. First, we have established the internal consistency and overall reliability of a unique measure of the therapist resolution processes within the context of the therapeutic relationship. Further, we have successfully demonstrated a solid link between the presence of therapist internal states and behaviors hypothesized to facilitate the rupture resolution process and several other measures of psychotherapy process. Our findings support the current literature regarding the importance of attending to and focusing on ruptures in maintaining a positive alliance. We have also provided important information regarding the implications of rupture
resolution for other in-session therapeutic processes, such as perceived depth, smoothness, and overall helpfulness.

While the predictive validity of this instrument remains unclear, there is evidence of some relationship between the presence of therapist resolution processes and patient-rated outcome data. The finding that therapist resolution processes are more firmly related to outcome tailored to individual patients (i.e., PTC) is particularly interesting and also consistent with the literature. In light of this finding, it may prove interesting to evaluate the relationship between the RRQ-T and other outcome measures tapping into more personalized dimensions of change.

General limitations of this study. The main limitation of this study concerns the difficulty in gaining a definite understanding of precisely what therapeutic processes are being measured by this scale. It is not entirely clear that this scale is a straightforward measure of therapist resolution processes. Although the scale unquestionably taps into therapist internal processes that are conducive to resolution, it may be the case that the scale also represents a broader measure of more global processes that are associated with contemporary relational psychoanalytic thinking. Authenticity, interpersonal awareness, intersubjective negotiation, and mutual recognition are all fundamental elements of a relational approach that are captured by the RRQ-T. It may be that many of the therapist processes captured by this scale are positive ways of thinking and being with patients in a general sense, and that perhaps these internal states become particularly useful in the face of conflict. In will be important for future studies to focus more intensively on this issue in order to more clearly delineate the construct validity of the scale.
There were a few methodological limitations encountered in the current study. First, the overall sample size was relatively small (N = 49), and as is common in psychotherapy research, the data was incomplete for many subjects, particularly with regard to outcome data (N = 18-21). This limit restricted the power of many of the statistical analyses, and may have masked existing relationships between the RRQ-T and outcome. Furthermore, the restricted sample size did not permit the potentially meaningful classification of subjects into groups. For example, it may have been interesting to classify patients according to their diagnosis, to the type of treatment they received, or to whether or not they completed the treatment.

Another methodological limitation of the present study pertains to the inclusion criteria for each analysis. For the purposes of this study, all completed RRQ-T questionnaires were used in assessing the relationship between this scale and all other measures. Thus, the current design does not discriminate between sessions with tension and those without. It would have been interesting, and perhaps more meaningful, had we used RRQ-T data only for sessions where a rupture was reported.

A statistical limitation of the present study concerns the lack of effect size data. At this time, it is not clear that GEE can determine effect sizes in a clear and straightforward way. This data would have been very helpful in terms of gaining a better understanding of the magnitude of the observed relationships. Perhaps future studies using this statistical approach can find a way to incorporate another statistical analysis so as to be able to determine the magnitude of the effect.
**Future Directions.** One future direction that would likely provide additional and important information about the RRQ-T, and its utility as a measure of psychotherapy process, would be to further clarify the underlying dimensions of the scale. Given the substandard reliability estimate of the Separation-Individuation subscale, and just to get a better sense of how the items and subscales hang together in an overall sense, a factor analysis seems to be indicated. This may provide some insight into the overall make-up of the subscales, and allow for a more fine-tuned approach to assessing therapist processes conducive to conflict negotiation.

A similar issue regarding the dimensions of the RRQ-T that could also be better addressed if the subscales were better defined concerns the impact of the individual subscales on the relationship between the RRQ-T and other measures. In interpreting these results, a question often arose about the individual contribution of each of the subscales, and the relationship of each, to the other process and outcome measures used in this study. In other words, do these distinct therapist processes have a similar or divergent impact on other measures of therapeutic process and outcome? For example, what is the relationship between therapist ability to “own their own role in the interaction” and the strength of the therapeutic alliance?

**Conclusion**

The study of ruptures, and the resolution of strains in the therapeutic alliance, has become an increasingly emphasized line of inquiry in recent years. This is not surprising due to the importance of understanding and promoting the stability and strength of the therapeutic relationship in psychotherapy. The chief aim of this dissertation was to
further our knowledge of the process of rupture resolution through the validation of a therapist self-report measure (RRQ-T). That aim was largely met, and though additional work will be needed in order to gain increased understanding of this multifaceted construct, this study has worked to further our understanding of the therapist experience of negotiating impasses in the therapeutic alliance. We have successfully established the reliability and concurrent validity of a new and unique measure of this process from the therapist perspective. Although it is clear that the scale may require some revisions, it is our hope that it will play an important role in future investigations into psychotherapy process, and into the process of negotiation within the therapeutic relationship. Given the largely undisputed association between alliance and outcome, this measure may also serve to elucidate the processes involved in maintaining the strength of the alliance, especially in the face of tension. As researchers continue to focus on the factors that promote the development and maintenance of the alliance, it is our expectation that the research community will continue to place increasing emphasis on the process of resolving strains within the alliance. As this line of inquiry continues, it is our hope to have shed some light on this often subtle and always complex phenomenon.
### APPENDIX A

**RUPTURE RESOLUTION QUESTIONNAIRE – THERAPIST VERISON (RRQ – T)**

Please rate the extent to which each of the following statements reflect your experience during this session.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Somewhat</th>
<th>Definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I felt a closer connection with my patient.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. I found myself talking about feelings I didn’t know I had.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. My patient and I were able to work through a conflict and connect in a stronger way.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d. I saw how I was contributing to the difficulties my patient and I were having.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e. I acted in a way that felt more authentic or genuine for me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f. I recognized and accepted my patient’s limitations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>g. I felt freer to make mistakes with my patient.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>h. I became aware of ways in which I avoid creating conflicts and misunderstandings with my patient.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>i. I saw that I can expose risky feelings and not be rejected/criticized by my patient.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>j. I began to get the sense that I don’t have to protect my patient.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>k. I felt more comfortable with expressing vulnerability or anger towards my patient.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>l. I told my patient something I had been hesitant to say.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
m. I felt able to disagree with my patient.  

n. I began to accept a part of myself, which I had not fully acknowledged before.  

o. I said something to my patient, which I had felt for a while and it left me with a sense of relief.  

p. I saw that I was doing something to distance myself from my patient or push him/her away.  

q. I felt more trusting of my patient.  

r. I was afraid something I said would upset or hurt my patient but I found out that it did not.
APPENDIX B

DEFINITIONS OF THE DIMENSIONS OF RUPTURE RESOLUTION

1. Affective Attunement. This dimension refers to the extent that the therapist is emotionally connected to the patient. In many ways the dimension of affective attunement reflects the bond aspect of the therapeutic alliance. (RRQ-T Items a, c, and q).

2. Separation-Individuation. This dimension emphasizes themes of self-emancipation and self-acceptance on the part of the therapist. It captures a clinician’s ability to respond in a way that feels more authentic, spontaneous, and accepting of his or her own limitations. At the same time, this dimension seems to tap into the idea of therapists recognizing patients’ robustness, and their ability to see the patient as a subject rather than an object. (RRQ-T Items f, g, and m).

3. Therapist Owns Role in Interaction. This dimension refers to the therapist’s ability to recognize and acknowledge the role he or she plays in contributing to problematic interactions with their patient. (RRQ-T Items d, h, and p).

4. Expansion of Self-Definition. This dimension refers to the extent to which the therapist begins to develop an expanded concept of him or herself through acknowledgment of previously avoided emotions that emerge in the exploration of the rupture with the patient. This will sometimes involve the acknowledgement of feelings of anger or vulnerability. (RRQ-T Items b, k, and n).

5. Coming Clean. This dimension refers to the therapist experience of genuinely speaking their mind, thereby freeing him or herself up in some way. The idea behind this dimension is that if a therapist is holding back, or not saying something that is on her mind, she is restricting her ability to work effectively in the moment. (RRQ-T Items e, l, and o).

6. Disconfirmation. This dimension refers to the extent to which the therapist gains a greater sense of the patient’s resiliency or ability to tolerate an authentic confrontation. (RRQ-T Items i, j, and r).
APPENDIX C

MEANS, STANDARD DEVIATIONS, CORRECTED ITEM-TOTAL CORRELATIONS, AND ALPHA IF ITEM DELETED FOR THE RRQ – T TOTAL SCALE AND EACH SUBSCALE.

RRQ – T total scale (n=43):

<table>
<thead>
<tr>
<th>Items</th>
<th>Mean</th>
<th>SD</th>
<th>Corrected Item-Total Correlation</th>
<th>Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>3.33</td>
<td>.78</td>
<td>.4688</td>
<td>.9336</td>
</tr>
<tr>
<td>b.</td>
<td>1.53</td>
<td>.83</td>
<td>.6873</td>
<td>.9302</td>
</tr>
<tr>
<td>c.</td>
<td>2.23</td>
<td>1.21</td>
<td>.6053</td>
<td>.9313</td>
</tr>
<tr>
<td>d.</td>
<td>2.16</td>
<td>1.29</td>
<td>.6139</td>
<td>.9313</td>
</tr>
<tr>
<td>e.</td>
<td>3.07</td>
<td>1.22</td>
<td>.6601</td>
<td>.9300</td>
</tr>
<tr>
<td>f.</td>
<td>3.23</td>
<td>.87</td>
<td>.3509</td>
<td>.9355</td>
</tr>
<tr>
<td>g.</td>
<td>2.74</td>
<td>1.20</td>
<td>.7374</td>
<td>.9282</td>
</tr>
<tr>
<td>h.</td>
<td>2.72</td>
<td>1.20</td>
<td>.7503</td>
<td>.9279</td>
</tr>
<tr>
<td>i.</td>
<td>2.56</td>
<td>1.26</td>
<td>.7955</td>
<td>.9268</td>
</tr>
<tr>
<td>j.</td>
<td>2.67</td>
<td>1.23</td>
<td>.6525</td>
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</tr>
<tr>
<td>k.</td>
<td>1.91</td>
<td>1.04</td>
<td>.6386</td>
<td>.9305</td>
</tr>
<tr>
<td>l.</td>
<td>2.23</td>
<td>1.31</td>
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<td>.9297</td>
</tr>
<tr>
<td>m.</td>
<td>2.98</td>
<td>1.03</td>
<td>.2663</td>
<td>.9377</td>
</tr>
<tr>
<td>n.</td>
<td>1.63</td>
<td>.82</td>
<td>.7776</td>
<td>.9288</td>
</tr>
<tr>
<td>o.</td>
<td>1.98</td>
<td>1.22</td>
<td>.7214</td>
<td>.9286</td>
</tr>
<tr>
<td>p.</td>
<td>1.86</td>
<td>.97</td>
<td>.6230</td>
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<tr>
<td>q.</td>
<td>3.00</td>
<td>1.09</td>
<td>.7566</td>
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</tr>
<tr>
<td>r.</td>
<td>2.47</td>
<td>1.28</td>
<td>.7818</td>
<td>.9271</td>
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</tbody>
</table>

RRQ – T subscales:

**Affective Attunement (n=45)**

<table>
<thead>
<tr>
<th>Items</th>
<th>Mean</th>
<th>SD</th>
<th>Corrected Item-Total Correlation</th>
<th>Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>3.31</td>
<td>.87</td>
<td>.5885</td>
<td>.6734</td>
</tr>
<tr>
<td>q.</td>
<td>3.04</td>
<td>1.11</td>
<td>.6408</td>
<td>.5833</td>
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<tr>
<td>c.</td>
<td>2.24</td>
<td>1.23</td>
<td>.5335</td>
<td>.7339</td>
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</table>

**Separation – Individuation (n=45)**

<table>
<thead>
<tr>
<th>Items</th>
<th>Mean</th>
<th>SD</th>
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<th>Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>f.</td>
<td>3.29</td>
<td>.90</td>
<td>.4559</td>
<td>.2503</td>
</tr>
<tr>
<td>m.</td>
<td>2.98</td>
<td>1.03</td>
<td>.2989</td>
<td>.4697</td>
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<tr>
<td>g.</td>
<td>2.78</td>
<td>1.18</td>
<td>.2715</td>
<td>.5422</td>
</tr>
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</table>
### Therapist Owns Role (n=44)

<table>
<thead>
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<th>Items</th>
<th>Mean</th>
<th>SD</th>
<th>Corrected Item-Total Correlation</th>
<th>Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>d.</td>
<td>2.16</td>
<td>1.27</td>
<td>.5820</td>
<td>.6988</td>
</tr>
<tr>
<td>h.</td>
<td>2.68</td>
<td>1.22</td>
<td>.6347</td>
<td>.6278</td>
</tr>
<tr>
<td>p.</td>
<td>1.84</td>
<td>.96</td>
<td>.5836</td>
<td>.7038</td>
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</tbody>
</table>

### Expansion of Self-Definition (n=45)

<table>
<thead>
<tr>
<th>Items</th>
<th>Mean</th>
<th>SD</th>
<th>Corrected Item-Total Correlation</th>
<th>Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>b.</td>
<td>1.56</td>
<td>.84</td>
<td>.7382</td>
<td>.7614</td>
</tr>
<tr>
<td>k.</td>
<td>1.91</td>
<td>1.02</td>
<td>.6088</td>
<td>.9020</td>
</tr>
<tr>
<td>n.</td>
<td>1.69</td>
<td>.85</td>
<td>.8134</td>
<td>.6902</td>
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</table>

### Coming Clean (n=45)

<table>
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<th>Items</th>
<th>Mean</th>
<th>SD</th>
<th>Corrected Item-Total Correlation</th>
<th>Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.</td>
<td>3.07</td>
<td>1.21</td>
<td>.5567</td>
<td>.8809</td>
</tr>
<tr>
<td>l.</td>
<td>2.24</td>
<td>1.32</td>
<td>.7592</td>
<td>.6856</td>
</tr>
<tr>
<td>o.</td>
<td>2.02</td>
<td>1.29</td>
<td>.7548</td>
<td>.6913</td>
</tr>
</tbody>
</table>

### Disconfirmation (n=44)

<table>
<thead>
<tr>
<th>Items</th>
<th>Mean</th>
<th>SD</th>
<th>Corrected Item-Total Correlation</th>
<th>Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>i.</td>
<td>2.25</td>
<td>1.24</td>
<td>.7828</td>
<td>.7473</td>
</tr>
<tr>
<td>j.</td>
<td>2.68</td>
<td>1.22</td>
<td>.6495</td>
<td>.8689</td>
</tr>
<tr>
<td>r.</td>
<td>2.52</td>
<td>1.32</td>
<td>.7602</td>
<td>.7685</td>
</tr>
</tbody>
</table>
APPENDIX D

Therapist post-Session Questionnaire (PSQ) – 2002 version

BRIEF PSYCHOTHERAPY RESEARCH PROJECT | Beth Israel Medical Center | Tel: 212.420.3819

THERAPIST POST-SESSION QUESTIONNAIRE - V2002
Complete immediately after session. Please answer all questions.

<table>
<thead>
<tr>
<th>Your initials:</th>
<th>Your patient's initials:</th>
<th>Session number:</th>
<th>Date of session:</th>
</tr>
</thead>
</table>

SECTION A

1. Please rate how helpful or hindering to your patient this session was overall by circling the appropriate number.

2. Please rate to what extent your patient's problems are resolved.

SECTION B: Please circle the appropriate number to show how you feel about this session.

This session was:

- Bad
- Safe
- Difficult
- Valuable
- Shallow
- Relaxed
- Unpleasant
- Full
- Weak
- Special
- Rough
- Comfortable

SECTION C: The following items reflect your working relationship with your patient based on your most recent session. Please circle the appropriate number to indicate how you felt about this session.

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Somewhat</th>
<th>Completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
<td>1 2 3 4 5 6 7</td>
</tr>
</tbody>
</table>

1. My patient and I agreed about the things he/she needs to do in therapy to help improve his/her situation.

2. My patient believed that what we are doing in therapy gave him/her new ways of looking at his/her problem.

3. My patient believed that I like him/her.
4. My patient believed that I did not understand what he/she is trying to accomplish in therapy.

5. My patient was confident in my ability to help him/her.

6. My patient and I worked toward mutually agreed-upon goals.

7. My patient felt appreciated by me.

8. We agreed on what is important for him/her to work on.

9. My patient and I seemed to trust one another.

10. My patient and I seemed to have different ideas on what his/her problems are.

11. We have established a good understanding of the kind of changes that would be good for him/her.

12. My patient believed the way we were working with his/her problem was correct.

SECTION D

1. Did you experience any tension or problem, any misunderstanding, conflict or disagreement, in your relationship with your patient during the session?

2. If yes, please rate how tense or upset you felt about the problem during the session:

3. To what extent did you find yourself and your patient overly accommodating or overly protective of each other?

4. Please describe the problem:

5. To what extent was this problem addressed in this session?

6. To what degree do you feel this problem was resolved by the end of the session?

7. What do you think contributed to the resolution of the problem? Please describe:

8. Please rate the extent to which each of the following statements reflects your experience during this session.
a. I felt a closer connection with my patient. 1 2 3 4 5
b. I found myself talking about feelings I didn’t know I had. 1 2 3 4 5
c. My patient and I were able to work through a conflict and connect in a stronger way. 1 2 3 4 5
d. I saw how I was contributing to the difficulties my patient and I were having. 1 2 3 4 5
e. I acted in a way that felt more authentic or genuine for me. 1 2 3 4 5
f. I recognized and accepted my patient’s limitations. 1 2 3 4 5
g. I felt freer to make mistakes with my patient. 1 2 3 4 5
h. I became aware of ways in which I avoid creating conflicts and misunderstandings with my patient. 1 2 3 4 5
i. I saw that I can expose risky feelings and not be rejected/criticized by my patient. 1 2 3 4 5
j. I began to get the sense that I don’t have to protect my patient. 1 2 3 4 5
k. I felt more comfortable with expressing vulnerability or anger towards my patient. 1 2 3 4 5
l. I told my patient something I had been hesitant to say. 1 2 3 4 5
m. I felt able to disagree with my patient. 1 2 3 4 5
n. I began to accept a part of myself, which I had not fully acknowledged before. 1 2 3 4 5
o. I said something to my patient, which I had felt for a while and it left me with a sense of relief. 1 2 3 4 5
p. I saw that I was doing something to distance myself from my patient or push him/her away. 1 2 3 4 5
q. I felt more trusting of my patient. 1 2 3 4 5
r. I was afraid something I said would upset or hurt my patient but I found out that it did not. 1 2 3 4 5

SECTION E: Please check any of the following adjectives to describe how you felt in this session with your patient. A check beside the word means “Yes.” You may check as many or as few adjectives as you would like.

1__HELPFUL  11__SURPRISED  21__HAPPY
2__TIRED    12__ANGRY     22__THREATENED
3__ENTHUSIASTIC  13__RECEPTIVE  23__ANXIOUS
4__OBJECTIVE  14__STRONG    24__OVERWHELMED
5__MANIPULATED  15__BORED    25__RELAXED
6__MOTHERLY   16__CAUTIOUS  26__CONFUSED
7__DISAPPOINTED  17__EMBARRASSED  27__INDIFFERENT
8__INTERESTED  18__AFFECTIONATE  28__ALOOF
9__SUSPICIOUS   19__SAD     29__SYMPATHETIC
10__INADEQUATE  20__DISLIKED  30__FRUSTRATED

Not at all    Somewhat   Completely
31. To what extent do you feel uncomfortable or badly about having any of these feelings in the session?  
1 2 3 4 5 6 7
32. To what extent did any of these feelings emerge as new or different for you in this session?  
1 2 3 4 5 6 7

SECTION F: The following items reflect your working relationship with your patient based on your most recent session. Please circle the appropriate number to indicate how you felt about this session.

<table>
<thead>
<tr>
<th>Item</th>
<th>Not at all</th>
<th>Somewhat</th>
<th>Completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I liked my patient.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I struggled to understand my patient.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I felt appreciated by my patient.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I felt uncomfortable with my patient.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I felt confident in my ability to help my patient.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I felt that I am not totally honest about my feelings toward my patient.</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Progress Note: Please write a few sentences about the session.

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

SIGNATURE

H: Brief/Forms/psqth 2002-revised.doc
APPENDIX E

Patient post-Session Questionnaire (PSQ) – 2002 version

BRIEF PSYCHOTHERAPY RESEARCH PROJECT | Beth Israel Medical Center | Tel: 212.420.3819

PATIENT POST-SESSION QUESTIONNAIRE - V2002
Complete immediately after session. Please answer all questions.

<table>
<thead>
<tr>
<th>Your initials:</th>
<th>Your therapist initials:</th>
<th>Session number:</th>
<th>Date of session:</th>
</tr>
</thead>
</table>

SECTION A

1. Please rate how helpful or hindering to you this session was overall by circling the appropriate number below.

1 2 3 4 5 6 7 8 9
Extremely hindering Neutral Extremely helpful

2. Please rate to what extent you feel the problems you had at the beginning of therapy are resolved.

1 2 3 4 5 6 7 8 9
Not at all Moderately Completely

SECTION B: Please circle the appropriate number to show how you feel about this session.

This session was:

Bad 1 2 3 4 5 6 7 8 9 Good
Safe 1 2 3 4 5 6 7 8 9 Dangerous
Difficult 1 2 3 4 5 6 7 8 9 Easy
Valuable 1 2 3 4 5 6 7 8 9 Worthless
Shallow 1 2 3 4 5 6 7 8 9 Deep
Relaxed 1 2 3 4 5 6 7 8 9 Tense
Unpleasant 1 2 3 4 5 6 7 8 9 Pleasant
Full 1 2 3 4 5 6 7 8 9 Empty
Weak 1 2 3 4 5 6 7 8 9 Powerful
Special 1 2 3 4 5 6 7 8 9 Ordinary
Rough 1 2 3 4 5 6 7 8 9 Smooth
Comfortable 1 2 3 4 5 6 7 8 9 Uncomfortable

SECTION C: The following items reflect your working relationship with your therapist based on your most recent session. Please circle the appropriate number to indicate how you felt about this session.

1. My therapist and I agreed about the things I need to do in therapy to help improve my situation.

Not at all Somewhat Completely
1 2 3 4 5 6 7

2. What we are doing in therapy gave me new ways of looking at my problem.

Not at all Somewhat Completely
1 2 3 4 5 6 7

3. I believed that my therapist liked me.

Not at all Somewhat Completely
1 2 3 4 5 6 7
4. My therapist did not understand what I am trying to accomplish in therapy.  
5. I was confident in my therapist's ability to help me.  
6. My therapist and I worked toward mutually agreed-upon goals.  
7. I felt that my therapist appreciates me.  
8. We agreed on what is important for me to work on.  
9. My therapist and I seemed to trust one another.  
10. My therapist and I seemed to have different ideas on what my problems are.  
11. We have established a good understanding of the kind of changes that would be good for me.  
12. I believed the way we were working with my problem was correct.  

SECTION D

1. Did you experience any tension or problem, any misunderstanding, conflict or disagreement, in your relationship with your therapist during the session?  
2. If yes, please rate how tense or upset you felt about the problem during the session:  
3. To what extent did you find yourself and your therapist overly accommodating or overly protective of each other?  
4. Please describe the problem:  

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Occasionally</th>
<th>Constantly</th>
<th>Not at all</th>
<th>Somewhat</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3</td>
<td>4 5</td>
<td></td>
<td>1 2 3</td>
<td>4 5</td>
<td></td>
</tr>
</tbody>
</table>

5. To what extent was this problem addressed in this session?  
6. To what degree do you feel this problem was resolved by the end of the session?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Somewhat</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3</td>
<td>4 5</td>
<td></td>
</tr>
</tbody>
</table>
7. What do you think contributed to the resolution of the problem? Please describe:


8. Please rate the extent to which each of the following statements reflects your experience during this session.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all</th>
<th>Somewhat</th>
<th>Definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I felt a closer connection with my therapist.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. I discovered feelings toward my therapist that I had not been fully aware of.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. My therapist and I were able to work through a conflict and connect in a stronger way.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d. I saw how I was contributing to the difficulties my therapist and I were having.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e. I acted in a way that felt more authentic or genuine for me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f. I recognized and accepted my therapist’s limitations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>g. I felt freer to make mistakes with my therapist.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>h. I became aware of ways in which I avoid creating conflicts and misunderstandings with my therapist.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>i. I saw that I can expose risky feelings and not be rejected/criticized by my therapist.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>j. I began to get the sense that I don’t have to protect my therapist.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>k. I felt more comfortable with expressing vulnerability or anger towards my therapist.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>l. I told my therapist something I had been hesitant to say.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>m. I felt able to disagree with my therapist.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>n. I began to accept a part of myself which I had not fully acknowledged before.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>o. I said something to my therapist which I had felt for a while and it left me with a sense of relief.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>p. I saw that I was doing something to distance myself from my therapist or push him/her away.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>q. I felt more trusting of my therapist.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>r. I was afraid something I said would upset or hurt my therapist but I found out that it did not.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

SECTION E: Please check any of the following adjectives to describe how you felt in this session with your therapist. A check beside the word means “Yes.” You may check as many or as few adjectives as you would like.

1. HELPFUL
2. TIRED
3. SURPRISED
4. ANGRY
5. HAPPY
6. TIRED
7. THREATENED
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>ENTHUSIASTIC</td>
<td>13</td>
</tr>
<tr>
<td>4</td>
<td>OBJECTIVE</td>
<td>14</td>
</tr>
<tr>
<td>5</td>
<td>MANIPULATED</td>
<td>15</td>
</tr>
<tr>
<td>6</td>
<td>MOTHERLY</td>
<td>16</td>
</tr>
<tr>
<td>7</td>
<td>DISAPPOINTED</td>
<td>17</td>
</tr>
<tr>
<td>8</td>
<td>INTERESTED</td>
<td>18</td>
</tr>
<tr>
<td>9</td>
<td>SUSPICIOUS</td>
<td>19</td>
</tr>
<tr>
<td>10</td>
<td>INADEQUATE</td>
<td>20</td>
</tr>
</tbody>
</table>

31. To what extent do you feel uncomfortable or badly about having any of these feelings in the session?

32. To what extent did any of these feelings emerge as new or different for you in this session?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Somewhat</th>
<th>Completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

H: Brief/Forms/psqpt 2002-revised doc.
APPENDIX F:
THERAPIST TARGET COMPLAINTS INDEX

TARGET COMPLAINTS FORM - THERAPIST / INTAKE

Pt. Name: __________________ Date: __________________

These are the main problems or difficulties that your patient would like help with in treatment. Please rate in general how much each problem seems to bother your patient by circling the appropriate number.

(1)

__________________________________________________________

In general, how much does this problem bother your patient?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>not</td>
<td>a</td>
<td>pretty</td>
<td>very</td>
<td>couldn't</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>at all</td>
<td>little</td>
<td>much</td>
<td>much</td>
<td>be worse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(2)

__________________________________________________________

In general, how much does this problem bother your patient?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>not</td>
<td>a</td>
<td>pretty</td>
<td>very</td>
<td>couldn't</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>at all</td>
<td>little</td>
<td>much</td>
<td>much</td>
<td>be worse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(3)

__________________________________________________________

In general, how much does this problem bother your patient?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>not</td>
<td>a</td>
<td>pretty</td>
<td>very</td>
<td>couldn't</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>at all</td>
<td>little</td>
<td>much</td>
<td>much</td>
<td>be worse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX G:
PATIENT TARGET COMPLAINTS INDEX

TARGET COMPLAINTS (P/I)

Name: __________________________ Date: __________________________

What are the main problems or difficulties that you have which you would like help with in treatment? Please describe them briefly and rate in general how much each problem bothers you by circling the appropriate number.

(1)


In general, how much does this problem bother you?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td>a little</td>
<td>pretty</td>
<td>much</td>
<td>very</td>
<td>much</td>
<td>couldn't</td>
<td>be worse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(2)


In general, how much does this problem bother you?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td>a little</td>
<td>pretty</td>
<td>much</td>
<td>very</td>
<td>much</td>
<td>couldn't</td>
<td>be worse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(3)


In general, how much does this problem bother you?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td>a little</td>
<td>pretty</td>
<td>much</td>
<td>very</td>
<td>much</td>
<td>couldn't</td>
<td>be worse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX H:  
THERAPIST INVENTORY OF INTERPERSONAL PROBLEMS - 32

SUBJECT ID#: ___________________ TIME: ______________ DATE: _________________

Inventory of Interpersonal Problems-SC

Here is a list of problems that people report in relating to other people. Please read the list below, and for each item, consider whether that item has been a problem for you. Then select the number that describes how distressing that problem has been, and circle that number.

Part I. The following are things this person finds hard to do with other people.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. join in on groups</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2. keep things private from other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>3. tell a person to stop bothering him/her</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>4. introduce him/herself to new people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5. confront people with problems that come up</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>6. be assertive with another person</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>7. let other people know when he/she is angry</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>8. socialize with other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>9. show affection to people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>10. understand another person’s point of view</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>11. be firm when he/she needs to be</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>12. experience a feeling of love for another person</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>13. be supportive of another person’s goals in life</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>14. feel close to other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>15. feel good about another person’s happiness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>16. ask other people to get together socially with him/her</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>17. attend to his/her own welfare when somebody else is needy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>18. be assertive without worrying about hurting the other person’s feelings</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Part II. The following are things that this person does too much.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. he/she is too easily persuaded by other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>20. he/she opens up to people too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>21. he/she is too aggressive toward other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>22. he/she tries to please other people too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>23. he/she wants to be noticed too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>24. he/she tries to control other people too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>25. he/she puts other people’s needs before his/her own too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>26. he/she is too suspicious of other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>27. he/she tells personal things to other people too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>28. he/she argues with other people too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>29. he/she keeps other people at a distance too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>30. he/she lets other people take advantage of him/her too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>31. he/she is affected by another person’s misery too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>32. he/she wants to get revenge against people too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX I:
PATIENT INVENTORY OF INTERPERSONAL PROBLEMS - 64

Inventory of Interpersonal Problems

Here is a list of problems that people report in relating to other people. Please read the list below, and for each item, consider whether that problem is a problem for you with respect to people in your life. Then select the number that describes how distressing that problem is and circle that number.

---

**EXAMPLE**

How much have you been distressed by this problem?

<table>
<thead>
<tr>
<th>It is hard for me to:</th>
<th>Not at all</th>
<th>Moderately</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. get along with my relatives.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

---

**Part I. The following are things you find hard to do with other people.**

<table>
<thead>
<tr>
<th>It is hard for me to:</th>
<th>Not at all</th>
<th>Moderately</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. trust other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. say &quot;no&quot; to other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. join in on groups.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. keep things private from other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. let other people know what I want.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6. tell a person to stop bothering me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7. introduce myself to new people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8. confront people with problems that come up.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9. be assertive with another person.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10. let other people know when I am angry.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11. make a long-term commitment to another person.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>12. be another person’s boss.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>13. be aggressive with other people when the situation calls for it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>14. socialize with other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>15. show affection to people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Item</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>16. get along with people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>17. understand another person's point of view.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>18. express my feelings to other people directly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>19. be firm when I need to be.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>20. experience a feeling of love for another person.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>21. set limits on other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>22. be supportive of another person's goals in life.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>23. feel close to other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>24. really care about other people's problems.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>25. argue with another person.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>26. spend time alone.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>27. give a gift to another person.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>28. let myself feel angry at somebody I like.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>29. put someone else's needs before my own.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>30. stay out of other people's business.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>31. take instructions from people who have authority over me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>32. feel good about another person's happiness.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>33. ask other people to get together socially with me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>34. feel angry at other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>35. open up and tell my feelings to another person.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>36. forgive another person after I've been angry.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>37. attend to my own welfare when somebody else is needy.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>38. be assertive without worrying about hurting the other person's feelings.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>39. be self-confident when I am with other people.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
Part II. The following are things that you do too much.

40. I fight with other people too much. 0 1 2 3 4
41. I feel too responsible for solving other people's problems. 0 1 2 3 4
42. I am too easily persuaded by other people 0 1 2 3 4
43. I open up to people too much. 0 1 2 3 4
44. I am too independent. 0 1 2 3 4
45. I am too aggressive toward other people. 0 1 2 3 4
46. I try to please other people too much. 0 1 2 3 4
47. I clown around too much. 0 1 2 3 4
48. I want to be noticed too much. 0 1 2 3 4
49. I trust other people too much. 0 1 2 3 4
50. I try to control other people too much. 0 1 2 3 4
51. I put other people's needs before my own too much. 0 1 2 3 4
52. I try to change other people too much. 0 1 2 3 4
53. I am too gullible. 0 1 2 3 4
54. I am overly generous to other people. 0 1 2 3 4
55. I am too afraid of other people. 0 1 2 3 4
56. I am too suspicious of other people. 0 1 2 3 4
57. I manipulate other people too much to get what I want. 0 1 2 3 4
58. I tell personal things to other people too much. 0 1 2 3 4
59. I argue with other people too much. 0 1 2 3 4
60. I keep other people at a distance too much. 0 1 2 3 4
61. I let other people take advantage of me too much. 0 1 2 3 4
62. I feel embarrassed in front of other people too much. 0 1 2 3 4
63. I am affected by another person's misery too much. 0 1 2 3 4
64. I want to get revenge against people too much. 0 1 2 3 4
APPENDIX J:
THERAPIST GLOBAL ASSESSMENT SCALE

Global Assessment Scale (GAS)

Robert L. Spitzer M.D., Miriam Gibbon M.S.W., Jean Endicott Ph.D

Rate the subject's lowest level of functioning in the last week by selecting the lowest range which describes his functioning on a hypothetical continuum of mental health-illness. For example, a subject whose "behavior is considerably influenced by delusions" (range 21-30) should be given a rating in that range even though he has "major impairment in several areas" (range 31-40). Use intermediary levels when appropriate (e.g. 35, 58, 62). Rate actual functioning independent of whether or not subject is receiving and may be helped by medication or some other form of treatment.

Name of Patient ______________________ ID No. ___________ Group code _________

Admission Date ___________ Date of rating _________ Rater __________

GAS Rating ________________

100 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his warmth and integrity.

91 No Symptoms.

90 Good functioning in all areas, many interests, socially effective, generally satisfied with life. There may or may not be transient symptoms and "everyday" worries that only occasionally get out of hand.

80 No more than slight impairment in functioning, varying degrees of "everyday" worries and problems that sometimes get out of hand. Minimal symptoms may or may not be present.

70 Some mild symptoms (e.g. depressive mood and mild insomnia) or some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships and most untrained people would not consider him "sick".

60 Moderate symptoms or generally functioning with some difficulty (e.g. few friends and flat affect, depressed mood and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behavior).

50 Any serious symptomatic or impairment in functioning that most clinicians would think obviously requires treatment or attention (e.g. suicidal preoccupation or gestures, severe obsessive rituals, frequent anxiety attacks, serious antisocial behavior, compulsive drinking, mild but definite manic syndrome).

40 Major impairment in several areas, such as work, family relations, judgment, thinking or mood (e.g. depressed woman avoids friends, neglects family, unable to do housework) or some impairment in reality testing or communications (e.g. speech is at times obscure, illogical or irrelevant), or single suicide attempt.

30 Unable to function in almost all areas (e.g. stays in bed all day) or behavior is considerably influenced by either delusions or hallucinations or serious impairment in communication (e.g. sometimes incoherent or unresponsive) or judgment (e.g. acts grossly inappropriately).

20 Needs some supervision to prevent hurting self or others, or to maintain minimal personal hygiene (e.g. repeated suicide attempts, frequently violent, manic excitement, smears feces) or gross impairment in communication (e.g. largely incoherent or mute).

10 Needs constant supervision for several days to prevent hurting self or others (e.g. requires an intensive care unit with special observation by staff), makes no attempt to maintain minimal personal hygiene, or serious suicide act with clear intent and expectation of death.

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# APPENDIX K: PATIENT SYMPTOM CHECK LIST - 90

## SCL—90—R®

### INSTRUCTIONS:
Below is a list of problems people sometimes have. Please read each one carefully, and circle the number to the right that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Circle only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example below before beginning, and if you have any questions please ask about them.

### EXAMPLE

**HOW MUCH WERE YOU DISTRESSED BY:**

<table>
<thead>
<tr>
<th>HOW</th>
<th>NOT AT ALL</th>
<th>A LITTLE</th>
<th>MODERATELY</th>
<th>GROSSLY</th>
<th>EXTREMELY</th>
</tr>
</thead>
</table>

**VISIT NUMBER:**

### How Much Were You Distressed By:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not At All</th>
<th>A Little</th>
<th>Moderately</th>
<th>Grossly</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Headaches</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Nervousness or shakiness inside</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Repeated unpleasant thoughts that won’t leave your mind</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Faintness or dizziness</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Loss of sexual interest or pleasure</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling critical of others</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. The idea that someone else can control your thoughts</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Feeling others are to blame for most of your troubles</td>
<td>8</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Trouble remembering things</td>
<td>9</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Worried about sloppiness or carelessness</td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Feeling easily annoyed or irritated</td>
<td>11</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Pains in heart or chest</td>
<td>12</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13. Feeling afraid in open spaces or on the streets</td>
<td>13</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. Feeling low in energy or slowed down</td>
<td>14</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. Thoughts of ending your life</td>
<td>15</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. Hearing voices that other people do not hear</td>
<td>16</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17. Trembling</td>
<td>17</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. Feeling that most people cannot be trusted</td>
<td>18</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. Poor appetite</td>
<td>19</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. Crying easily</td>
<td>20</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21. Feeling shy or uneasy with the opposite sex</td>
<td>21</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>22. Feelings of being trapped or caught</td>
<td>22</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23. Suddenly scared for no reason</td>
<td>23</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24. Temper outbursts that you could not control</td>
<td>24</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25. Feeling afraid to go out of your house alone</td>
<td>25</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26. Blaming yourself for things</td>
<td>26</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27. Pains in lower back</td>
<td>27</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28. Feeling blocked in getting things done</td>
<td>28</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29. Feeling lonely</td>
<td>29</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30. Feeling blue</td>
<td>30</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31. Worrying too much about things</td>
<td>31</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>32. Feeling no interest in things</td>
<td>32</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>33. Feeling fearful</td>
<td>33</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>34. Your feelings being easily hurt</td>
<td>34</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>35. Other people being aware of your private thoughts</td>
<td>35</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Item</td>
<td>No At All</td>
<td>A Little</td>
<td>Moderately</td>
<td>Very Much</td>
<td>Extremely</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----------</td>
<td>----------</td>
<td>------------</td>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>36. Feeling others do not understand you or are unsympathetic</td>
<td>36</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>37. Feeling that people are unfriendly or dislike you</td>
<td>37</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>38. Having to do things very slowly to ensure correctness</td>
<td>38</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>39. Heart pounding or racing</td>
<td>39</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>40. Nausea or upset stomach</td>
<td>40</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>41. Feeling inferior to others</td>
<td>41</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>42. Soreness of your muscles</td>
<td>42</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>43. Feeling that you are watched or talked about by others</td>
<td>43</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>44. Trouble falling asleep</td>
<td>44</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45. Having to check and double-check what you do</td>
<td>45</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46. Difficulty making decisions</td>
<td>46</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47. Feeling afraid to travel on buses, subways, or trains</td>
<td>47</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>48. Trouble getting your breath</td>
<td>48</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>49. Hot or cold spells</td>
<td>49</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>50. Having to avoid certain things, places, or activities because they frighten you</td>
<td>50</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>51. Your mind going blank</td>
<td>51</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>52. Numbness or tingling in parts of your body</td>
<td>52</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>53. A lump in your throat</td>
<td>53</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>54. Feeling hopeless about the future</td>
<td>54</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>55. Trouble concentrating</td>
<td>55</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>56. Feeling weak in parts of your body</td>
<td>56</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>57. Feeling tense or keyed up</td>
<td>57</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>58. Heavy feelings in your arms or legs</td>
<td>58</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>59. Thoughts of death or dying</td>
<td>59</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>60. Overeating</td>
<td>60</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>61. Feeling uneasy when people are watching or talking about you</td>
<td>61</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>62. Having thoughts that are not your own</td>
<td>62</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>63. Having urges to beat, injure, or harm someone</td>
<td>63</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>64. Awakening in the early morning</td>
<td>64</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>65. Having to repeat the same actions such as touching, counting, or washing</td>
<td>65</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>66. Sleep that is restless or disturbed</td>
<td>66</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>67. Having urges to break or smash things</td>
<td>67</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>68. Having ideas or beliefs that others do not share</td>
<td>68</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>69. Feeling very self-conscious with others</td>
<td>69</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>70. Feeling uneasy in crowds, such as shopping or at a movie</td>
<td>70</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>71. Feeling everything is an effort</td>
<td>71</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>72. Spells of terror or panic</td>
<td>72</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>73. Feeling uncomfortable about eating or drinking in public</td>
<td>73</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>74. Getting into frequent arguments</td>
<td>74</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>75. Feeling nervous when you are left alone</td>
<td>75</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>76. Others not giving you proper credit for your achievements</td>
<td>76</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>77. Feeling lonely even when you are with people</td>
<td>77</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>78. Feeling so restless you couldn’t sit still</td>
<td>78</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>79. Feelings of worthlessness</td>
<td>79</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>80. The feeling that something bad is going to happen to you</td>
<td>80</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>81. Shouting or throwing things</td>
<td>81</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>82. Feeling afraid you will faint in public</td>
<td>82</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>83. Feeling that people will take advantage of you if you let them</td>
<td>83</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>84. Having thoughts about sex that bother you a lot</td>
<td>84</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>85. The idea that you should be punished for your sins</td>
<td>85</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>86. Thoughts and images of a frightening nature</td>
<td>86</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>87. The idea that something serious is wrong with your body</td>
<td>87</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>88. Never feeling close to another person</td>
<td>88</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>89. Feelings of guilt</td>
<td>89</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>90. The idea that something is wrong with your mind</td>
<td>90</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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APPENDIX L:
THERAPIST INFORMED CONSENT

Therapist Consent

Purpose of program
The purpose of this study is to explore the factors that contribute to the success of psychotherapy. There is one form of psychotherapy used in this study: A time-limited (30 session), integrative therapy including cognitive-behavioral and relational principles.

Conditions of participation
As a therapist taking part in this study, you will practice psychotherapy in this therapeutic modality. Therapy consists of weekly, individual, fifty-minute sessions. Each therapist is responsible for videotaping therapy sessions, for completing a post-session questionnaire after every session, and for making patient assessments during the admission, mid-phase, and termination phases of therapy. Some of this data, as well as information obtained from videotaped recordings of sessions, may be used by the research staff for scientific purposes, such as professional publications or educational presentations in the transcribed, audiotaped, or videotaped format. Therapists are also required to attend weekly individual and group supervision meetings. Certain patient information, such as patient post-session questionnaires, will be kept confidential.

Questions
If you have any questions, you may contact the Brief Psychotherapy Research office at 420-3819 or Chris Muran, Ph.D. at 420-4662. You may request a copy of this form at any time.

Therapist __________________________ Date __________________________

Witness __________________________ Date __________________________

Principal Investigator __________________________ Date __________________________
APPENDIX M:
PATIENT INFORMED CONSENT

Beth Israel Medical Center
St. Luke's Roosevelt Hospital Center

CONSENT FOR PARTICIPATION IN RESEARCH

J. Christopher Muran, Ph.D.

Name of Subject (Printed)
Principal Investigator

Brief Psychotherapy Research Program

Title of Project

Page 1 of 3 Pages

IRB/COSA # 048-88 (15)

Attached to this form is a full description of the study in which we are asking you to participate. The description tells you about the reason for the study, the procedures, interviews, and drugs or devices which may be involved; the duration of the study; and any risks and benefits to you. The description also gives you information about other medical treatments you may receive if you do not want to participate in this study.

If you have questions concerning this research project or your rights as a research subject, or if you have a research-related injury, you may telephone the Principal Investigator
J. Christopher Muran, Ph.D. at 420-4662 or the Patient Representative Ms. Laura Weil at 420-3818.

CONSENT TO PARTICIPATE -- ADULT

I have read the attached study description. The purpose of the study, the risks of the study and what it means to participate in the study have all been explained to me, and my questions have been answered. I agree to participate in the study and agree to take all the tests or procedures mentioned in the study description. If I am injured in the study, I understand only immediate essential medical treatment will be provided free of charge. I understand that participating in the study is voluntary, that I can decline to participate, and that I can stop participating at any time. I also understand that my decision to participate in or to withdraw from the study will not affect the health care I receive, now or in the future. I have been told that records of this investigation will be kept confidential to the extent permitted by law but are subject to inspection by the U.S. Food and Drug Administration and study sponsors.

Signature of Subject or Legal Guardian Date

Signature of Witness Date

Signature of Authorized Representative or Person Giving Consent Date Relationship to Subject

I , have clearly and fully explained to the above subject (or person giving consent) the nature, requirements and risks of the study.

Signature of Researcher Date

COMMITTEE ON

JUN 24 2003

SCIENTIFIC ACTIVITIES (stamp)

DISTRIBUTION: Original to Research Records; copies for Subject (or Person Giving Permission), Investigator, Hospital/Chart and Pharmacy (other appropriate).
Brief Psychotherapy Research Program

Purpose and Nature of Program
You are being asked to participate in a study involving an integrative form of time-limited psychotherapy incorporating cognitive–behavioral and relational techniques. The techniques used in this integrative treatment have already been demonstrated to be significantly effective. We are now attempting to learn more about the relative contributions of these techniques in effecting overall change so that you and others like you can receive the benefit of the best available treatment approaches.

Treatment Conditions
If you decide to participate, you will first complete a thorough assessment evaluation to determine if time-limited treatment is appropriate for you. You will then be assigned to a therapist based on schedule availability. The therapy will be conducted once per week for 30 weeks. This type of psychotherapy incorporates a generally high level of therapist activity with a focus on specific, targeted problem areas.

If you chose to participate in this study you will be asked to do the following:
1. Not participate in other psychotherapy or take psychoactive medication while receiving treatment in this program.
2. Be available for 30 psychotherapy sessions and any relevant assessment evaluations.
3. Complete a package of questionnaires to evaluate your progress at four points in the treatment:
   a. Before beginning treatment
   b. Midway during treatment
   c. At termination of treatment
   d. Six months after treatment is completed
4. Complete a post-session questionnaire after each session.
5. Agree to have evaluation and treatment sessions videotaped.
6. Consent to have information obtained from videotaped recordings of sessions used for scientific purposes, such as a research study, professional publication, and educational presentations in transcribed, audiotaped, or videotaped format by the program staff.

Treatment Fees
There is no fee for any of the assessment evaluations. The fee for the 30 sessions of therapy is established on an income-sensitive scale, ranging from $30 to $100 per session.

Possible Risks
We know of no inherent risks associated with these treatments. Each type of treatment may cause some emotional discomfort at times, but this is generally considered a natural part of the therapeutic process.

Confidentiality
Information that is obtained in connection with this study that can be identified with you, including evaluation materials and videotaped recordings, will be held in the strictest confidence and would be voluntarily disclosed only with your explicit permission, although confidentiality can never be guaranteed in the absolute sense. The one exception to our ongoing efforts to protect your confidentiality is in the event that you may be in danger of harming yourself or someone else. In accordance with New York State laws, relevant individuals or authorities would be notified. Otherwise, we will share such information only with members of our research and treatment team at Beth Israel Medical Center. The post-session questionnaire, which is not available to your therapist, will identify you solely by your confidential identification number provided at the outset. This provision is made because some of the material in this questionnaire pertains to your relationship with your therapist. While it is possible that at some point in the future selected excerpts from your sessions will be either presented or published for
scientific purposes, adequate precautions will be taken to maintain complete confidentiality, according to the customary professional ethics of Beth Israel Medical Center.

Possible Benefits
The treatment offers possible therapeutic benefits to you because it follows clinical principles that have been tested and proven effective. We are attempting to study specific aspects of cognitive and relational techniques that contribute to, or detract from, their efficacy, particularly in terms of specific types of individuals and specific types of problems. Your participation in the research may be beneficial to you and other mental health treatment consumers in terms of contributing to the development of the most effective integrative, time-limited psychotherapy.

Withdrawal
You may withdraw or cancel your participation at any time and you are under no obligation to participate. If you choose not to participate in this study, or if it is determined that the therapy is not appropriate for you, you will be provided with referrals for alternative forms of treatment. If you withdraw at a later date, you will not jeopardize your future care by doing so. In this event, you will be provided with standard Beth Israel care on the usual basis.

Questions
If you have any questions, you may contact Christopher Muran, Ph.D., Program Director, at 420-3819. If you have any unsatisfied complaints, you may contact Laura Weil, Patient Representative at 420-3818. You may request a copy of this consent form at any time. You may also request feedback regarding aspects of the study upon the termination of your treatment and the completion of the assessment protocol.
Bibliography


