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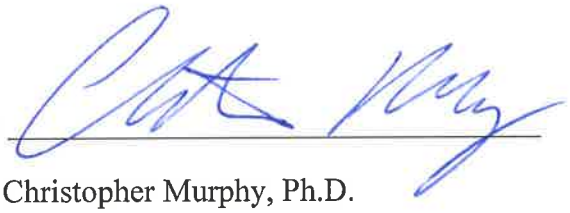
Dissertation and Abstract Approved: 

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ABSTRACT

Title of Document: Influence of Therapist Response Style on Group Member Interactions and Clinical Outcomes in a Male Intimate Partner Violence Treatment Group

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Directed by: Christopher Murphy, Ph.D

Current research indicates that IPV treatment has limited efficacy in reducing IPV behaviors. Given the damaging impact of IPV, it is essential to improve treatment approaches. The aim of this study was to address the role of the therapists in facilitating change in IPV treatment. Utilizing videos of 16 IPV treatment groups, 6 therapists interpersonal styles in response to key intervention statements where determined based on the CLOPT-R. Findings suggested that specific interpersonal styles influence client's verbalization of negative relationship beliefs and post treatment IPV behaviors. Specifically, a Friendly-Dominant style was associated with fewer partner reported IPV behaviors 6-months after treatment. This study is a step towards enhancing therapist training and treatment approach to improve the efficacy of IPV treatment.

INFLUENCE OF THERAPIST RESPONSE STYLE ON GROUP MEMBER INTERACTIONS AND CLINICAL OUTCOMES IN A MALE INTIMATE PARTNER VIOLENCE TREATMENT GROUP

By
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DEDICATION

To my mother, Elaine, for your inspiration and unconditional support.

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A heartfelt thank you to my two favorite men, my dear husband, Chuck Sailey and my sweet dog, Eko. Chuck, thank you for always pushing me to keep going, and for providing me laughter and love throughout the longest dissertation process ever.

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Intimate partner violence (IPV) has been defined as a set of behaviors that include physical, sexual, and/or psychological abuse perpetrated by partners, ex-partners, family members, or others in a close relationship with the victim (Goodyear-Smith & Laidlaw, 1999). The Center for Disease Control (CDC) completed a national survey, the National Intimate Partner and Sexual Violence Survey, to determine the rates of interpersonal violence in the United States. According to the survey results, one-third (1/3) of women in the U.S. reported experiencing rape, physical violence, and/or stalking in their lifetime (Breiding, Chen, & Black, 2014). Nearly 6% of women (7 million) experienced relationship violence (inclusive of sexual, physical, and psychological) during the 12 months prior to completing the survey. An estimated 48% of women (57.6 million) experienced psychological aggression from an intimate partner in their lifetime, with approximately 14% (16.6 million) having experienced psychological aggression in the 12 months prior to completing the survey. In addition, the survey found that women who have experienced IPV had significantly higher rates of a variety of physical health issues, such as headaches, sleep issues, asthma, and irritable bowel syndrome. Of the women who reported experiencing IPV, 22.3% indicated experiencing at least one PTSD symptom, nearly 8% needed medical care, and about 15% received an injury of some sort. Overall, 80.8% of women experiencing IPV reported a negative impact in some manner, such as missing work, needing medical care due to abuse, or needing to seek mental health or advocacy services (Black, et al., 2010; Breiding et al., 2014).

IPV has also been found to affect negatively the children in the home. Children who witnessed IPV are more likely to become IPV offenders themselves (Goodyear-Smith &

Laidlaw, 1999). IPV offenders were also more likely to abuse their children than other parents (Goodyear-Smith & Laidlaw, 1999). These children often had higher rates of internalizing and externalizing disorders, poor relationships, and an increased likelihood of aggressive behaviors and depression (Holt, Buckley, & Whelan, 2008). The effect on the victim and the children in the home could be long lasting and, at times, devastating. Intervention services for all individuals in the cycle of IPV would be essential to help victims minimize the lifetime impact of their experience and prevent offenders from victimizing others.

Given the lifetime prevalence, with over 30% of U.S. women experiencing IPV, it would be essential that effective treatment for offenders be developed and implemented. However, the treatment approach and staffing of IPV offender treatment programs has often been mandated by state laws and determined by legislation with minimal acknowledgement of evidenced based best practices. IPV offender interventions have included two major dimensions: (1) criminal justice system responses that include arrest, criminal sanctions, probation, and protection orders, and (2) court mandated psychoeducational counseling. As of 2008, forty-five (45) states had formal protocols implemented for IPV counseling interventions (Maiuro & Eberle, 2008). Nearly 98% required a group format despite no decisive research comparing group therapy to individual treatment for IPV offenders (Maiuro & Eberle, 2008).

IPV Treatment Efficacy

This reliance on group formats lacked empirical support, as much of the research concerning the effectiveness of IPV treatment, typically in a group setting, yielded mixed results. Babcock and colleagues (2004) pooled multiple studies and conducted a meta-

analytic review of 22 quasi-experimental and experimental studies. These studies all included a follow-up period of assessment, a comparison group, and victim or police reports of offender behavior. Of these 22 studies, one had an undefined treatment modality, and the remaining 21 examined group treatments, with some studies incorporating other treatment conditions as well. Similar to previous meta-analysis (Feder & Wilson, 2005) finding small to near-zero effect sizes, this meta-analysis found that IPV treatment had a small effect size on recidivism rates. The effect size (Cohen's d) of treatment on recidivism rates for police reports (d = 0.12) and victim reports (d = 0.09) fell into the small range (Babcock, Green, & Robie, 2004). This suggested that, statistically, treatment had a minor impact on client change and treatment outcomes. These findings were consistent regardless of treatment type, theoretical approach, and outcome reporting method (Babcock et al., 2004).

The meta-analysis also estimated that untreated offenders had a 35% chance of remaining non-violent and treated offenders a 40% chance (Babcock et al., 2004). Babcock and colleagues (2004) compared these percentages to outcomes to treatment response for psychotherapy in general and for individuals in correctional settings. About 70% of individuals receiving psychotherapy report benefit and improvement in problem areas, while only about 12% of those in correctional settings report improvement in criminal and problem behaviors (Babcock et al., 2004). These comparisons suggested that IPV treatment has considerable room for improvements to enhance efficacy. The available evidence suggested that IPV treatment produced substantially poorer outcomes than psychological treatment for most other emotional and behavioral problems and

somewhat poorer treatment response than rehabilitation programs for incarcerated populations in terms of changing behavior.

Peer Contagion in Group Treatment

There could be a myriad of reasons for the limited efficacy of IPV group treatment. One of these possibilities may be the peer contagion theory. The peer contagion theory posited that groups of individuals with problem behaviors reinforce each other's negative behaviors and expose each other to additional deviant behaviors in a group setting (Boxer, Guerra, Huesmann, & Morales, 2005), thus making treatment counterproductive (Mager, Milich, Harris, & Howard, 2005). A majority of this research has been focused on juvenile delinquents.

Research utilizing data from the Metropolitan Area Child Study (MACS) supported the peer deviancy training model (Boxer et al., 2005). The study assessed 82 groups (46 groups of 3rd graders; 36 groups of 6th graders) consisting of 504 youth who had been randomly assigned to one of four conditions based on their level of aggression. The youth were placed in no treatment groups, classroom only groups that consisted of social cognition programs and teacher training, classroom groups combined with small groups of youth identified as high aggression and a classroom, with small group and family intervention for high aggression youth (Boxer et al., 2005). These groups were implemented in inner-city low resource or urban moderate resource schools. The study found that individuals in the group tended to move towards the group mean for aggression. Specifically, those individuals with low levels of aggression at the beginning of treatment increased in aggression and those high in aggression decreased in aggression, meeting in the middle (Boxer et al., 2005). The findings indicated that the

impact of treatment varied by the youth's individual characteristics and that group was more beneficial for individuals with higher levels of aggression and detrimental for individuals with lower levels of aggression. However, these results should be interpreted with caution as highly aggressive individuals may have the most room for improvement or a natural regression toward the mean by both groups may have occurred. It may also be that individuals in the group influence one another in either negative or positive ways dependent on the individual's personal characteristics. This study provided qualified support for the hypothesis that peers influence one another's aggressive behaviors in group treatment (Andrews, 1995; Barlow, Fuhriman, & Burlingame, 2004; Bradender, Fallon, & Smolar, 2004).

Another study addressed peer contagion from both a deviancy and normative training model (Mathys, Hyde, Shaw, & Born, 2013). Seventy adolescent males in Belgium were assigned to one of three groups. One group was considered a "pure delinquent" group and consisted of 24 adolescents, who were in a juvenile correctional facility. A second group was considered a "mixed" group and consisted of 24 adolescents, 12 of whom were considered delinquent from juvenile correctional facilities and 12 of whom were considered normative from public schools. The third group was considered normative and consisted of 22 adolescents from public schools. The groups met three times. In each session, an adult researcher presented two stories, one containing normative content and the other antisocial content. Other than presenting the story, the researcher remained silent. The adolescents were asked to discuss the stories. The groups were videotaped and observers rated the amount of antisocial talk, normative talk, antisocial reinforcement, and normative reinforcement among the adolescents. In addition to the observational

codes, measures of the family's socio-economic status and self-reports of delinquent behaviors were collected. Hierarchical Linear Modeling was conducted to determine the relationship between group assignment and verbal behaviors. Overall, analyses found adolescents in the "mixed" group displayed lower levels of antisocial talk and a greater level of normative talk than the "delinquent" group. The "mixed" group engaged in more normative talk than the "delinquent" group. In terms of reinforcement, adolescents from "mixed" and "normative" groups had a greater amount of reinforcement of normative talk than adolescents from the "delinquent" group. The "delinquent" group engaged in more reinforcement of antisocial talk than the "mixed" group. The researchers concluded that the more deviant peers in a group the greater amount of deviant talk and the more likely peers were to reinforce the deviant talk, especially when the topic presented contained deviant concepts (Mathys et al., 2013).

A few studies have made efforts to explore the impact of negative peer behaviors on adult behaviors. In an effort to understand the role of adolescent peer associations on young adult intimate relationship behaviors, 206 males in the Oregon Youth Study (OYS) were assessed for their attitudes and behavior toward women (Capaldi, Dishion, Stoolmiller, & Yoerger, 2001). Researchers observed and coded adolescent males' interactions with a male peer of their choice at the age of 17-18 (Capaldi et al., 2001). During these taped interactions, the subject and their friend were asked to plan an activity, discuss solutions to four self-identified problems regarding their interactions with peers and families, and talk about what they like and dislike about females. These interactions were then coded for their content, with particular attention to statements that suggested hostility or negative attitudes toward women. At two time points, (age 17-20

and 20-23) individuals completed relationship questionnaires and taped interactions with women they identified as their significant other. During these taped interactions, the couple was asked to plan a party, discuss self-identified relationship problems, and their individual goals. These interactions were coded for behaviors and statements that indicated negative relationship behaviors, such as psychological abuse, physical abuse, and negative interaction, in addition self-report measures of relationship behaviors were completed by both partners (Capaldi et al., 2001).

A path analysis supported the primary hypothesis. Specifically, a pathway from early childhood deviance led to mid-adolescent association with deviant peers, to late adolescent statements indicating hostility towards women, which in turn led to an abusive pattern of behavior in intimate relationships in young adulthood. All of the hypothesized paths were significant, suggesting late adolescent statements to peers that indicated hostility towards women were uniquely associated with later abusive intimate partner relationships. The researchers suggested the findings reflected a socialization process in deviant peer groups where destructive and hostile beliefs and attitudes toward women were reinforced and, in turn, later manifest behaviorally in intimate relationships (Capaldi et al., 2001). This study highlighted LeBon's (1896/2001) theory of negative peer contagion, in that individuals were more likely to engage in negative behaviors when their peers reinforced them.

A study by Duncan and colleagues (2005) also highlighted the reinforcing effect of peers on negative behaviors, specifically those behaviors that were already present. The authors examined the role of peer effects on problem behaviors (e.g., sexual behavior, binge drinking, and marijuana use) with a sample of 435 freshman college students.

Students were randomly assigned roommates at the beginning of first year as a matter of routine practice. Students entering their first year in three consecutive fall semesters were invited to participate in the study. At recruitment, they completed surveys about their high school behaviors for binge drinking, marijuana use, and sexual activity. They then completed these surveys two years later, at the end of either their second, third, or fourth year of college (Duncan, Boisjoly, Kremer, Levy, & Eccles, 2005).

Concerning sexual behavior, roommates appeared to have no influence on the frequency of sexual behavior (Duncan et al., 2005). Those who were not sexually active in high school paired with a roommate who was sexually active during high school were no more likely to engage in sexual behavior during college than those paired with a roommate not sexually active in high school. Additionally, those who were sexually active in high school showed no change in behavior regardless of the level of sexual activity of their roommates. The same outcomes were found with marijuana use as well. Past marijuana use predicted college use, while roommate pairings had no impact on use (Duncan et al., 2005).

The notable finding, regarding peer influence, was in relation to binge drinking. College roommates had no influence on college drinking behavior of those who did not drink in high school (Duncan et al., 2005). Additionally, when a high school binge drinker and a high school non-drinker were paired there was no notable influence of either roommate. However, when high school binge drinkers were paired up, they binge drank more often than other students did during college. This suggested that the pairing of individuals with problem behaviors could magnify the negative behavior, specifically with respect to alcohol consumption (Duncan et al., 2005). It is also important to note that

peer influences were not universal to all problem behaviors. This study lends support to the role of peers in maintaining and reinforcing some negative behaviors.

A study addressing the role of group influence in offender treatment was conducted in the federal correctional system in Canada (Lloyd, Hanby, & Serin, 2014). This was an archival study utilizing information in correctional facility files of 1,832 male inmates. Inmates were included if they had been admitted to a facility during a specified period of time and engaged in a rehabilitation program. Six specific treatment groups were selected for consideration, including Living Skills, Attitudes, Substance Abuse, Violence, Family Violence, and Sex Offending. The primary goal was to determine the effect of group composition on specific outcomes. Treatment behaviors were assessed and included changes in effort during treatment, performance during treatment, and responsivity to treatment. All inmates were assigned a risk level based on past behaviors and demographic information, which was then used to determine the group's average risk to re-offended and the range (or diversity) of risk for the group. Recidivism was assessed as a return to incarceration due to a violation of release or the commitment of a new crime (Lloyd et al., 2014).

Hierarchical Linear Modeling analyses found that group assignment significantly accounted for post-release recidivism (Lloyd et al., 2014). In addition, average risk to re-offend (a proxy for level of deviance in the group) was significantly associated with Family Violence and Sex Offending. In these groups, offenders grouped with peers who had lower average risk for recidivism tended to have lower recidivism rates. The researchers concluded that there might be peer effects in specific groups, Family Violence and Sex Offending, but limited support for peer effect in other groups (Lloyd et

al., 2014).These findings were consistent with Duncan and colleagues' (2005) findings that specific deviant behaviors were exacerbated by association with individuals engaging in the same deviant behaviors.

This same influence may be seen in IPV groups where individuals with similar problem behaviors may reinforce negative beliefs and behaviors in other group members, thus limiting the positive effect of group treatment. In an effort to elucidate the impact of peer influence in adult treatment groups, Meis (2009) conducted research with an adult sample of male IPV offenders' in group treatment. The sample comprised 130 men across 15 treatment groups. The primary goal of the study was to understand the impact of group members' responses to counter-therapeutic (CT) statements made by other group members on subsequent rates of CT talk later in treatment and rates of post-treatment IPV. Negative client statements, referred to as CT talk, were deemed to be any statements that were counter to the goals of IPV offender treatment, such as hostile statements about women, statements endorsing negative relationship behaviors, or statements endorsing criminal or violent behavior. CT statements in early and late sessions were identified, and group members' responses to those statements were coded as supportive, non-supportive, or neutral with respect to the statements (Meis, 2009).

In general, rates of CT statements were related to client's individual characteristics (Meis, 2009). Individuals with higher levels of pre-treatment IPV behaviors and lower readiness to change had higher rates of CT statements during treatment sessions (Meis, 2009). In terms of post-treatment behavior, individuals with higher rates of CT statements in late sessions had higher rates of post-treatment IPV behaviors, such as a greater number of police visits, greater levels of psychological aggression, and a higher

frequency of aggressive incidents. These individuals, interestingly, also tended to have lower levels of partner injury (Meis, 2009). Additionally, greater rates of supportive responses to early session CT statements were associated with less of a decline in rate of late session CT statements (Meis, 2009). Taken together, these findings indicate that (1) individuals with higher levels of pre-treatment problematic behavior and lower motivation to change were more likely to voice counter therapeutic statements during early group sessions, (2) groups in which individuals consistently and strongly supported CT statements had lower rates of decline in CT statements over the course of treatment, (3) stronger non-supportive responses by group members in early sessions predicted higher frequency of CT talk in later sessions (contrary to hypotheses), and (4) individuals with higher rates of CT statements were more likely to engage in problematic behavior, although with fewer partner injuries, after treatment completion.

As for the potential for peer group contagion, groups with more CT statements in early sessions tended to have higher rates as a group of post-treatment psychological aggression towards their partner, and those groups with higher rates of late session CT statements tended to have greater rates of post-treatment police visits as a group (Meis, 2009). Additionally, greater levels of non-supportive responses from other group members to CT statements (e.g., rejection or criticism of an individual's CT statements by other group members) in later sessions were related to greater declines in partner injuries, aggressive incidents, and physical assaults post-treatment (Meis, 2009). Group members participating in groups characterized by higher rates of support for CT statements late in treatment experienced less of a decline in post-treatment police visits than those in groups less supportive of CT statements. Similarly, participation in groups with higher rates of

non-support for CT statements in late sessions was associated with greater declines in aggressive incidents. A finding opposite of the anticipated trend showed that higher rates of non-supportive statements in early sessions related to lesser decline in psychological aggression (Meis, 2009). One potential implication of these findings involved the importance of timing in responses by peers. If early in sessions an individual feels rejected (i.e. receives a non-supportive response) by peers, they may pull away from the group and gain less from treatment, whereas challenges from peers later in treatment may be more effective in changing attitudes and behaviors.

Overall, peer behaviors in groups appeared to have both positive and negative influences on adult males' behaviors after treatment, consistent with research in adolescent populations. Those who received support for their CT statements tended to have less improvement post treatment, while those who received non-supportive feedback had greater declines in problematic behaviors. However, early in treatment, non-supportive reactions to CT statements appeared to backfire, perhaps because the group has not yet developed a sufficient sense of cohesion and trust. Premature efforts to challenge or contradict CT statements may be perceived as critical and rejecting, negatively influencing the effectiveness of the intervention (Meis, 2009). There also appeared to be a peer influence on behaviors within the group, as individuals tended to have a lower reduction in rates of counter therapeutic statements later in treatment when they received support for their negative statements earlier in the treatment process. This finding suggests that the negative peer influence hypothesis (Bradender et al., 2004) may be a factor in IPV group treatment.

In general, peer deviancy research indicated that individual's display of problem behaviors and responses by others to those behaviors influence those around them. However, this influence might be limited to individuals already engaging in the problematic behavior, as evidenced by Duncan and colleagues (2005) or only to specific behaviors (Lloyd et al.,2014). IPV offenders who expressed negative statements in groups might be both positively and negatively influenced (Meis, 2009), and individuals with more severe problematic behavior may have the best opportunity for positive change in group settings (Boxer et al., 2001). The studies by Boxer and colleagues (2001), Mathys and colleagues (2013), and Meis (2009) highlighted the importance of peer influence in groups that supported observations of the potential positive impact of group relationships (Andrews, 1995; Barlow et al., 2004; Bradender et al., 2004), as well as observations of the potentially negative impact (Bradender et al., 2004; LeBon, 1896, 2001).

Ultimately, the development of negative peer contagion and the remedy might be largely influenced by effective group therapists. Statements that reflected negative beliefs or behaviors specific to the problem area of concern in treatment, as described by Meis (2009), might provide critical key intervention opportunities in which therapists and group members could effectively stimulate change and group learning by identifying and challenging underlying distorted cognitions and problematic behavioral strategies. Change in relationship-relevant cognitions and behaviors were the basic change mechanisms underlying cognitive-behavioral group therapy for IPV offenders (Murphy & Eckhardt, 2005). Change might be most likely to be facilitated through intervention by therapists and group members during pivotal destructive and productive group

interactions (Riva, Watchel, & Laskey, 2004). Interactions around such statements might also provide a window into how the group and therapists respond when topics central to the goals of treatment for IPV offenders are encountered (e.g., spontaneous discussions of violence and controlling behavior in relationships, criminal behavior, alcohol abuse) and might foreshadow treatment response. The ability of the group to learn from these key intervention moments might be largely determined by therapist behaviors, as therapists were responsible for providing structure and setting the norms of group therapy (Nicholas, 1977; Riva et al., 2004; Yalom & Leszcz, 2005). They were seen as a primary influence in group (Bloch, Crouch, & Reibstein, 1981) and responsible for building the group to be an agent of change (Yalom & Leszcz, 2005).

Therapist Differences in Treatment Response

Little research has been done looking at the therapist as a change agent in group therapy in general. The limited research conducted has focused primarily on intervention techniques used by the therapist. Further, very little research has been done examining the therapist's influence in IPV groups. Therefore, the following review of therapist influence was largely based on individual, rather than group, therapy approaches.

Therapists have been viewed in much treatment research as a source of unwanted variation. In the late seventies, the research arena moved away from the therapist as an active ingredient of treatment success and began focusing on the theory and technique as the key active ingredients (Garfield, 1997; Okiishi, Lambert, Nielson, & Ogles, 2003). Both the medical model and managed care systems encouraged manualized treatments in an effort to "purify treatment" and standardize treatment approaches (Lambert & Okiishi, 1997). In order to ascertain the impact of the treatment technique, these approaches

tended to conceptualize therapist influence as unwanted error variance. The therapist was viewed as a deliverer of the independent variable rather than an active and dynamic part of the treatment process (Beutler, 1997). Standardizing treatment delivery through treatment manuals erroneously assumes that therapists were homogeneous and performed equally well when given manuals (Blow, Sprenkle, & Davis, 2007; Garfield, 1997). Efforts to standardize the therapist influence led to the belief that dose and medication was more important than the person who delivered it (Blow et al., 2007). Therefore, the therapist remained a poorly understood variable in the therapy process (Blow et al., 2007).

Despite efforts to neutralize therapist impact through standardizing intervention protocols, research consistently found differences in therapists' effectiveness, both within the same treatment and across different treatments (Beutler, 1997; Garfield, 1997; Strupp & Anderson, 1997). Studies comparing therapists' caseloads found that outcomes varied greatly among therapists (Lambert & Barley, 2002; Lambert & Okiishi, 1997; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Okiishi, Lambert, Egget, Nielson, & Dayton, 2006). Collectively, these data suggested that therapist influence treatment in a unique way aside from theoretical techniques.

For example, Luborsky and colleagues (1997) conducted a series of seven studies comparing therapists' caseloads. All studies compared three treatment conditions; (1) Supportive Expressive (SE) Dynamic therapy plus drug counseling, (2) Cognitive Behavioral Therapy plus drug counseling, and (3) drug counseling alone. Therapists were considered experienced and followed treatment manuals for each condition, with adherence checks. Across all studies, therapists varied in their effectiveness in relation to

patient improvement. Interestingly, therapists who had the greatest patient improvement in one study had the greatest patient improvement in other studies.

In all seven studies, the Beck Depression Inventory (BDI) and Addiction Severity Index (ASI) were the common reported outcome measures (Luborsky et al., 1997). The Hamilton Depression Rating Scale (HDRS) and the Global Assessment of Functioning (GAF) were collected for samples six and seven, in addition to the BDI. Assessment occurred at pre-treatment and one-month post treatment. Three of the samples were a Veteran's population receiving opiate addiction treatment, two samples were outpatient community populations receiving opiate addiction treatment, and the final two were outpatient samples receiving treatment for depression. Significance tests were reported for studies one (1) through three (3), but not for studies four (4) through seven (7).

Across all seven samples clear patterns emerged that suggested differences in patient outcome as a function of therapist (Luborsky et al., 1997). In all samples, therapists' caseloads were evaluated by determining the mean percentage change of their patients from pre-treatment to one month post-treatment on outcome measures. Across all seven samples therapist average caseload change score in BDI ranged from -4% (indicating worsening) to 81% (indicating quite dramatic average improvement). ASI caseload change scores ranged from -3% to 61% across all seven samples. For samples six and seven, HDRS caseload change scores ranged from 10% to 24% and the GAF change scores ranged from 14% to 73%. In addition, therapist's ranks in caseload changes were similar on all outcome measures for a given sample. For example, therapist one in sample one had the highest percent change on the BDI and ASI. In samples one through three, there was a significant difference among therapists in average caseload change (Luborsky

et al., 1977). In the remaining three samples, caseload differences should be cautiously interpreted due to lack of significance testing.

In addition to evidence of therapist differences in promoting client change within a specific sample of patients, some therapists showed consistency in their patient caseload change scores across samples representing distinct clinical trials. Three therapists provided treatment for more than one of the sample groups. Two of those therapists consistently had the highest caseload change scores in three separate samples, ranking either first or second for positive change. The third therapist had more variability in caseload change scores across samples. The consistent and positive impact of these two therapists across samples, despite use of a manualized treatment to limit variability in techniques used, supported the hypothesis of a unique effect of therapist beyond the effect of clinical technique utilized (Luborsky et al., 1997).

To understand what lies behind these differences, Luborsky and colleagues (1997) examined possible explanations. The examination of patient characteristics found no significant mean differences on pre-admission scores for symptom severity or demographics across therapists. Additionally, there were no differences found among other therapists' ratings of the treating therapists' interest in helping others and the treating therapists' personal psychological health and skill. A significant positive correlation was found between working alliance and outcomes. Those therapists with greater improvement in their caseloads also had stronger working alliances with their patients as indicated by greater agreement on goals and objectives for treatment. Greater patient improvement was seen with therapists who adhered more closely to the manual than those who did not. Although positive alliance and adherence to manuals were both

correlated with increased positive changes in one's caseload, it remained unclear how these factors work within the therapy process (Luborsky et al., 1997).

This series of studies highlighted the unique impact of the therapist independent of technique and patient variables. The patients were randomized to a condition and within a condition to a therapist, analyses indicated no significant pre-treatment differences in pathology, and manuals were utilized to standardize approaches, yet several therapists had consistently favorable or relatively unfavorable performance across samples. While definitive statements could be made due to absence of significance testing and the presence of considerable variation across cases by some therapists for some samples, these studies suggested that something unique about the therapist might be driving patient change based on the pattern of outcomes and the consistency of well-performing therapists. However, it was unclear what therapist qualities and behaviors account for these differences in outcome.

An inpatient study in Germany by Dinger and colleagues (2008) further supported the influence of therapist on patient outcomes and suggests these differences were separate from common therapeutic factors (i.e. therapeutic alliance). Hierarchical Linear Modeling (HLM) analyses found therapist assignment significantly ($p < 0.001$) accounted for unique variance in outcome measures (ranging from 3.3% to 16.6%). In addition, some therapists were better than others were with more severely impaired patients. A significant interaction ($p < 0.01$) effect between therapists and pre-treatment severity of patient symptoms suggested that the impact of pre-symptom severity on post-treatment symptom severity was not consistent across therapists. The association between alliance and outcome was not consistent among therapists either. While a positive outcome was

associated with better alliance, the amount of influence of a positive alliance varied by therapist (Dinger, Strack, Leichsenring, Wilmers, & Schauenburg, 2008). This study highlighted the differential impact of therapist not only on outcome, but also on the treatment relationships and the impact of those relationships.

A study utilizing the ALERT database reinforced the findings of Luborsky and colleagues (1997), as well as Dinger and colleagues (2008). The study utilized the case outcomes for 281 therapists across 10,812 patients participating in individual therapy (Brown, Lambert, Jones, & Minami, 2005). As part of routine care patients completed questionnaires about symptoms, relationships, and daily functioning (Brown et al., 2005). Therapists were rank ordered and categorized based on a patient's residualized change scores from pre to post treatment on the Life Status Questionnaire (LSQ). Residualized change scores were calculated based on the difference between the predicted and actual scores on the outcome measures with predicted outcome based on case features including age, gender, diagnosis, and intake LSQ score. Therapists were categorized as highly effective or "other" based on residualized change scores. Those with a residualized change score of 2.8 or higher were classified as highly effective (25%) and the remaining therapists were labeled "other" (75%; Brown et al., 2005). A statistically significant difference was found between the two groups of therapists on patient change on the LSQ. Therapists maintained their standing in a second set of analyses where change scores were examined based on therapist's original category of effectiveness during a later time, in an effort to replicate the original findings (Brown et al., 2005).These finding indicated that therapists were consistent in their effectiveness over time and across patients.

To probe these therapists' differences, comparisons were made only with patients who met the clinical cutoff scores for the LSQ at intake (Brown et al., 2005). Again significant differences were seen on LSQ change scores with patients of highly effective therapists showing greater improvement than those with therapist categorized as 'other' (Brown et al., 2005). This study was unique in that it had a large therapist sample size with a diagnostically varied population without the confines of a manualized treatment. The second validation analysis highlighted the consistency of effective therapists. It also allowed examination of the impact of therapist on more symptomatic populations, indicating that those who were deemed highly effective also showed greater effectiveness than other therapists with highly symptomatic patients.

In an effort to determine what accounted for therapist differences Wampold and Brown (2005) utilized a sample from the ALERT database. The 6,146 patients included in the sample were treated by one of 581 therapists. The LSQ was utilized as the outcome measure. Analyses indicated that 8% of the outcome variance in the LSQ could be attributed to therapists. When pre-treatment LSQ scores were accounted for in the analysis, 5.5% of the LSQ post treatment score was accounted for by therapist influence. In order to determine the specific therapist characteristics that may be playing a role, including therapist age, sex, years of experience, and professional degree, were entered into the model. The proportion of variance attributable to the therapist ranged from 5% to 6% when these specific variables were included, suggesting that these demographic and experience indicators added little to the understanding of therapist influence (Wampold & Brown, 2005). This study supported previous research indicating therapist influence in

patient improvement and further indicated that obvious demographic and training characteristics of therapists do not account for these differences.

The Treatment of Depression Collaborative Research Program (TDCRP) found similar results when looking at 28 therapists conducting individual therapy with similar caseloads across several research sites (Blatt, Sanislow, Zuroff, & Pilkonis, 1996). An overall estimate of therapist treatment efficacy was determined by creating a composite of outcomes for each patient and averaging the patient scores for each therapist (Blatt et al., 1996). Based on these composite scores therapists were divided into three categories: less effective, moderately effective, and more effective. No effect of treatment condition (CBT versus interpersonal psychotherapy), site, or patient characteristics were found among the three groups. PhD level therapists were noted to be more effective than MD level therapists were. Additionally, less effective therapists had fewer patients' complete treatment (Blatt et al., 1996).

A series of ANOVAs was completed to compare therapist groups (Blatt et al., 1996). As expected, therapists that are more effective had significantly more patients improve compared to less effective therapists. However, moderately effective therapists were not found to be significantly different from more or less effective therapists (Blatt et al., 1996). The variability within therapists' caseload differed significantly among the groups ($p = 0.023$; Blatt et al., 1996). The variability in outcomes was lowest for the most effective therapists, intermediate for the moderately effective therapists, and highest for the least effective therapists. Therapists that were more effective tended to be more consistent in their treatment outcomes than moderately and less effective therapists (Blatt et al., 1996).

The therapists' beliefs about etiology and treatment technique were not related to outcomes or assigned groups (Blatt et al., 1996). However, therapists that were more effective tended to have a basic clinical orientation that was psychological in nature rather than biological in nature. Psychologically oriented therapists tended to view learned maladaptive behaviors, distorted cognitions, predisposing personality traits, and a sense of helplessness as key areas of clinical focus, as opposed to a genetic or biological treatment focus. Therapists who were more effective in this study had previous clinical approaches that included less use of medication than other therapists (Blatt et al., 1996).

This study indicated that the therapists' beliefs about treatment approach and type of educational training influence patient outcomes. Additionally, the study concluded that therapists that were more effective tended to be consistently effective across patients, whereas less effective therapists had much more variability in outcomes. This study provided additional evidence for the importance and unique contribution of therapists in the treatment process.

A meta-analysis confirmed the unique influence of therapists in individual therapy (Crits-Christoph, Baranackie, Kurcias, & Beck, 1991). This meta-analysis included 15 studies with 27 groups of participants and 141 therapists. The dependent variable of therapist influence was determined by the amount of outcome variance due to the therapist. The outcome construct was different for each study and a one-way ANOVA with therapist as a random factor was used to estimate therapist variance in predicting treatment outcome (Crits-Christoph et al., 1991).

Therapist experience, length of treatment, manualization, and treatment orientation were the independent variables being assessed for their role in explaining therapist

variance (Crits-Christoph et al., 1991). The percent variance component for therapists was calculated from the equations of the expected means derived from ANOVAs for each treatment outcome per group and divided by the total variance. This provided an overall index of therapist's contribution to treatment outcome expressed as a proportion of variance in outcome. The therapist's "highest variance" was also derived from the single scale on which the therapist had the highest variance, and used as a measure of the largest therapist effect demonstrated. Treatment type was highly correlated with use of a manual and was therefore dropped from further analyses. Therapist experience and use of a manual had the strongest correlations with therapist variance in the outcome, such that higher levels of experience and the use of a manual reduced the amount of variance among therapists. Use of a manual and therapist experience correlated with a therapist's overall average variance (based on the average of all scales). Individual therapist's largest variance (based on a single scale) correlated with the use of a manual and therapist experience, as well. Combined together, therapist experience, use of manual, and treatment type accounted for 41% of the variance in the average overall therapist variance and 42% of the variance in an individual therapist's largest amount of variance (Crits-Christoph et al., 1991).

These analyses suggested that some of the treatment variance attributed to the therapist could be accounted for by therapist experience and the structure (e.g., manual) of therapy itself (Crits-Christoph et al., 1991). However, given the significant correlations among the three remaining independent variables it was difficult to parse out how they uniquely contribute to therapist effects. Additionally, this study indicated that more than 50% of the variance in outcomes attributable to therapists was not accounted for by these

variables, suggesting that there were other unidentified reasons for therapists' differences in treatment outcomes.

An outpatient study utilizing cases from the United States and Sweden provided additional support for therapist effects on treatment outcomes (Nissen-Lie, Goldberg, Hoyt, Falkenstrom, Holmqvist, Nielsen, & Wampold, 2016). The researchers' completed two separate studies, an initial study and a replication study. The first study included 5,828 patients treated by 158 therapists from an outpatient public university clinic in the western United States. Therapists were included in the study if they had ten or more cases in the dataset and their patients met specific criteria. Therapists practiced from a variety of theoretical orientations, 40% were female, and 38% were licensed providers, 30% were trainees, and the remaining were transitioning from trainee to licensed providers. Additional demographic information was not available for the therapists. Patients included in the study needed to have completed at least three sessions, the Outcome Questionnaire-45 (OQ-45) at intake and post-treatment, and received a score of at 63 or above (i.e. clinical range for problem areas) on the OQ-45 at intake. Patients were primarily Caucasian, 63% were women, and the average age at intake was 22 years. No diagnostic assessment was completed at intake; therefore, formal diagnoses were not available. The OQ-45 was the primary outcome measure for this sample. It was a 45-item self-report measure assessing progress in treatment from week to week on three domains: Symptom Distress, Interpersonal Relationships, and Social Role performance. Patients rated the frequency of each item (i.e. I tire quickly) on a scale of one (1; Never) to five (5; Almost Always) each week (Nissen-Lie et al., 2016).The second sample, considered the replication study, was drawn from a primary care outpatient unit and a psychiatric

specialty clinic, both in Sweden (Nissen-Lie et al., 2016). The study included 520 patients treated by 31 therapists from the primary care setting, and 96 patients treated by seven (7) therapists in the specialty clinic, totaling 616 patients treated by 38 therapists. The criteria for inclusion were identical to the initial study, with the exception of the outcome measure. The therapists practiced from a variety of theoretical orientations, 80% were female, and all were trained providers (i.e. 20 social workers, 10 psychologists, and 1 psychiatric nurse). The patient sample from the primary care clinic was 80% female, with an average age at intake of 37 years. The patient sample from the psychiatric care clinic was 58% female, with an average age of 32 years at intake. No additional demographic data were available. No diagnostic assessment was completed at intake; therefore, formal diagnoses were not available. For the Swedish sample, the Clinical Outcomes in Routine Evaluation –Outcome Measure (CORE-OM), a 34-item self –report measure assessing Subjective Well-Being, Problems, Function, and Risk, was utilized as the outcome measure. These four (4) primary scales subsume ten (10) sub-scales. The sub-scales used for the replication study include Subjective Well-Being, Depression, Anxiety, Problems in Close Relationships, Problems in General Functioning, and Problems in Social Functioning. Patients completed the scale weekly and rated each item (i.e. I have felt despairing or hopeless) on a scale from zero (0; Never) to four (4; Almost all the time; Nissen-Lie et al., 2016).

A series of multilevel factor analysis were completed to determine the therapist effects on patient outcomes. In the initial and replication samples, results indicated that overall patients showed improvement over the course of treatment. For the initial study, results indicated that therapists accounted for less than 2% of the variance in the outcome

measures, and in the replication study, therapists accounted for about 1% of the variance in the outcome measures (Nissen-Lie et al., 2016).

A second set of analyses was conducted to determine whether these therapists were effective or ineffective consistently across all domains measured, such as Symptom Distress, Interpersonal Relationships, and Social Role performance on the QC-45 in the initial study. Researchers' utilized a multilevel Confirmatory Factor analysis (CFA) with the underlying latent factor considered therapist effectiveness (Nissen-Lie et al., 2016). Results from the initial study indicated the presence of a latent therapist effectiveness factor on the overall QC-45 scale, and the three sub-scales: Symptom Distress, Interpersonal Relationships, and Social Role performance. The replication study yielded mixed results finding a latent therapist effectiveness variable for Subjective Well-Being, Depression, Close relationships, and Social Relationships. Anxiety and General Functioning did not appear to have an underlying latent therapist effectiveness factor (Nissen-Lie et al., 2016).

The findings of this study indicated that therapists account for 1 to 2% of the variation in patient outcome, and appear to do so in a generally consistent manner. The varied patient sample and settings lent further to support to the idea that therapists influence treatment outcomes beyond specific models of treatment, diagnoses, or settings.

A study conducted in the United Kingdom addressed therapist effects and examined whether there was a differential influence of therapist based on client presentation (Saxon & Barkman, 2012). This archival study utilized the Clinical Outcomes in Routine Evaluation Practice-Based Evidence Database-2008. This study used data for 10,786 patients seen by 119 therapists across 22 clinic sites. In order to be included in the study,

therapists needed to have a minimum of 30 patients. Patients were included if they were 18 years of age or older, completed at least two (2) sessions, one of which must be an intake and the remaining individual treatment, and completed pre and post-treatment measures. Therapists' demographic and theoretical orientation information was not available. Patients included in the study were primarily female (71%) and Caucasian (94%) with an average age of 42 years, and 50% were on medication. No formal diagnoses were recorded at intake (Saxon & Barkman, 2012).

The primary outcome measure was the CORE-OM, a 34- item self-report measure assessing Subjective Well-Being, Symptoms, Functioning, and Risk. Patients completed the scale at intake and post-treatment (Saxon & Barkham, 2012).

Average change scores on the CORE-OM were used to categorize therapists as "average effectiveness," "significantly above average effectiveness," or "significantly below average effectiveness." If a therapist's caseload change score fell within the 95% confidence interval for the average therapist caseload change, they were labeled "average effectiveness." If the average caseload change score was above the score range for the average therapist, they were considered "significantly below average effectiveness," as positive change scores indicated a worsening of symptoms. If the average caseload change score was below the score range for the average therapist, they were considered "significantly above average effectiveness." In addition, "statistical recovery rates" were calculated for each patient by calculating change scores using the CORE-OM. An increase of five (5) or greater points indicated a worsening of symptoms and a decrease of five (5) or greater points indicated an improvement in symptom presentation (Saxon & Barkham, 2012).

Multilevel analyses were conducted to assess therapist effects on the outcome. The models allowed the slope and intercepts to vary to test whether therapist effects on the outcome varied based on the patient's initial risk status as measured by intake CORE-OM scores. The Variance Partition Coefficient (VPC), similar to the ICC, was calculated by dividing level two variance (therapist) by the total variance and multiplying by 100 to determine the therapist effect.

The initial model assessed the therapist effect in relation to intake CORE-OM scores on the outcome (i.e. change in CORE-OM scores; Saxon & Barkham, 2012). The VPC indicated that therapist effect was 6.6% for this model. Additionally, higher intake severity scores were associated with poorer outcomes; however, there was a less detrimental effect on outcome with the more effective therapists. Overall, the likelihood of recovery was nearly twice as likely with more effective therapists. In turn, the likelihood of patient deterioration with least effective therapists was more than three times more likely than with other therapists (Saxon & Barkham, 2012). This study further supported the hypothesis that therapists influence treatment outcomes and, in the case of this study, patient characteristics differentially influenced outcomes based on therapist effectiveness.

A qualitative case file analysis was completed focusing on treatment failure cases within a sample of 71 male clients in group IPV treatment (Lynch, DeDyn, & Murphy, 2003). These clients participated in a 16-week cognitive behavior group treatment. Of these 71 men, seven were deemed treatment failures. Any client who was reported to have committed multiple and/or severe acts of physical aggression toward their partner, per the partner's report, during the six months after group treatment, was deemed a

treatment failure. These men were clustered in four of the 13 treatment groups that were reviewed. Almost all of the treatment failure cases had multiple risk factors for poor response, including evidence of personality disorders, mood disorder, a history of childhood trauma, or substance use problems. Of relevance to the current study, review of session recordings identified a single therapist who was common to two of the four groups in which the seven failure cases clustered (Lynch et al., 2003). A review of treatment session videos suggested problematic dynamics in these groups, with group members bonding to reject the therapists' influence attempts. Although the sample was very small and no quantitative findings were presented, the results provide an interesting hypothesis, namely that failure in IPV treatment reflects a combination of difficult client characteristics and problematic group dynamics that are not effectively managed by the therapists.

Overall, the above research studies highlighted consistent differences among therapists in their ability to stimulate client growth and change. Although treatment manualization appeared to reduce these effects, it clearly did not eliminate them. Given that therapists' relative success was quite consistent across different samples and different treatments, the success of therapy could be in part accounted for by therapist (Brown et al., 2005; Luborsky et al., 1997; Nissen-Lie et al., 2016; Saxon & Barkham, 2012). Research provided evidence of the therapist themselves having a direct impact on treatment outcomes in an individual therapy setting.

Current Study Purpose

There has been a lack of research focusing specifically on the therapist in group treatment, and thus it has remained unclear whether differences associated with therapist

assignment generalize from individual to group therapy. Additionally, there has been a lack of research in forensic populations addressing the therapist influence aside from treatment technique and common therapy factors (i.e. therapeutic alliance). In order to effectively select and train therapists to conduct IPV groups, more research has been needed to focus on how the therapist affects therapeutic interactions among group members and treatment outcomes for this population.

A multitude of therapist factors and their interactions with one another have likely impacted group treatment. At this point research has been sparse in regards to these therapist factors in group psychotherapy. It would important to examine individual therapist factors to determine their impact on treatment to provide a starting point for understanding which factors influence group treatment processes and outcomes. This study proposed to examine one understudied therapist factor. The main purpose of this study was to examine associations between key treatment outcomes in group treatment for intimate partner violence (IPV) offenders and therapists' communication style, both what they said (i.e., content) and how they said it (i.e., non-content verbal behaviors), after key intervention (KI) statements. KI statements were viewed as verbal illustrations of negative cognitions regarding women or statements supportive of abusive or violent behaviors, which were the primary focus of change. Therapist behaviors were examined to determine their influence on group members' responses during treatment sessions and treatment outcomes to determine the therapist response style(s) with the greatest likelihood to stimulate change and foster change-facilitating group dynamics. Therapists' non-content verbal behaviors during group have been an understudied component of IPV treatment that might be potentially alterable through graduate training programs, on-

going training, and supervision, as such behaviors could be taught and developed (Derlega, Hendrick, Winstead, & Berg, 1991). Shedding light on the influence of the therapist could aid in increasing the efficacy of group treatment programming for the IPV offender population.

In recent years, research had begun to focus on the therapist as an important factor in treatment success. Returning to our discussion of KI opportunities in IPV offender treatment, the actual content of what therapists verbalize in these KI moments was important; however, this content could not be divorced from the method in which it was delivered (non-content verbal behaviors). There has been significantly less research addressing therapists' communication style or the how of their verbalizations in either individual or group therapy contexts.

Communication Style

It has been hypothesized that messages contain both relational and content information (Adler, Rosenfeld, & Towne, 1986, 1991, 2007). Content information would be the part of the message that contained facts and information or the what of communication. In treatment, this might be reflected as the techniques and content of the therapist's interventions. Relational would refer to the part that conveyed emotion or affect. The relational or expressive aspect would be the manner in which one communicated the content (Adler et al., 1986, 1991, 2007) or the how of communication. The delivery of expression came from the non-content verbal aspects of communication, the qualities of our communication (Duncan, Rice, & Butler, 1968). These non-content verbal behaviors included things such as tone of voice, sighs, pitch, and loudness (Adler

et al., 1986, 2007; Knapp, 1978) and contributed to the relational or emotive information in a message.

Research in social psychology suggested that the relational aspect of spoken communication might have a strong influence on the interpretation of content (Adler et al., 1991, 2007). Non-content verbal aspects of communication were hypothesized to contribute a considerable amount to the meaning of a message, sometimes even more than the content itself (Adler et al., 1986, 2007). Adler and colleagues (2007) posited that the content of a verbalization conveys the basic information and the relational aspect conveyed the attitude or meaning of the verbalization. For example, one could state, "Close the door behind you." The content of this statement was clear; the individual wanted the door closed. However, the speaker's tone would inform the listener as to the meaning or emotional aspect of the statement. The speaker's tone might have suggested irritation, seductiveness, or factual neutrality, which in turn would have informed the listener of the intent and meaning of the statement. There should be a connectedness of the what and the how that would be needed in communication. This would guide the response of the listener.

In considering KI statements in IPV treatment, there was evidence that the client influenced group member verbalizations through the content of their verbal responses to other group members' counter-therapeutic comments (Meis, 2009). It could be posited that the therapist as a member of the group, albeit in a different capacity, had the ability through their verbalizations to influence and guide the group interactions. Research in the communications field suggested that the relational or how of verbalizations influenced the listener's interpretations of meaning of the same content.

The Interpersonal Circle

Interpersonal interactions have been well researched in other avenues and multiple theories have emerged. One in particular made efforts to draw from various theories and studies to create a taxonomy of interpersonal interactions that was inclusive of relational and contextual aspects of communication from the perspective of typical interactions. This focus on normal daily interactions and the weaving of contextual and relational aspects allowed for definitions that portray the perspective of the layperson rather than a technical perspective from a specific theory of psychotherapy.

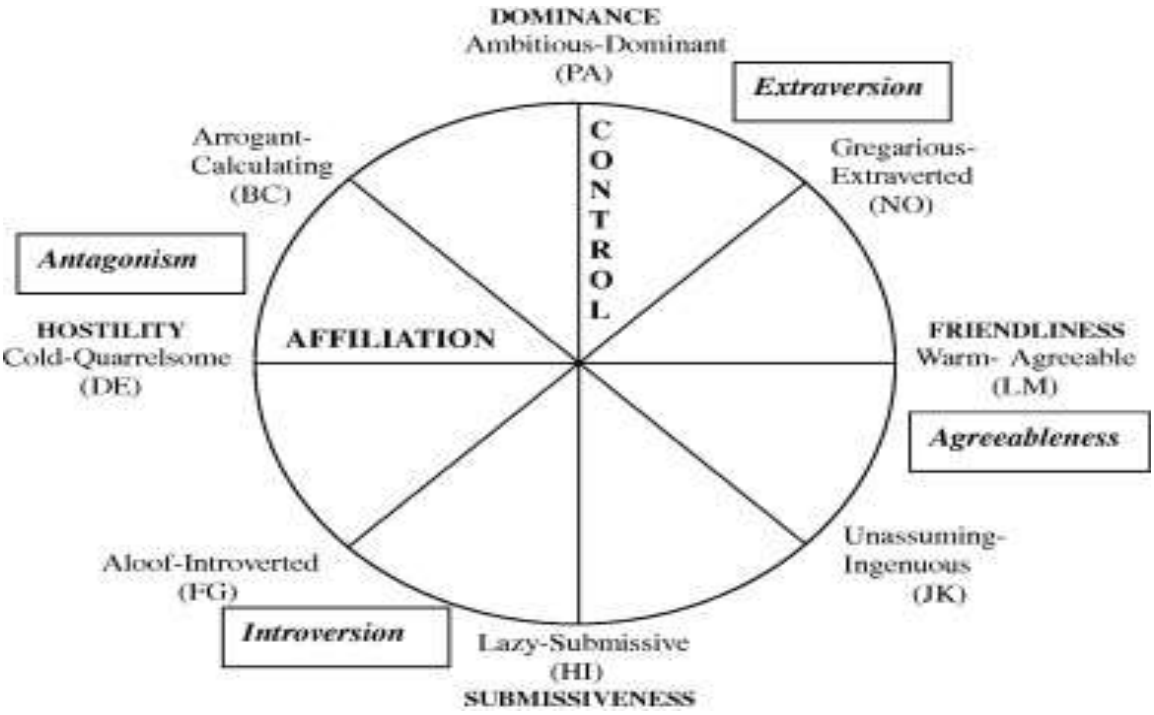
The Interpersonal Circle (Figure A) was an attempt to create taxonomy of interpersonal behavior (Kiesler, 1983) using "ordinary language" (Benjafield & Carson, 1985**,** pg. 339). It was in part prompted by the desire to create a comprehensive system of measurement for interpersonal behaviors. The focus was on the transaction between individuals not the individual (Marcus & Holahan, 1994). The initial step for the creation of the 1982 Interpersonal Circle was to review the leading measurement scales for adult interpersonal behavior, which included the Interpersonal Checklist (ICL), the Interpersonal Behavior Inventory (IBI), the Interpersonal Adjective Scale (IAS), and the Impact Message Inventory (IMI). The IAS was used as the primary starting point as it contained the broadest range of categories. The final model identified sixteen interpersonal complementary categories. These were Dominant, Competitive, Mistrusting, Cold, Hostile, Detached, Inhibited, Unassured, Submissive, Deferent, Trusting, Warm, Friendly, Sociable, Exhibitionistic, and Assured (Kiesler, 1983).

The 16 categories were laid out in a circular pattern with polar opposites. For example, dominant and submissive were defined as polar opposites. These 16 categories

were then reduced to a two dimensional model (Figure A; Benjafield & Carson, 1985; Kiesler, 1983). The axes represented affiliation and control. The Affiliation axis ranged from friendly to hostile and the control axis from dominant to submissive (Benjafield & Carson, 1985; Kiesler, 1983). It was thought that these dimensions were at the core of all interactions and when individuals interacted, they were doing so in a complementary manner (Kiesler, 1983).

Kiesler (1983) used the model to examine the complementarity of interactions and early studies focused on this aspect of human interactions. This complementarity was essentially the action –reaction aspect of communication. Someone spoke then someone listened and reacted, which in turn caused a reaction in the first speaker and the interaction flowed along this pattern of action-reaction. Research with the model had typically used dyadic relationships and had not explored the unique dynamics of the group (Marcus and Holahan, 1994).

Figure A. The Interpersonal Circle



Traupman, E., Smith, T., Uchino, B., Berg, C., Trobst, K., & Costa, P. (2009). Interpersonal circumplex octant, control and affiliation scales for the NEO-PI-R. *Personality and individual differences*, 47(5), 457-463.

It could be hypothesized that in group psychotherapy we would see a complementarity of sorts. Research findings have suggested group members responded to other group members in a similar manner as the therapist responded (Barlow, Hansen, Furhiman, & Finely,1982; Sandahl, Lindgren, & Herlitz, 2000). In terms of the axis of affiliation, we would expect that if the therapist were friendly, the group members would also be this way. If the therapist fell closer to hostility, so would the group members. Kiesler and Goldston (1988) researched this hypothesis within a therapy setting. Utilizing the Gloria films, a set of films created with Albert Ellis, Fitz Perls, and Carl Rogers providing therapy for the same patient (Gloria), the theory of interpersonal complementarity was tested. A group of undergraduate students reviewed the films and rated each therapist and the patient with the Checklist of Psychotherapy transactions (CLOPT). The study concluded that the friendlier the therapist behaved, the friendlier

Gloria behaved, and in turn, the more hostile a therapist was deemed, the more hostile Gloria appeared (Kiesler & Goldston, 1988).

In terms of dominance, it was theorized that during interactions, submission evoked dominance and dominance evoked submission (Kiesler & Goldston, 1988). In the Gloria films study, the researchers concluded that when the therapist fell closer to dominance along the continuum Gloria became more submissive (Kiesler & Goldston, 1988). In a group setting, we would anticipate a complementarity such that a dominant therapist would create submissive group members and a submissive therapist would create a dominating group. The therapist would typically be expected to set the norms of interactions in groups (Bogers & Koeing, 1983; Riva et al., 2004) as early as possible (Agazarian, 1999; Bradender et al., 2004). With norm setting occurring in the beginning of the group process and was in large part the therapist's responsibility to guide, a therapist might appear more dominant in early sessions than in later session of group therapy.

Impact of Therapist Communication Style in Group Treatment

Research supported the importance of the relationship aspects of communication and suggested that this aspect was influential. Two studies highlighted the importance and necessity of speaker tone to bring meaning to content (Burns & Beier, 1973; Mehrabian & Weiner, 1967). Both studies made efforts, in different ways, to manage the interrelatedness of tone and content. One study used films with neutral content delivered in various emotive tones along with visual cues (i.e. facial expressions) and a control of written content (Burns & Beier, 1973). The films were edited to filter out tone, visual cues, or content (Burns & Weiner, 1973). The second study used audiotapes of words

considered negative, positive, or neutral and delivered in negative, positive, or neutral tones (Mehrabian & Weiner, 1967). A control condition of written content was used as well. The instructions made an effort to parse out various aspects. Four judging groups were provided specific directions to consider tone only (audiotape), content only (audiotape), all information available (audiotape) or content only (written; Mehrabian & Weiner, 1967). Both studies used a comparison group (Burns & Beier, 1973; Mehrabian & Weiner, 1967). Both studies had the tapes reviewed and rated for emotional content before judging. Those audiotapes and films that had high inter-rater reliability were used in the studies and the identification of emotion/attitude in the comparison group was used as the "correct" meaning (Burns & Beier, 1973; Mehrabian & Weiner, 1967).

Despite the differing approaches and potential confound, both studies found that content alone (written) was not enough to identify accurately the meaning of a message (Burns & Beier, 1973; Mehrabian & Weiner, 1967). The use of all available information was the most informative condition with the highest rate of correctly identifying the emotion/attitude being conveyed (Burns & Beier, 1973, Mehrabian & Weiner, 1967). In the film study, verbal tone and visual cues (i.e. facial expressions) were better than content, both written and verbal, in identifying the emotive meaning (Burns & Beier, 1973). In the audio study, tone was found to have a proportionately greater effect than content in determining the attitude of a message (Mehrabian & Weiner, 1967).

These findings on nonverbal communication were supported in the psychotherapy literature as well. The manner of delivery mattered when therapists provided positive, supportive content feedback to clients (Derlega et al., 1991). Those who gave feedback in a formal, clipped (i.e. short) manner were seen as less genuine and warm, and the positive

content of the message was overshadowed (Derlega et al., 1991), thus supporting the importance of non-content verbal behavior. A study utilizing one therapist showed that the same therapist providing the same content had very different results when changing their tone of voice (Strupp & Anderson, 1997). The therapist, using the same content, adopted either a controlling, harsh manner, or a warm, open manner. The clients who received the warm, open manner showed more improvement in their therapy goals than did the other clients (Strupp & Anderson, 1997). This supported the notion that technique or content, while important, can be overshadowed by the delivery in therapy sessions.

A recent study supported the importance of therapist relational behaviors in treatment processes. The study examined the impact of therapist communication behaviors on client's level of collaboration in treatment sessions (Li, Jauquet, & Kivlighan, 2016). This study utilized the first four sessions from three therapist-client dyads from a university counseling center to examine the effect of therapists' level of dominance, affiliation, and immediacy of addressing in-session interpersonal behaviors on client's level of collaboration during the session. The Therapist Response Questionnaire (TRQ), an observer rating system, was used to quantify dominance-submission, approach-avoidance, and meta-communication behaviors. Higher scores on the dominance-submission scale indicated the therapist provided and asserted structure, direction, and advice. Higher scores on the approach-avoidance scales indicated the therapist showed agreement friendliness, warmth, and encouragement. Higher levels of meta-communication indicated the therapist made process comments and pointed out the connection between client's in-session behaviors and out-session problems. Three students in a counseling psychology program reviewed the transcripts for each session

and rated therapist behaviors. Client collaboration was rated by three experienced therapists using the Use coding system. The Use subscale is rated on a 5-point Likert scale assessing whether the client is "making optimal use of the therapist's intervention," such as the client exploring their feelings in response to an empathetic comment from the therapist (Li et al., 2016).

Researchers used a multilevel analysis approach to account for the nesting of client and therapist behaviors within sessions and within dyads (Li et al., 2016). Initial analyses indicated that metacommunication behaviors (i.e. process comments) did not have a statically significant impact on the level of client collaboration, but it was noted that process comments delivered later in the session were followed by greater client collaboration than when process comments were delivered early in the session. The second set of analyses addressed the interaction of timing of process comments with approach-avoidance and dominance-submission. In terms of dominance-submission, it appeared that lower levels of dominance were associated with greater client collaboration. The findings for approach-avoidance suggested that higher levels of approach behaviors served as a protective factor when process comments were delivered early in the session, but higher levels of approach behaviors did not enhance potential positive effects of process comments later in the session. Further, it appeared that lower levels of affiliation later in session were more desirable when process comments were delivered. In general, the researchers concluded that a facilitative, non-expert approach by therapists would enhance the positive impact of process comments in regards to client collaboration in treatment sessions, and that a warm approach would moderate any negative effective of process comments early in sessions. It appeared that meta-

communication behaviors were moderated by therapists' interpersonal style and timing of those comments in session, indicating that the "how" of the delivery of the statements moderated their impact on client's collaboration behaviors within the session (Li et al., 2016).

The above research highlighted the importance and impact of a person's tone of voice and interpersonal behaviors in communication and therapy. It would be important to note that these findings did not negate the influence of verbal content, but brought to the forefront the importance of the relational aspect of communication. Relational and content aspects of communication have been viewed as entangled and each required the other to create meaning. One without the other would not be possible in human interactions. The tone of the speaker's voice provided the emotional climate through which the content was interpreted (Adler et al., 2007). Social theorists posited the notion of emotional contagion in interactions (Adler et al., 2007), similar to the idea of peer contagion asserted by LeBon (1896, 2001). Individuals would react and interact with another based on the emotional tone that had been set. In group settings, the therapist has been responsible for setting an appropriate emotional tone and guiding interactions to promote personal exploration, growth, and behavior change.

In the group research literature there have been many studies focused on therapist's verbal content, typically framed as techniques or style, and measured through analysis of content. In contrast, there has been relatively little research addressing the relational aspects of therapist communication in group treatment, and no studies were revealed in the literature search addressing this issue within IPV group treatment. These relational aspects might be especially important when dealing with KI statements in sessions, as a

therapist might make a more direct statement or gentle confrontation of behavior through the how of communication and the emotional tone that was set. This concept of a gentler relational style has been emphasized in Motivational Interviewing (MI) approaches to treatment. While MI embraced the importance of therapist relational behavior, there has been limited research in group settings (Rose, 2010). Several group treatment studies, some of which addressed MI approaches, did not address therapist relational behaviors and others limited communication behaviors to content only (LaChance, Ewing, Bryan, & Hutchinson, 2009; Michael et al., 2006; Santa Ana, Wulfert, & Nietert, 2007), thus restricting our understanding of role of therapist relational style in group treatment.

The majority of research addressing therapist communication behaviors focused on the technique or content communicated and labeled it as therapist style, often ignoring the non-content aspects of verbalizations. Researchers have labeled behaviors such as directive/non-directive and confrontational/non-confrontational, and speculative/confrontational behaviors as the style of a therapist (Barlow et al., 1982; Nicholas, 1977, Nicholas & Taylor, 1975; Gilstein, Wright, & Stone, 1977). The literature review below focused on group treatment and the influence of therapist communication behaviors on members' in-session behaviors and client outcomes. Given the dearth of research on relational behaviors (i.e. tone of voice), studies addressing therapist communication "style" and content verbalizations were reviewed. Therapist communication style was operationally defined in various ways; it could be arguable that "style" was highly confounded with technique. The same holds true for therapist verbalizations that were not explicitly defined as style or technique. The overall goal of this section was to highlight the influence of therapist verbalizations in their many

defined forms and manifestations, typically operationalized in terms of content. The following studies addressed various therapist styles and verbalizations as they were labeled by the researchers. Overall, these studies found therapist communication style and verbalizations directly impacted clients' in-session behaviors as well as outcomes relevant to the specific treatment.

The group process should be viewed as complex and involving multiple components that determine its success or failure. Individual client behaviors, level of engagement, topic focus, and group interactions were a few components that research has addressed. Several studies have highlighted the influence of therapist verbalizations on these components.

Two studies addressed the verbal content of therapists in early sessions on members' type of in-group verbalizations during the same session (Nicholas, 1977; Nicholas & Taylor, 1975) and in later sessions (Nicholas, 1977). Therapist's communication style was defined as confrontational or non-confrontational on a 5-point scale, where a five indicated the therapist used challenging language (e.g. content) and addressed problematic client behaviors. Intervention techniques (i.e. clarification, reflection) were also coded. The content of client verbalizations were rated on their level of engagement and involvement, their focus on self, and sharing of experiences (Nicholas, 1977; Nicholas & Taylor, 1975).

For both of these studies the impact of therapist communication style on same session client behavior was significant (Nicholas, 1977; Nicholas & Taylor, 1975). Of the 21 subjects, five (5) had no diagnosis, and the remaining subjects were diagnosed with personality disorders, neurosis, or psychosis. Each therapist utterance was rated on a

confrontation scale, where confrontation was defined as the degree to which the therapist challenged the patient's defenses. Utterances that were low in challenges and ego-syntonic (in harmony with client's beliefs of self) were considered low confrontation. In groups where therapists were rated as higher in confrontational verbalizations, clients tended to be more emotion focused, made more self-statements, shared experiences in the group from their daily lives, and addressed more in-group issues (Nicholas, 1977; Nicholas & Taylor, 1975). Similar effects were found when assessing early session therapist behavior and later session client verbalizations. Groups with more confrontational therapists tended to have higher emotive statements, more self-statements, and a greater level of addressing in-group issues (Nicholas, 1977).

The influence of therapist verbal content on client in-session behaviors was also supported in a study, which categorized content as directive or non-directive (Gilstein et al., 1977). Forty-one undergraduates served as subjects in a 12 member group that met weekly for six (6) weeks. The same leader, who was trained to be directive or non-directive, led each group. Directive leader behaviors were defined as verbally directing the group conversation, challenging, confrontational, and evaluative. Non-directive leader behaviors were deemed supportive, encouraging of group member feedback, and allowing the group to be responsible for the discussion. Groups with the non-directive style tended to be more focused on the group relationship, other members, and treatment work and goals than groups with a directive style (Gilstein et al., 1977)

Therapist's communication style was also influential when defined as interpersonal versus intrapersonal (Shoemaker, 1987) and coded from session transcripts. Subjects were 50 university students randomly assigned to one of five groups, which met weekly

for eight (8) weeks. Group leaders were doctoral interns and psychologists from the university-counseling center and raters were pre-doctoral interns at the center. Therapists were labeled with an interpersonal style when their content focused on their own or a group member's feelings or perceptions of another. Intrapersonal therapist style was defined as content focusing on self-exploration and their interpretations of their own behavior and feelings, and encouragement of client's focus on their own (client's) behavior and feelings. When therapists had a more interpersonal style participants tended to show greater interpersonal gains (i.e. empathy, friendliness) post treatment compared to clients with intrapersonal style therapists. In contrast, clients with intrapersonal therapists had greater self-esteem gains post-treatment (Shoemaker, 1987).

These studies on therapist communication style, as characterized by content verbalizations, suggested that therapist verbalizations influence the course of group work. Therapists influenced the clients' focus on self versus others, in versus out of group experiences, and the content of the group conversation (i.e. group goals). In addition to the group work content, research found the therapist also influenced the group member interactions.

Gilstein and colleagues (1977) and Shoemaker (1987) found that group members' level of interaction was also influenced by therapist communication style. In Gilstein and colleagues (1977) study, group members interacted more when therapists were less directive. Shoemaker (1987) found that clients with interpersonal style therapists tended to have greater levels of member interactions. One of the primary factors for a successful group posited by early group theorists and researchers was the importance of group member interactions (Andrews 1995; Bradender et al., 2004). As LeBon theorized (1896,

2001) and consistent with Meis' (2009) research with IPV offenders, group member interactions were influential in treatment, however these interactions were not always positive. Given that therapists could influence the frequency of interactions, it could be theorized they can influence the characteristics of the interaction as well through their verbalizations.

Studies have shown that therapist's communication style was often mimicked by group members (Barlow et al., 1982; Sandahl et al., 2000). Barlow and colleagues (1982) examined the influence of therapist's verbal content categorized as style (speculative and confrontational) on group member's responses contiguous to the leader verbalizations and on the general tendency of the group's verbal behavior. Initial ratings were done via audio tape, with reliability ratings completed from written transcripts. Six co-therapy teams of teaching assistants and doctoral practicum students were trained in specific approaches reflecting a speculative style, a confrontational style, or a control condition where style was not dictated (Barlow et al., 1982).The subjects were 48 undergraduate students randomly assigned to one of six groups, which met for 30 hours total in a ten-day span. Each co-therapy team facilitated only one group. The speculative style was characterized by speaking for oneself in questioning the meaning of self or other's behavior. The confrontive style focused on stating the impact their or other's behavior had on themselves. Member verbal style was also coded with the categories of speculative and confrontive. Clients completed measures of self-concept and therapist leadership style (Barlow et al., 1982).

Analysis confirmed that, in general, members spoke significantly differently across groups. Members matched the therapist style, such that confrontive members spoke in

confrontive styles with a focus on superficial comments or defensive and argumentative stances and less in a speculative style. In groups with speculative therapist styles, members spoke less often in confrontive styles and more in the speculative style. Groups with a speculative style therapist focused on intellectual interactions, therapeutic work, and member interactions regarding problematic behaviors (Barlow et al., 1982).

In addition to the general tendency of the group to mimic the therapist, it was found that contiguous verbalizations by members following a therapist style were more likely to be in the style of the therapist. In examining the first group member responder after a therapist verbalization 81% were in the same style as the therapist. This same pattern of mirroring the therapist style occurred for second speaking member verbalizations (78%) and third speaking member verbalizations (77%; Barlow et al., 1982). This suggested that clients were mimicking the therapist's verbal style in relational and content aspects. The mirroring of verbal style indicated the therapist could guide client interactions during KI statements in a therapeutically productive manner.

A study addressing communication patterns in theoretically different groups for alcohol dependence, cognitive behavioral (CBT) and analytically oriented, gave further support to the influence of therapist verbal behaviors. The primary purpose of the study was to determine if communication patterns of therapists delivering different theoretical interventions differed and if so, how those verbal patterns influenced the group members (Sandahl et al., 2000). In this study, 59 clients, dependent on alcohol, were randomized to one of two treatment approaches and attended group therapy once per week for 15 weeks. Of the eight therapists, five were trained in analytical approaches and three in behavioral approaches. Therapist and client verbalizations were coded for content (e.g. personal;

factual; orienting; empathize). In addition, clients completed anxiety and depression questionnaires. When considering all verbalizations, both therapist and clients, in a group session, CBT therapists had considerably more verbalization than did analytic therapists (40% and 15%) respectively. While clients with CBT-oriented therapists had fewer verbalizations than did clients with analytically oriented therapists, CBT therapist verbalizations were characterized as compete (i.e. yes, but), influence (i.e. opinion), and orienting (i.e. direction through reinforcement) statements more often than analytical therapists. In turn, analytical therapists verbalizations were characterized as personalize (i.e. personal information) and empathize (i.e. inner-person related) statements more often than CBT therapists. For all groups, clients' verbalizations followed those of their therapist, such that CBT clients' statements contained the same characteristics as CBT therapists and analytical clients were characterized similarly to analytic therapists (Sandahl et al., 2000). These studies indicated that clients modeled their therapist's interaction style.

In addition to client verbal behaviors, therapists' interpersonal behaviors have been found to influence the development of group alliance. One study (Romeo, Meyer, Johnson, & Penn, 2014) investigated the relationship between therapists' characteristics and group alliance, as well as treatment outcomes. This study utilized 65 clients who were diagnosed on the Schizophrenia spectrum. Clients were part of a larger study comparing cognitive behavioral therapy to supportive therapy for individuals with treatment refractory auditory hallucinations. All attended a 1-hour weekly group therapy session for 12 weeks. These sessions were facilitated by ten (10) therapists, for eight (8)

of the groups the therapists worked in dyads and for two (2) groups there was a single therapist (Romeo et al., 2014).

The therapist behaviors were rated via videotape by research assistants using the Vanderbilt Psychotherapy Process Scale (VPPS; Romeo et al., 2014). Raters coded forty-four (44) specific behaviors on a 5-point Likert scale, which collapsed into three subscales. The Therapist Warmth and Friendliness (TWF) scale assessed level of therapist warmth and involvement with the client. The Negative Therapists Attitude (NTA) scale assessed whether the therapist displayed an intimidating or threatening attitude. The Therapist Exploration (TE) scale assessed therapist attempts to explore underlying reasons for emotions and behaviors. The VPPS was completed for the first five (5) sessions of each treatment group. Group Alliance was measured using the Group Working Alliance Inventory (WAI-G), a 36-item client completed questionnaire assessing client's view of group bond, group common tasks, and shared group goals. Each item was rated on a 7-point Likert scale and collapsed into a total Group Alliance score. The WAI-G was completed at week six (6) of treatment. Client symptoms were assessed pre and post-treatment by a clinically trained graduate assistant utilizing the PANSS, a semi-structured interview addressing positive and negative symptom severity for psychosis. The Beck Cognitive Insight Scale (BCIS), a self-report measure, was completed pre and post treatment by the client. The Social Functioning Scale, a self-report scale, was completed pre and post treatment to assess client's social functioning behaviors. Treatment engagement and attendance were rated on the Psychosocial Treatment Compliance Subscale, a 17-item therapist rated scale.

Multiple linear regression analyses were conducted. Findings concluded group alliance at week six (6) was associated with higher levels of therapist warmth and friendliness in the previous sessions (Romeo et al., 2014). Findings also suggested, although it was a trending result, that higher average levels of negative therapist attitudes in sessions one (1) through five (5) were associated with lower session six (6) group alliance scores. No significant associations were found between therapist exploration and alliance scores. Higher levels of negative therapist attitudes in early sessions were also associated with greater levels of client post-treatment symptoms. Overall, researchers concluded that therapists' warmth and negative attitudes were associated with client perception of group alliance and post-treatment outcomes, and therapist technique (i.e., therapist exploration) was not associated with group alliance and post-treatment outcomes (Romeo et al., 2014). These findings highlight the importance of therapist relational behaviors and interpersonal style on group process and treatment outcomes.

The above research clarified that therapist's verbal content and relational behaviors were influential in group treatment processes with varying populations. While limited, research also supported the hypothesis that therapist verbal content would be influential in forensic treatment populations, and specifically in treatment for IPV offenders. With the influence of negative peer behaviors in IPV group treatment (Meis, 2009) the therapist's ability to guide the conversation to counter this influence would be important.

A study of therapist influence in a sex offender population in the United Kingdom confirmed the influence of therapist verbalizations in a forensic population. Two studies were conducted addressing therapist's verbal behaviors in cognitive behavioral therapy groups for incarcerated sex offenders (Marshall, 2005). Therapist verbal behaviors were

coded for content and relational qualities, such as empathy, confidence, confrontation, warmth, and appropriate voice tone (Marshall, 2005). Outcomes specific to sex offender treatment were measured for clients (e.g. denial of responsibility, victim blaming; Marshall, 2005).

Two distinct sets of therapist behaviors emerged as influential (Marshall, 2005). Both studies found that warmth, empathy, rewardingness, and directiveness were related to beneficial change on client outcomes. When therapists employed those verbal characteristics clients engaged in less victim blaming, had a greater degree of empathy for their victims, and accepted responsibility for their offenses. Confrontational, defined as a harsh challenging approach, and non-confrontational, defined as firm but supportive challenges, impacted client's movement towards positive changes as well. Confrontational approaches by the therapist hindered positive client progress on behaviors such as accepting responsibility for their offenses and victim blaming attitudes. This finding was only true for the first study, as therapists did not engage in confrontational verbal behaviors in study two. During the time between study one and study two, therapists were educated about the outcome of study one and received training to reduce their level of confrontation, therefore little to no confrontation was observed in study two therapists communication (Marshall, 2005). In general, the studies suggested that when working with sex offenders the therapist should take an empathic and warm approach with a degree of directiveness, and challenge in a supportive manner. These therapist behaviors influenced cognitions and beliefs related to the offending behavior in a productive manner, which has implications for considering other offender populations, such as IPV offenders. Additionally, the changes in level of confrontation from study one

to study two highlighted the ability to train and teach therapists particular verbal styles and interaction approaches. When therapists were provided feedback on what worked and did not work with this offender population, they were able to alter their behavior in a way that was therapeutically productive. This study varied from other group treatment research reviewed as it made efforts to include relational, non-content aspects of communication. The results indicated that these relational aspects influence treatment progress.

A study conducted with a sex offender population in the UK also supported the influence of therapist interpersonal style on group treatment process, in particular the therapeutic alliance (Watson, Daffern, & Thomas, 2017). This study examined the interpersonal style of therapist from the offender perspective and the offender interpersonal style from the therapist perspective, and the potential interaction between those perceptions and the therapeutic alliance. The sample consisted of 75 male offenders, 60 of whom were incarcerated, over the age of 18 years. The community based offenders attended 3-hour group sessions once per week for three (3) to eight (8) months. The incarcerated offenders attended 3-hour group sessions twice per week from three (3) to eight (8) months. The length of treatment for both groups was dependent on their level of risk for re-offending. Treatment groups were run by therapist dyads. No information was provided regarding the total number of therapists in the sample or therapist characteristics (Watson et al.,2017).

The therapists and offenders rated one another on the Impact Message Inventory-Circumplex (IMI), a 56-item inventory assessing the emotional experience of interpersonal behaviors (Watson et al., 2017). Each item is rated on a 4-point rating scale

of not at all to very much so, in response to their perception regarding the interpersonal behaviors of another (i.e. when I am with this person he makes me feel bossed around). The IMI collapsed into eight (8) octant scales: Dominant, Hostile-Dominant, Hostile, Hostile-Submissive, Submissive, Friendly-Submissive, Friendly, and Friendly-Dominant. For this study, the Dominant, Hostile, Submissive, and Friendly subscales were used. For some analyses, the octants were collapsed into two scales for Affiliation (i.e. levels of friendly behaviors) and Control (i.e. levels of control behaviors). IMI was completed at week three (3) or four (4). The therapist completed forms for each individual in the group and the offender completed forms for each therapist. The Working Alliance Inventory-Short Form (WAI-SF), a 12-item questionnaire addressing therapeutic alliance, was administered at week three (3) or four (4). Each therapist completed a form for each group member, and each group member completed a form for the two therapists leading their group. Individuals rated items on a 7-point Likert scale ranging from never to always.

A series of ANOVAs determined that overall offenders' ratings on Goal, Task, and Total Alliance scores were significantly higher than therapist ratings, and no significant differences were found on the Bond subscale (Watson et al., 2017). The complementarity of interpersonal style of the offender and therapist were assessed using the IMI reports. An independent samples t-test indicated that this sample had a higher level of complementarity on the Control axis then the Affiliation axis, and when compared to the normative samples displayed lower levels of Control complementarity. Correlation analyses were conducted to assess the relationship between ratings on the WAI-SF and IMI. Offenders' ratings of therapist Affiliation were significantly positively correlated

with offender ratings on all the WAI-SF scales. Offenders' ratings of therapist control were significantly negatively correlated with offender ratings on all scales of the WAI-SF. Parallel findings emerged for therapists' perception of offender interpersonal behaviors and therapeutic relationships. A significant positive correlation was observed for therapists' perception of the offender behavior Affiliation and all scales on the WAI-SF. A significant negative correlation was found for therapists' perception of offender Control and all scales on the WAI-SF. No statistically significant correlations were found for complementarity of Affiliation and Control and WAI-SF subscale. In terms of Hostility and Dominance subscales on the IMI and WAI-SF scales, therapists' ratings of offender hostility were associated with lower ratings on the WAI-SF by the offender. Therapists' ratings of offender dominance were not significantly correlated with offender ratings on the WAI-SF (Watson et al., 2017).

The researchers concluded that in general the therapists' rating of therapeutic alliance were lower than in other treatment populations, which may be due more challenging client interpersonal behaviors in a forensic population (Watson et al.,2017). The researchers also found that when therapists' rated offenders as friendlier rather than hostile, they also viewed the therapeutic alliance as more positive. This finding was also true for the relationship for offender perceptions of therapist friendliness and the therapeutic alliance. Therapists who rated the offenders as more dominant than submissive tended to view the therapeutic alliance more negatively. In turn, offenders who rated therapists as more controlling tended to view the therapeutic alliance more negatively. The researchers posited that the perception of interpersonal behaviors was associated with the treatment process for developing therapeutic alliance. In general, it

appeared that a friendly therapist approach would likely lead to a more positive therapeutic relationship, whereas a dominating therapist may have poor therapeutic relationships (Watson et al., 2017).

A study conducted with IPV offenders in the UK also confirmed the influence of therapist verbalizations in a forensic population. Clients in an IPV group treatment program participated in the study (Bowen, 2010). Clients completed questionnaires regarding their beliefs about IPV, their experience of anger, and social desirability. Law enforcement records were reviewed for evidence of re-offending. All group members and group leaders completed the Group Environment Scale to assess cohesion, leader support, expressiveness, independence, task orientation, self-discovery, anger and aggression, order and organization, leader control, and innovation (Bowen, 2010).

Group members who perceived group leaders as supportive had clinically significant change on more IPV related outcomes (i.e. reoffending) than group members who rated their therapist as low in supportive qualities (Bowen, 2010). While this study suggested that a supportive therapist was beneficial, the lack of objective ratings of therapist verbal behavior limits the ability to state conclusively that therapist verbal behavior was influential. However, one could cautiously conclude that the therapist's behaviors as perceived by the client were influential and that verbal support was involved.

Overall, the above research supported the influence of therapist verbal behaviors in group treatment. There was some evidence that client outcomes, specific to beliefs and cognitions, were influenced by therapist verbal behavior, including in forensic populations (Marshall, 2005). In addition, therapist interpersonal style as observed by others impacts treatment alliance and outcomes (Romeo, Meyer, Johnson, & Penn, 2014)

and the clients' perception of therapists' interpersonal style appeared to play a role in the development of the therapeutic alliance in a forensic population (Watson et al.,2017). In addition, several studies supported the idea that therapist verbal behaviors shaped the group norms. These norms included individual behaviors, such as frequency of verbalizations, and focus on topics, such as self or others, and group work focusing on the process occurring within versus outside the group (Barlow et al., 1982; Nicholas, 1977, Nicholas & Taylor, 1975; Gilstein et al., 1977; Sandahl et al., 2000). The above studies were also supportive of the suggestion that group members modeled therapist behaviors. Several studies found that group member's verbal responses were similar to the group therapist's verbalizations, indicating that therapists set a group norm about how to speak to one another in group (Gilstein et al., 1977; Sandahl et al., 2000). In addition, there was also evidence that group therapist's verbalizations influenced the rate of participation and feedback members engage in (Gilstein et al., 1977; Shoemaker, 1987).

This research provided support to the hypothesis that therapists had the ability to influence group member's response style, interactions, and focus during group treatment. This was pivotal in IPV groups as evidence suggested that during KI moments the influence of other group members could move the group in productive or unproductive directions (Meis, 2009). With client interactions, in part driving the movement of the group, the therapist could have a pivotal opportunity to shape those interactions. With limited evidence to support the efficacy of group treatment for an IPV population, yet a mandated reliance on group approaches, utilizing the therapist to improve group treatment through capitalizing on the client interactions would seem a valid and potentially fruitful area for investigation.

Therapist Communication Style and IPV Group Treatment

The actual content of what therapists verbalized in these KI moments was important; however, the impact of the content (i.e., what is said) was limited without group norms that supported change and the supportive, appropriate delivery of this content by therapists (i.e., how it is said). Norms should be considered the unwritten rules of behavior created by client expectations and molded by the direct and indirect efforts of the therapist (Yalom & Leszcz, 2005). These norms should govern the group process and member behavior (Agazarian, 1999). This shaping could be either direct, by modeling the desired types of interactions during group, or more indirect through reinforcement of desirable behaviors (Bogers & Koeing, 1983; Riva et al., 2004). The norms for interactions should create an open environment, allowing members to interact and express themselves in a non-defensive and positive climate (Agazarian, 1999; Dies, 1977; Nicholas & Taylor. 1975; Riva et al., 2004). Research supported the ability of the therapist to shape norms to create a climate conducive to communication and change (Dies, 1977) by influencing behavior and group member reactions (Barlow et al., 1982; Bowen, 2010; Gilstein et al., 1977; Marshall, 2005; Nicholas, 1977; Nicholas & Taylor, 1975; Sandahl et al., 2000; Shoemaker 1987).

It would be essential that the therapist shape these norms of interaction early in treatment through effective verbal behavior focused on both the contextual and relational aspects of this communication, as these norms might be difficult to alter later in treatment (Agazarian, 1999; Bradender et al., 2004). Tuckman's (1965; Hare, 2010) theory of group development suggested that the early stage of group involved the testing of limits and boundaries and a reliance on the therapist for guidance. What occurred in this early

stage of group development could profoundly influence later group progress and dynamics (Agazarian, 1999). The challenge to shaping group norms around client statements in an IPV group would be not to inhibit clients' expression of beliefs and emotions that needed to be addressed in treatment, but to provide an open environment that allowed for dialogue among all members to encourage change.

As reviewed above, research suggested that relational aspects of communication were key features of the interaction process (Adler et al., 1991). Non-content verbal aspects of communication could overshadow the content of the message conveyed (Derlega et al., 1991). Ultimately, how something was said by a therapists might be as, or even more, important than precisely what was said. Therapists should be aware of and able to alter their non-content verbal behaviors in order to address issues with clients effectively, as the content's interpreted meaning changes with its delivery (Adler et al., 1986). How a message was delivered in sessions modeled communication behaviors for other group members, and could in turn move an important interaction in productive or unproductive directions. Using the therapist to model communication style could teach effective communication skills and affects interactions in group, through shaping group members' responses and the norms of group behaviors.

Understanding the usefulness of the relational, non-content verbal behaviors might aid therapists in effectively addressing KI statements. It was suggested that when responding to KI points, such as negative behaviors or irrational beliefs, the emotions and feelings of the client could be supported, but the negative beliefs and behaviors should be challenged (Derlega et al., 1991). These challenges should be designed to encourage change, and should be done empathically, (Van Denburg & Kiesler, 2002), with

gentleness (Gellar, 2005), and free of judgment and criticism, to avoid hostility or frustration for the client (Brown & Keller, 1973). Even a simple statement of observation could cause the other to feel judged (Brown & Keller, 1973). Given the importance of therapist communication behaviors in modeling of appropriate verbal behavior and norm setting, an understanding of the content and the non-content verbal behaviors would be essential to improving group treatment in general, and specifically for hard to treat populations, such as IPV offenders.

The challenge in research has been disentangling one's manner of speaking from the content. The how and what of therapist's communication have been viewed as intertwined and necessary to the therapeutic process. For this study, both were utilized to determine the therapist's communication style when responding to KI moments. However, in contrast to other studies, the what was not be based on theoretical techniques, instead it was viewed from the perspective of a how a non-therapist population, such as a client, would most likely interpret the communication style. A client would not label communication as a warm and complex reflection. Instead, a client would more likely label and experience communication as hostile or friendly.

Summary

Based on the research reviewed it was clear that the manner in which content was delivered influenced a listener's interpretation of the information (Burns & Beier, 1973; Derlega et al., 1991; Mehrabian & Weiner, 1967, Strupp & Anderson, 1997). There was also sufficient evidence to support Yalom and others' assertion that clients observed and mimicked therapists' communication behaviors (Barlow et al., 1982; Sandahl et al., 2000). Additionally, therapists' behaviors influenced rates of participation, specifically

member-to-member feedback in treatment groups (Gilstein et al., 1977; Nicholas, 1977; Nicholas & Taylor, 1975; Shoemaker, 1982). In addition, several research studies indicated that therapist verbal behaviors also influenced treatment processes and outcomes (Bowen, 2000; Marshall, 2005, Watson et al.,2017). Overall, these findings provided strong support for the therapist's role in setting norms and influencing group interactions.

The emerging evidence that group member interactions were, in part, responsible for poor outcomes in both IPV group interventions (Meis, 2009) and juvenile deviancy group interventions highlighted the need to manage these relationships. The reviewed research also suggested that therapists could be trained to alter their verbal behaviors in groups (Marshall, 2005). Therefore, training therapists to attend to and manage the relational and content portions of their verbalizations in order to guide group behaviors and relationships would be a cost-effective and efficient way to improve the efficacy of group treatment in IPV populations. Before training in verbal behaviors could be initiated, we should determine if the research supporting variability in treatment outcome due to therapist influence applied to IPV treatment outcomes and group interactions, and, if so, whether therapist verbalizations accounted for part of this influence.

A key consideration was how to define therapist verbalizations to capture both the content and relational aspects of communication. The majority of research reviewed utilized content as a means of measurement, excluding the relational factor. Content aspects of communication were easier to label and measure and thus more likely to be studied. Those studies that included the relational factor tended to limit their definitions to warmth or empathy, potentially missing other key elements of relational behaviors.

Deconstructing communication into relational and content components would be theoretically possible, however generally unrealistic in a "real world" setting. Clients in group therapy settings did not tease apart the communication behaviors of their therapists; instead, they processed and interpreted the information as a whole, including both verbal and nonverbal elements. It would be important to measure both components of therapist interactions, as they would likely to be heard by the client, as intertwined.

Research Hypotheses

The primary goal of this study was to determine the amount of influence therapists have on client verbalizations in group therapy sessions and on clients' post treatment behaviors.

Hypothesis 1: Clients' rate of KI statements, response to KI statements, and post-treatment IPV behaviors would differ significantly among therapists.

Hypothesis 1A: Significant differences would be found among therapists in rate of client KI statements in late sessions and average rate of change in amount of KI statements from early to late sessions.

Hypothesis 1B: Significant differences would be found among therapists in group members' overall level of verbal support of KI statements and in the strength of supportive and non-supportive responses of group members to KI statements in late sessions.

Hypothesis 1C: Significant differences would be found among therapists in clients' post treatment reports and client's partner report at post-treatment and 6-month follow-up of IPV behaviors.

Hypothesis 2: Clients' rate of KI statements, group member response to KI statements, and post-treatment IPV behaviors would be significantly associated with therapists' verbal response style.

Hypothesis 2A: Rate of individual late session KI statements and client's average rate of change from early to late sessions would be significantly associated with early session therapist response styles.

Hypothesis 2B: Group members' overall level of verbal support to KI statements in late sessions and the strength of supportive and non-supportive group member responses would be significantly associated with early session therapist response style.

Hypothesis 2C: Clients' report of post-treatment IPV behaviors and partner's report of post-treatment and 6-month follow up of IPV behaviors and would be significantly associated with early session therapist response style.

Chapter 2: Methods

Participants

Clients. The client sample consisted of 114 men from two previous clinical research studies of IPV offenders, who received treatment at a community-based treatment program for domestic violence offenders. Participants were included in the study sample if they completed the intake process, were deemed eligible for services at the agency research site, provided written consent for research participation, and were at least 18 years old at the time of program intake. All clients had a problem with abusive behaviors in relationships as documented by self-report, partner report, and/or arrest records. Individuals were considered ineligible for treatment if signs of active psychosis were

evident during the program intake, if the individual refused to provide consent for program staff to contact the victim partner, or if the individual refused to comply with referral to substance use treatment (in cases with clear evidence of substance dependence disorders). For individuals receiving psychotropic medications for a major psychiatric condition, clearance for participation in the group program was obtained from the treating physician. Individuals who did not attend at least one of the early and one of the late group sessions chosen for coding were excluded from the current study.

The majority of clients were court-mandated to treatment (79%), 7% had a pending court case at the time of intake, and 14% reported no court involvement. At the time of intake, 22% were married or co-habitating, 44% were separated, 21% were never married, and 13% were divorced. With respect to racial and ethnic background, 58% identified as Caucasian, 36% as African-American, 0.9% as Hispanic, 1.8% as Native American, 2.6% as Asian, and 0.9% identified as "other" race. Client's ages ranged from 19 to 61 years, with a mean age of 36 years. About 15% of clients reported not having completed high school, 36% completed high school, 26% had some post high school education, 13% reported completing a bachelor's degree, 6% had some education beyond a bachelor's degree and less than 1% received a graduate degree. About eighty-eight percent (88%) of clients reported being employed full time at intake. Reported annual income was as follows: 8% had no income, 37% had income below $10,000, 29 % between $10,001 and $30,000, 20% between $30,001 and 80,000, and 5% above $80.000.

Therapists. The sample consists of six (6) primary therapists across 14 treatment groups. Group size varied from six (6) to 10 clients. The number of groups facilitated per

therapist varied as follows: One therapist conducted five (5) groups, one therapist conducted three (3)groups, two (2) therapists conducted two (2) groups each, and two (2) therapists conducted 1 group each. Primary therapists had master's-level training and prior supervised experience conducting the CBT group program. Therapist client load ranged from eight (8) clients to 48 clients. All primary therapists are Caucasian. Four of the primary therapists were male and two female.

Measures

Intimate Partner Violence Behavior. The Conflict Tactics Scale (CTS) was a self-report inventory that measured the tactics used by partners during conflicts and was designed to address how a couple manages and attempts to resolve conflict (Straus, 1979). The CTS did not measure if resolution occurs, only the tactics and behaviors that occurred during conflict (Straus, Hamby, Boney-McCoy, and Sugarman, 1996).

Three CTS scales were used in this study. The Psychological Aggression scale measured verbal and non-verbal tactics used to hurt the other person (nonphysical) and consisted of items such as "Insulted or swore at my partner (Straus, 1979)." The Physical Aggression scale assessed the use of physical force as a tactic and included items such as "Threw something at my partner that could hurt." The Injury scale assessed physical injuries that resulted from conflict and consisted of items such as "Went to the doctor because of a fight with my partner" (Straus, 1979).

The study utilized data from two cohorts from a mid-Atlantic domestic violence center; these cohorts were assessed with different versions of the CTS. For both cohorts CTS data on the client's abusive behavior were available by client self-report and collateral partner report at pre-treatment and immediate post treatment, and by collateral

partner report at follow-up 6-months after the scheduled end of treatment. Client self-report at post treatment, as well as partner report at post treatment and 6-month follow up were used as outcome measures.

Cohort 1 was assessed with the CTS2 (Appendix A), the revised version of the original CTS. The CTS2 contained 39 items. There were six (60 questions for Negotiation, eight (8) for Psychological Aggression, 12 for Physical Aggression, six (6) for Injury, and seven (7) for Sexual Coercion. Cohort 2 was assessed with a hybrid of the original CTS (Appendix A) and the CTS2. The hybrid version was a 29-item questionnaire. Negotiation (Reasoning for CTS) contained five (5) items, Psychological Aggression (Verbal Aggression for CTS) contained six (6,) Physical Aggression had nine (9), Injury had six (6), and Sexual Coercion contained three (3). This hybrid consisted of the psychological and physical aggression scales from the original CTS accompanied by additional CTS2 items assessing sexual coercion and injuries. Both versions of the CTS focused on specific acts and events that occurred in the relationship and the frequency of those acts.

In order to merge the two cohort's CTS data into a single usable set of items, those items that were unique to only one of the two versions were eliminated and any items that were identical or nearly identical were treated as equivalent. In some instances two items on the CTS2 were collapsed into a single item that became equivalent to an item on the original CTS. For example, on the CTS, an item read, "I pushed, grabbed, or shoved my partner," and on the CTS2, there were two items that read, "I pushed or shoved my partner" and "I grabbed my partner." These two items on the CTS2 were collapsed into a single item by summing frequency responses. This summed item was then treated as

equivalent to the original CTS item. The final version for the current study's analyses included five (5) items for Negotiation, eight (8) for Psychological Aggression, seven (7) for Physical Aggression, and six (6) for Injury.

For the original CTS, Straus and Gelles (1990) summarized studies assessing psychometrics and found internal consistency for the Negotiation (called Reasoning in the original CTS) scale ranged from .42 to .76, Verbal Aggression (equates with Psychological Aggression) from .62 to 0.88, and Physical Aggression from .69 to .88.

The internal consistency of the scales of the CTS2 range from $\alpha = .79$ to $\alpha = .95$ (Straus et al., 1996). During initial scale revisions reliability for Negotiation was $\alpha = .86$, Psychological Aggression $\alpha = .79$, Physical Aggression $\alpha = .86$, Physical Injury $\alpha = .95$, and Sexual Coercion $\alpha = .87$ (Straus et al., 1996).

Meis (2009), utilizing the same database that was used in the current study, assessed the internal consistency of the hybrid version of the CTS for collateral partner reports. The Psychological Aggression scale yielded an internal consistency reliability of .69 for post-treatment follow-up and .71 for the 6-month follow-up. Physical assault yielded .70 at post-treatment follow-up and .45 at the 6-month follow-up. The Injury scale yielded .75 at post-treatment and .84 at the 6-month follow-up (Meis, 2009).

Studies, as part of the development of the CTS and three replication studies, confirmed a three-factor structure for the CTS (Straus & Gelles, 1990). The factors identified were Reasoning/Negotiation, Verbal/Psychological Aggression, and Physical Aggression. One study supported the same initial two factors and found that the third factor, Physical Aggression, separated into two factors; physical aggression and a life threatening violence (Straus & Gelles, 1990).

Concurrent validity referred to the degree that a new instrument relates to other valid instruments measuring the same or similar construct, measured at the same time (Straus & Gelles, 1990). The Longitudinal Study on Child Abuse and Neglect (LONGSCAN) project assessed the concurrent validity of the CTS with the Self-Report Family Inventory (SFI) conflict scale and found it to be adequate; Reasoning (r = -.11), Verbal Aggression (r = .58), Minor Violence (r = .37), and Severe Violence (r = .38) (Hunter et al., 2003). Significant correlations were found between the SFI Family Conflict scale with Verbal Aggression and Minor Violence and Severe Violence (Hunter et al., 2003).

The CTS response set was a 7-point scale ranging from the act (0) never occurring to (6) occurring more than 20 times. Respondents were asked to indicate how many times each act occurred over a specified period. For this study, the post-treatment follow-up covered the 6-month period corresponding to the duration of assessment and treatment, with the assessment administered immediately prior to the end of scheduled treatment. At the 6-month follow-up, respondents were asked to report on behavior during 6-month period after the scheduled completion of treatment.

There were several approaches to scoring the CTS. For this study, variety scoring was utilized. Variety scores were based on a dichotomized scoring for each item: zero (0) indicated it did not occur at all during the specified time and one (1) indicated that it occurred one or more times during the specified time period. A scale score was created by summing the items of each scale, so each scale has a minimum score of zero and a maximum score equal to the total number of items on that scale. Variety scoring had several strengths. First, variety scores were typically less skewed than scores that preserve the frequency scale for each item (Moffitt et al., 1997). Second, they provided

equal weight to all acts reported. With frequency scores, acts that occurred most often were given the highest weight, even if they were less violent/serious acts. Third, variety scores tended to be more reliable than frequency scores on the CTS (Moffitt et al., 1997).

Observational Codes

Key intervention statements. A manualized coding system developed for a larger study, the Group Treatment Interaction Project (GTIP; Appendix B), was utilized to identify key intervention statements (KI statements) for the present study. In the prior study, these events were labeled countertherapeutic (CT) talk. For the current study, CT talk was referred to as key intervention statements (KI statements) to signify an opportunity for important therapist intervention. Two early and two late sessions from each group were reviewed and coded for KI statements (pass 1). Two early and two late session tapes were selected to maximize number of participants attending coded sessions. For this study, the identified events were used to determine when to code therapist responses. Several categories of behavior were coded for KI statements. In the GTIP manual, KI statements were defined as any statement that is counter to the global and specific goals of the treatment group (Meis, Grodack, & Murphy, 2008). The identified statements suggested a hostile resistance to treatment, abuse-promoting attitudes, negative beliefs about women, support for aggressive behaviors, or antisocial attitudes. The coding categories for statements are as follows: Hostile Resistance to Treatment, Illegal Activities, Aggressive Talk (not related to intimate relationships), Destructive Relationship Talk (specific to intimate relationships), Hostile Talk About Women, and Physical Aggression toward Women (Meis, Grodack, & Murphy, 2008). As a reminder, for this study these statements were considered a reflection of cognitions and

verbalizations that motivated and maintained partner violent behavior, and therefore signaled key opportunities to provide therapeutic intervention, particularly in light of group dynamics that might support or promote these perspectives.

As part of the coding process, statement events were identified. If a statement by a group member met the criteria for the coding categories, the individual's response was coded as well as fellow group members' responses to this statement (see below for group response coding). This coding event ended when one of the following criteria was met: the group discussion shifted away from the original comment or to a new speaker. The group as a whole must have shifted their focus to a new topic or person, the therapist's effort to change topic was not considered an end to the event (see Appendix B). The average number of events per client for early sessions was 2.87 (sd = 3.12) and for late sessions was 2.52 (sd = 2.49). The average number of events per group for early sessions was 22.05 (sd = 9.85) and for late sessions was 17.66 (sd = 8.61).

Advanced doctoral candidates in clinical psychology (including the current study author, details provided in Meis, 2009) completed all KI statements event coding during a first pass of session coding (pass 1). Reliability was determined by having both of the coders code 10 (17%) of the original 60 sessions. The reliability of the coding of negative client statements yielded a kappa of .58 with 91% agreement on the presence or absence of negative statements (Meis, 2009). This kappa represented a fair to good level of agreement (Fleiss, 1981).

The rates of individual KI statements in late sessions were utilized as a dependent variable. The number of late session KI statements was summed for each individual for the two late sessions and then divided by the number of late sessions attended by that

individual (either 1 or 2) to calculate rates of individual KI statements. The amount of change in number of KI statements from early to late session was also utilized. The mean number of late session KI statements was subtracted from the mean number of early KI statements to determine the rate of change for each individual.

Client response style. The Overall Group response code captured the overall type of response of the group members to specific KI statements. For each statement, there were both supportive and non-supportive responses to the KI statements and this code reflected the overall direction of the entire groups' response. Coders rated the group response on a 5-point Likert scaled ranging from one (1) to five (5) where one (1) was entirely non-supportive, two (2) was more non-supportive than supportive, three (3) was an equally mixed response, four (4) was more supportive than non-supportive, and five (5) was entirely supportive. Supportive response would include laughter or statements of agreement. Non-supportive would include statements reflecting disapproval or disagreement with the KI statements. A mixed response would include a roughly equal amount of supportive and non-supportive responses from different group members, or if it were a single responder a mixed response such as "I agree with you, but…" There was one global client response score for each KI statement. That global response score was then associated with the KI statement's speaker. For analyses, an average score for global responses during early and late sessions, separately, was calculated for each individual who articulated KI statements. This score reflected the overall average level of supportive versus non-supportive responses that the individual received for these key statements.

In addition to the overall response provided by group members to KI statements, which captured whether the responses were supportive or non-supportive, an additional

code was used to capture the strength, or intensity, of the supportive responses. The strength of supportive responses code reflected solely the supportive statements made in response to a KI statement. The scoring was a 5-point Likert scale where one (1) reflected a weakly supportive response and five (5) reflected an extremely supportive response. There was one score per KI statement, which was then associated with the KI statement speaker. For analyses, an average score for the strength of supportive responses during early and late sessions, separately, was calculated for each individual who articulated KI statements that received a supportive response. This score reflected the overall average strength (or intensity) of the supportive responses that the individual received for these key statements.

Similarly, the strength of non-supportive responses reflected solely the intensity of non-supportive statements made by the group in response to a KI statement. The scoring was a 5-point Likert scale where one (1) reflected a weakly non-supportive response and five (5) reflected an extremely non-supportive response. There was one score per KI statement, which was then associated with the KI statement speaker. For analyses, an average score for the strength of non-supportive responses during early and late sessions, separately, was calculated for each individual who articulated KI statements that received a non-supportive response. This score reflected the overall average strength (or intensity) of the non-supportive responses that the individual received for these key statements.

All three group response variables were re-coded a second time for 10 of the 60 session tapes (17%) by a second coder. Coders agreed upon group response codes 83% of the time with a kappa of .63. It has been generally accepted that a kappa coefficient

between .61 and .80 reflects substantial agreement (Landis & Koch, 1977; Donner & Eliasziw, 1987).

Therapist response style. The Checklist of Psychotherapy Transactions-Revised (CLOPT-R; Appendix C) was a 96-item observer rated checklist. The CLOPT-R was derived from the Checklist of Interpersonal Transactions – Revised (CLOIT-R) which was a 96-item transactant report. The CLOPT-R directed an observer to rate the therapist. The items described overt interpersonal behaviors that occurred in a human interaction. The client and therapist versions were identical in item content and order (Kiesler, Goldston, & Schmidt, 1991).

The CLOPT-R was derived from Kiesler's (1983) model of interpersonal behaviors, the 1982 Interpersonal Circle (reviewed above). There were 16 categories of interaction behavior based on the circular model with six (6) items per category. Within each category, the six (6) items were divided into two levels of intensity. Level one was a mild/moderate behavior and level two was an extreme manifestation of a behavior. For example, the levels for the Dominant category were controlling at level one and dictatorial at level two. An item at level one of Dominant behavior was "the therapist is quick to take charge of the conversation or discussion, or to offer suggestions about what needs to be done." At level two Dominant, an identified behavior was "the therapist states preferences, opinions, or positions in a dogmatic or unyielding manner." An observer watched the interaction and coded whether or not the behavior was present. The observer made a decision about all 96 items for a participant in an identified interaction (Kiesler, 1983). In this study, the verbalizations coded were the primary therapist's verbal response during an event in both early and late sessions.

The data were scored such that items endorsed at level one were given a score of one (1), items at level two a two (2), and all unendorsed items were given a zero (0). The items that corresponded to a given category were summed. Each of the 16 categories could have a score of zero (0; no items endorsed) to a nine (9; all six items endorsed). In order to reduce error the scale creators provided a scoring sheet. At this point in scoring, there were multiple approaches to using the data ranging from considering each of the 16 categories individually to collapsing the categories into octants, quadrants, hemispheres, and axes.

For this study, the quadrant approach was used with each therapist receiving a score for Hostile-Dominant (HD), Hostile-Submissive (HS), Friendly-Submissive (FS), and Friendly-Dominant (FD). High Hostile-Dominant scores suggested a person was competitive, hardworking, secretive, took advantage of others, and questioned others good intentions (Kiesler, 1983). For this study, Hostile-Dominant behavior was conceptualized as a tendency to be standoffish, harsh, aloof, and/or cold. Therapists expressing hostile dominant behavior would insert their opinion and advice often, would often tell others what to do instead of providing suggestions, would confront behaviors/statements directly, and tended to dominant the conversation. High Hostile-Submissive scores were assigned when the therapist stayed to themselves, tended to be unresponsive to others efforts to interact, and was indecisive (Kiesler, 1983). For this study, Hostile-Submissive behavior was conceptualized as a tendency to be standoffish, aloof, disinterested, and/ or cold in manner. Therapists expressing hostile submissive behavior would allow the group members to guide the conversation and when the therapist did interject it would be superficial and provide no guidance or advice. High

Friendly-Submissive scores were assigned when the therapist avoided challenges, gave up easily, deferred to others, and trusted and believed in others (Kiesler, 1982). For this study, Friendly-Submissive behavior was conceptualized as a tendency to be warm, friendly, and/or engaged. Therapists expressing friendly submissive behavior would allow the group to guide the conversation, and when the therapist did speak, it would be to affirm the group members or agree with them, and not to provide suggestions or direction. A high Friendly-Dominant score indicated that the therapist tended to seek others' company, fostered harmony, often jumped into action, and talked easily with others (Kiesler, 1983). For this study, Friendly-Dominant behavior was conceptualized as a tendency to be warm, friendly, and/or engaged. Therapists expressing friendly dominant behavior would offer suggestions and ideas for behaviors, guide the group conversation through questions, address behaviors and statements directly, but with warmth, and show an interest in the group members. Quadrant scores were calculated utilizing trigonometric weightings of the subscales (Kiesler et al., 1991). The specific potential ranges were not provided due to the complicated formulas nor were they calculated in the manual, however, observed ranges for this study are reported in Table 4. The formulas are as follows: $\underline{HD} = .707\ A + .924\ B + C + .924\ D + .707\ E$; $\underline{HS} = .707\ E + .924\ F + G + .924\ H + .707\ I$; $\underline{FS} = .707\ I + .924\ J + K + .924\ L + .707\ M$; $\underline{FD} = .707\ M + .924\ N + 0 + .024\ P + .707\ A$.

Higher scores indicated the therapist displayed higher levels of behaviors associated with the quadrant. Each therapist was given four (4) scores, one for each quadrant, for each event. These event scores were averaged within each client who provided the KI statement, then for each treatment group, and subsequently for each therapist.

Several research studies examined the internal consistency reliability of the CLOIT/CLOPT-R scales (Kiesler et al., 1991). The reliability for the quadrants ranged from α = .69 to .89 (HD = .89, HS = .71, FS = .88, FD = .69; Kiesler et al., 1991). This suggested that the internal consistency of the scale was adequate.

Inter-rater reliability has been evaluated in several studies and summarized in the CLOPT-R manual (Kiesler et al., 1991; Mahalik, Hill, O'Grady, Thompson, 1993). Inter-rater reliability for the 16 scales ranged from *r* = .97-.98. For octant scores studies reported reliability ranging from *r* = .60 to .97 (Kiesler et al., 1991). The variation in reliability scores appeared to have been due, in part, to biases associated with raters' personal characteristics (Kiesler et al., 1991). A study utilizing the CLOPT-R found that rater characteristics influenced their ratings (Mahalik et al., 1993). Specifically, raters' own levels of sociability, dominance, friendliness, and perception of similarity to the rated individual, influenced the rater's judgments on the affiliation axis, but no bias was found on the control axis. The authors suggested selecting only raters with certain characteristics, controlling for rater characteristics, and providing training (Mahalik et al., 1993).

For this study, training and pre-data collection reliability testing was completed on training videos to ensure that raters were approaching the content in the same manner. When the intra-class correlation coefficient for three consecutive training tapes was above .60, the reliability rater was able to code data sessions. Additionally, on-going checks and regular training occurred to clarify definitions as well as periodic review of training tapes to ensure drift did not occur. For the current study, reliability for the Quadrant scores was examined using Intraclass Correlation Coefficient (ICC). Specific to

this study, inter-rater reliability analysis on the CLOPT-R quadrant scores was conducted. Twelve sessions were randomly selected prior to data collection, and coded by the primary and reliability coders. The primary coder calculated the 16 CLOPT-R scales on the CLOPT-R coding sheet for the primary coder and secondary coder. These scale scores were entered into an SPSS database by session with a score for each coder on each scale. The scale scores for all events in a single session were summed for each coder, and divided by the number of events in the session to create an overall mean for each of the 16 subscales for each coder for each session. These scale score means were then utilized to calculate the quadrant scores using the trigonometric formula provided in the CLOPT-R manual. As a result of this data reduction strategy, each session had two scores per quadrant, one for the primary coder and one for the secondary coder. A mixed-model absolute reliability analysis was then run in SPSS. A mixed-model approach was chosen as the raters were fixed, the same two across all sessions, and the subjects were randomly chosen. An absolute model determined whether the raters were similar on the absolute value of the ratings. An ICC of below .40 was considered poor, .40 to .59 fair, .60 to .74 good, and .75 to 1.0 was considered excellent (Hallgren, 2012). Based on the ICC values the raters achieved good reliability on the Friendly-Submissive quadrant and excellent reliability on the remaining three quadrants. Results are reported in Table 1.

Table 1

Interrater Reliability for the CLOPT-R Quadrants

	HD	HS	FD	FS
ICC	.85	.84	.96	.63

Note: ICC = Intraclass Correlation Coefficient; HD-Hostile-Dominant; HS = Hostile-Submissive; FD = Friendly-Dominant; FS = Friendly Submissive

Concurrent validity for the CLOIT/CLOPT-R has been found to be adequate. In comparing the CLOPT to the Interpersonal Adjective Scale (IAS), the degree of overlap was high (axis r = .54 to .88; Kiesler et al., 1993). The IAS was a self-report measure based on the interpersonal circle asking individuals to check adjectives that apply to their interpersonal style, therefore overlap was expected given they were measuring similar constructs. The predictive validity for the CLOPT has also been found to be adequate. A study using college students was able to determine stressful from non-stressful interviews based on changes in responding during the course of the interview using the CLOPT-R (Kiesler et al., 1993). Individuals who were placed in stressful interviews showed an increase in submissive and deferent responding behaviors in the second half of the interview, whereas individuals in low/no stress interviews had no changes in behaviors (Kiesler et al., 1993). Distinct interpersonal categories using the CLOPT could be found among treatment groups of adolescent sex offenders, juvenile delinquents, and a non-referred control group (Chewning, 1990). Individuals in the sex offender group had higher rates of hostile style and the non-offending group had a friendlier style. Chewning (1990) determined that distinct interpersonal styles could differentiate among categories of forensic offenders and non-offenders. Kiesler and colleagues (1990) also found that group membership could be determined based on interpersonal style using the CLOPT. A series of eight videotapes were coded using the CLOPT and distinct interpersonal styles emerged based on diagnosis. For example, patients diagnosed with anti-social personality disorder scored highest on the hostile subscale and individuals diagnosed with histrionic personality disorder scored highest on the sociable and exhibitionist subscales (Kiesler, VanDenberg, Sikes-Nova, Larus, & Goldston, 1990). These studies indicated that the

CLOPT was able to differentiate effectively among groups of individuals based on their interpersonal style (Chewning, 1990; Kiesler and Goldston, 1988; Kiesler et al, 1990.)

Procedures

General procedures. Data for this study were collected via client self-report, collateral report (e.g. from victim partners), and observer ratings. Clients completed questionnaires and interviews at pre-treatment, and questionnaires at post-treatment to assess their relationship behaviors. Collateral partner report data were collected at pre-treatment, post-treatment, and 6-month follow-up by phone interviews conducted by research assistants. After clients completed the intake process, they were assigned to a 16-week treatment group (described later). Group sessions were videotaped. Individuals who served as coders for client behavior during group sessions had no direct contact with clients or their partners and were not otherwise involved in the treatment or assessment process for client behaviors during group sessions (e.g. KI statements, group responses). For this study, individuals not involved in the treatment, assessment, or data collection with the study participants coded therapist behaviors.

The treatment approach. During the time of the archival data collection, the standard group treatment at the agency research site was a closed-ended cognitive-behavioral group consisting of 16 weekly 2-hour sessions. Each group was co-led by a male and female therapist, one of whom had a master's degree or equivalent level of training within a doctoral program and had run at least three previous groups. All therapists received weekly group supervision.

Each weekly session contained both structured psycho-educational programming and open group discussion time. The group content covered four general topic areas,

addressing (in sequence), motivation to end abusive behavior, relationship crisis management, anger self-regulation, and communication and problem solving alternatives to abusive behavior. Weekly home assignments were provided for all sessions. The group goals were to develop alternatives to abusive behaviors by enhancing motivation to change, increasing emotional and behavioral self-regulation skills, and promoting constructive relationship communication and problem solving behaviors.

Coding procedures. For each group four sessions were coded; two early and two late sessions. The coding of two sessions for each time point allowed the maximization of participant data in the event that client did not attend one of the two chosen sessions. Sessions three and four were selected for early session coding as they had the highest rates of attendance in the first four sessions. Sessions 13 and 14 were selected for late session coding as they had the highest rates of attendance for the last 4 sessions and adhered to the standard format of the treatment protocol (the last two sessions, 15 and 16, contained more flexible content associated with termination and planning for future change).

Some selected sessions could not be coded as tapes were missing or damaged, or a therapist was absent from a session. When a session was unavailable or unable to be coded, an alternate session was selected and coded. For early sessions, the order of replacement was session two, five, and one. Session one was utilized as a last resort, as this session primarily involved introductions to the group and orientation to treatment. Session one in general contained high rates of formal information giving by the therapist, and low rates of client verbalization. Late session alternatives were sessions 15 and 16.

These sessions were reviewed and it was determined that the hour of coded time was equivalent in structure to sessions 13 and 14.

Session coding covered a one-hour period that began 15 minutes into the session and ended 1 hour and 15 minutes into the 2-hour long sessions. This period was selected to provide the most consistent opportunity for client KI statements. Eight randomly selected preliminary sessions were coded and rates of KI statements examined. Clients arriving late, members settling in, and higher rates of therapist formal information giving to introduce topics and focus the group often occurred during the initial 15 minutes of sessions. The last 45 minutes of the sessions were devoted to open group discussion, wrap-up, and homework assignment. It is common during this period of the session to have extensive focus on one or two clients experiencing problems or distress, and relatively common to focus discussion on topics such as employment, finances, children, and stress. Although potentially important to clients' change process and well-being, these discussions often limited the opportunity for negative statements about abuse, relationships, and women as defined in the coding manual.

There were three planned coding passes. Pass one identified client KI statements. Pass two identified and coded group members' global and individual supportive or non-supportive responses to negative statements. Pass three identified therapist response styles as coded with the CLOPT-R to KI statements.

Coders for pass one and two were graduate and undergraduate students from the University of Maryland, Baltimore County. Graduate students completed pass one coding. A graduate student (current study author) and undergraduate students completed pass two coding.

Both graduate students were advanced students with masters' level training with a minimum of one year of training as clinicians at the domestic violence center at which the data were collected. The training consisted of co-facilitating manualized treatment groups and providing individual treatment to partner-abusive men, as well as weekly supervision. The coding process began with a collaborative approach to manual development. Sessions that would not be used in the study were collaboratively coded and the manual refined. The coders then independently coded several sessions and reviewed codes to discuss disparities. The primary coder (first author of the GTIP manual) coded additional practice tapes. The reliability coder (the current study author) then coded these tapes and received feedback to improve rater agreement. Once this training process was complete, the primary coder coded all study sessions in random order. Twelve of these sessions were then randomly selected for reliability coding by the second author of the manual. The coding was compared to determine reliability.

For the current study and pass three of the coding, the ICC was used to assess reliability of coding at the quadrant level on CLOPT-R. The study author was the primary coder. The reliability coder was a 2nd year master's degree student in Public Health at a larger medical sciences university. For this study, the pass 1 and pass 2 training and criterion tapes were used for training the reliability coder. The reliability coder was trained on specific tapes, then coded criterion tapes until an ICC of .60 or greater was reached between the two coders on three consecutive training tapes. During the initial rating of the data tapes, the primary coder transcribed the entire event inclusive of therapist and client verbalizations. The reliability coder reviewed the audio of the session with the transcription and coded the therapist response. Periodically, the primary and

reliability coder coded random events from criterion tapes to ensure that drift from the standards had not occurred.

Chapter 3: Results

Descriptive Information

Prior to conducting hypothesis testing, an examination of primary (PT) and secondary (ST) therapist response rates were completed to ensure the PT was the most frequent responder of the two therapists. Analyses indicated that the PT responded more frequently than the ST did across both early and late sessions. Therefore, subsequent analyses were conducted utilizing PT responses for all groups. Results are reported in Table 2.

Table 2

Therapist Percent Response Rate to KI Statements by Session

	Primary Therapist	Secondary Therapist
Early Session	67%	39%
Late Session	71%	40.5%

A series of ANOVAs were conducted to determine if client characteristics differed among therapists. Descriptive information for client demographics and pre-treatment IPV behaviors organized by therapist are presented in Table 3. The one-way ANOVAs for client's age, $F(5,108) = 4.011$, $p = .00$, and for mean yearly income, $F(5, 107) = 19.65$, $p = .00$, demonstrated statically significant differences among the six primary therapists. There were no statistically significant differences among therapists for client's race, court ordered status, employment, marital status, or educational status. The one-way ANOVA for client's pre-treatment Psychological Aggression report $F(5,105) = 2.41$, $p=.04$ demonstrated statistically significant differences across the six primary therapists. No

statistically significant differences were found in regards to client reports of physical assault and injury, and partner reported psychological aggression, physical assault, or injury.

Information for therapist's CLOPT-R scores and groups facilitated has been presented in Table 4. Information for outcome variables has been presented in Table 5. Tables 6, 7, and 8 presented outcome data by therapist. Outcome variables with moderately or substantially skewed (greater than 2) or kurtotic (greater than 7) distributions were transformed using square root or LOG10+ .01 transformations. Client post treatment Physical Assault and Injury CTS scores were transformed using the LOG10+ .01 transformations (Field, 2013; Tabachnick & Fidell, 2001). Partner post treatment and follow up Physical Assault and Injury CTS scores were transformed using the square root transformation. Descriptive information for untransformed and transformed data has been provided when transformations were necessary.

Table 3
Client Demographics and Pre-treatment CTS Scores by Primary Therapist

	PT1	PT2	PT3	PT4	PT5	PT6
Demographics	(*n*=17)	(*n*=27)	(*n*=39)	(*n*=15)	(*n*=8)	(*n*=8)
Mean Age (SD)	32.35 (6.27)	36.41 (8.17)	39.95 (8.47)	32.73 (6.01)	32.63 (7.23)	33.25 (8.06)
Race (%)						
Caucasian	58.8%	63%	53.8%	53.3%	75.0%	50.0%
AA	35.3%	33.3%	41%	40.0%	25.0%	25.0%
Hispanic	0%	0%	2.6%	0%	0%	0%
NA	0%	0%	0%	1%	0%	12.5%
Asian	0%	3.7%	2.6%	0%	0%	12.5%
Other	5.9%	0%	0%	0%	0%	0%
Court Status						
Mandated	70.6%	70.4%	82.1%	93.3%	87.5%	75.0%
Pending	17.6%	7.4%	5.1%	6.7%	0%	0%
Voluntary	11.8%	22.2%	12.8%	0%	12.5%	25.0%
Marital						
Never Married	29.4%	22.2%	10.3%	13.3%	50.0%	37.5%

Separated	41.2%	40.7%	46.2%	53.3%	37.5%	37.5%
Married/Co-hab	17.6%	25.9%	33.3%	13.3%	0%	0%
Divorced	11.8%	11.1%	10.3%	20.0%	12.5%	25.0%
Widowed	0%	0%	0%	0%	0%	0%
Education						
No HS/GED	17.6%	7.4%	12.8%	33.3%	25.0%	12.5%
HS/GED	41.2%	37%	46.2%	33.3%	25.0%	0%
Some College	17.6%	25.9%	15.4%	26.7%	37.5%	50.0%
Bachelor	11.8%	18.5%	15.4%	6.7%	0%	25.0%
Some Grad	0%	7.4%	7.7%	0%	12.5%	12.5%
Graduate Degree	0%	0%	2.6%	0%	0%	0%
Employment						
Full	88.2%	85.2%	89.7%	73.3%	100%	100%
Part-time	0%	3.7%	7.7%	13.3%	0%	0%
Off & on	11.8%	11.1%	2.6%	13.3%	0%	0%
Unemp < 6mos	0%	0%	0%	0%	0%	0%
Unemp >6mos	0%	0%	0%	0%	0%	0%

Table 3 cont.

Income						
None	5.9%	11.1%	7.7%	13.3%	0%	0%
< 10,000	94.1%	85.2%	2.6%	0%	25.0%	0%
10,000-30,000	0%	0%	38.5%	66.7%	37.5%	62.5%
30,001-80,000	0%	0%	35.9%	20.1%	37.5%	37.5%
>80,000	0%	0%	15.4%	0%	0%	0%
Client Pre-Tx CTS	(*n*=16)	(*n*-27)	(*n*=37)	(*n*=15)	(*n*=8)	(*n*=8)
Client Psych	2.69 (2.36)	4.04 (1.83)	4.19 (2.41)	4.53 (3.20)	4.63 (2.62)	4.15 (2.48)
Client Physical	1.56 (2.58)	2.74 (2.52)	2.08 (2.47)	3.47 (3.11)	4.50 (4.57)	3.99 (1.41)
Client Injury	0.94 (1.53)	1.30 (1.77)	1.03 (1.77)	1.87 (1.89)	3.13 (3.56)	1.00 (1.51)
Partner Pre-Tx CTS	(*n*=17)	(*n*=25)	(*n*=33)	(*n*=12)	(*n*=5)	(*n*=5)
Partner Psych	2.06 (1.29)	2.28 (1.28)	2.12 (1.45)	2.75 (1.42)	3.20 (0.84)	2.00 (1.58)
Partner Physical	2.24 (1.99)	1.96 (1.96)	1.32 (1.89)	1.08 (1.17)	1.60 (1.52)	0.00 (0.00)
Partner Injury	1.88 (1.76)	1.52 (1.48)	1.00 (1.44)	0.83 (1.27)	2.00 1.23)	0.00 (0.00)

Notes: PT=Primary therapist; AA=African American; NA=Native American; Co-hab=Co-habitating; HS=High School; Unemp= Unemployed; Tx=Treatment; CTS= Conflict Tactics Scale; Psych = Psychological Assault; Physical = Physical Assault; n= reflects the number of clients with completed information for the demographics, client report for baseline CTS, and partner report for baseline CTS; n's vary as some individuals did not have complete data

Table 4
Therapist CLOPT-R Score Overall and by Group

				CLOPT-R QUADS										
				Early HD			Early HS			Early FD			Early FS		
		#Gr	#Cl	Mean (*sd*)	Range	*N*	Mean (*sd*)	Range	*N*	Mean (*sd*)	Range	*N*	Mean (*sd*)	Range	*N*
PT1	Total	2	17	1.11 (0.99)	0.18 –3.99	12	0.19 (0.32)	0.00-0.92	12	1.58 (0.52)	0.70-2.59	12	1.01 (0.35)	0.33-1.63	12
	Gr 1		8	0.99 (0.46)		5	0.47 (0.36)		5	1.50 (0.69)		5	0.84 (0.35)		5
	Gr 3		9	1.19 (1.29)		7	0.00 (0.00)		7	1.64 (0.42)		7	1.14 (0.31)		7
PT2	Total	3	28	0.57 (0.45)	0.00-1.41	19	0.03 (0.08)	0.00-0.35	19	1.39 (0.58)	0.02-2.45	19	0.98 (0.32)	0.31-1.54	19
	Gr 2		9	0.49 (0.60)		6	0.00 (0.00)		6	1.37 (0.83)		6	1.01 (0.26)		6
	Gr 4		9	0.26 (0.22)		6	0.00 (0.00)		6	1.07 (0.37)		6	1.21 (0.31)		6
	Gr 5		10	0.89 (0.20)		7	0.06 (0.13)		7	1.67 (0.37)		7	0.75 (0.26)		7
PT3	Total	5	47	0.47 (0.47)	0.00-1.71	29	0.06 (0.17)	0.00-0.71	29	1.54 (0.60)	0.71-3.02	29	1.20 (0.49)	0.35-2.55	29
	Gr 7		10	0.46 (0.67)		6	0.08 (0.20)		6	1.00 (0.17)		6	1.31 (0.70)		6
	Gr 9		8	0.18 (0.27)		6	0.00 (0.00)		6	1.81 (0.76)		6	1.26 (0.74)		6
	Gr 10		10	0.45 (0.54)		6	0.03 (0.07)		6	1.86 (0.57)		6	1.09 (0.27)		6
	Gr 11		9	0.77 (0.48)		5	0.00 (0.00)		5	1.53 (0.36)		5	1.20 (0.28)		5
	Gr 13		10	0.54 (0.50)		6	0.19 (0.28)		6	1.43 (0.61)		6	1.15 (0.43)		6
PT4	Total	2	15	0.65 (0.58)	0.00-1.87	12	0.12 (0.27)	0.00-0.92	12	1.27 (0.46)	0.77-2.41	12	1.04 (0.49)	0.00-1.85	12
	Gr 6		9	0.75(0.65)		8	0.17 (0.32)		8	1.39 (.47)		8	0.92 (0.51)		8
	Gr 8		6	0.45 (0.42)		4	0.00 (0.00)		4	1.02 (0.37)		4	1.29 (0.39)		4
PT5	Total	1	8												
	Gr 12		8	0.85 (0.73)	0.00-2.02	7	0.04 (0.09)	0.00-0.25	7	1.28 (0.41)	0.71-1.85	7	0.68 (0.40)	0.00-1.05	7
PT6		1	9												
	Gr 14		9	0.37 (0.42)	0.00-0.75	5	0.00 (0.00)	0.00-0.00	5	1.11 (0.77)	0.00-1.63	5	1.19 (0.31)	0.92-1.19	5

Note: HD = Hostile-Dominant; HS = Hostile-Submissive; FD = Friendly-Dominant; FS = Friendly-Submissive; Early = early sessions; PT = Primary Therapist; Gr= Group; #Gr = total number of Groups facilitated; #Cl = total number of clients; CLOPT-R n= reflects the number of clients who had at least one KI statement that would result in the coding of a therapist response; CLOPT-R n's are lower than total number of clients for each therapist, as not all clients had a KI statement; CLOPT-R ranges for all events: HD= 0.00-3.99; HS= 0.00-0.92; FD= 0.00-3.02; FS=0.00-2.55

Table 5

Descriptive Data for Untransformed and Transformed Outcome Variables

	Untransformed					Transformed				
	M	*sd*	Skew	Kurt	*n*	*M*	*sd*	Skew	Kurt	*n*
KI Statements										
Late	2.54	2.51	1.44	2.26	103	—	—	—	—	—
Change	-0.05	2.85	-0.46	1.82	103	—	—	—	—	—
Client Response										
Overall	2.39	1.39	.015	-0.32	83	—	—	—	—	—
Supportive	1.81	1.28	0.54	-0.01	83	—	—	—	—	—
Non-supp	0.66	0.99	2.06	6.52	83	—	—	—	—	—
Client Post Tx CTS										
Psych Agg	2.60	2.36	0.56	-0.70	99	—	—	—	—	—
Phy Assault	0.79	2.62	4.10	17.05	99	-1.62	0.93	2.09	2.67	99
Injury	0.55	2.15	4.79	23.12	99	-1.72	0.80	2.66	5.46	99
Partner Post Tx CTS										
Psych Agg	2.13	1.31	-0.35	-.95	83	—	—	—	—	—
Phy Assault	0.48	1.09	2.91	9.32	83	0.32	0.62	1.73	1.86	83
Injury	0.30	0.79	2.72	7.14	83	0.21	0.51	2.22	3.34	83
Partner F/U CTS										
Psyc Agg	1.84	1.35	-0.15	-1.28	69	—	—	—	—	—
Phy Assault	0.36	0.89	2.81	7.82	69	0.25	0.55	1.98	2.61	69
Injury	0.22	0.68	3.12	8.72	69	0.15	0.45	2.83	6.43	69

Note: ; n/a = not applicable as transformations were unnecessary; KI Statements =Key Intervention Statements; Late=Late session; Change = change from early to late session; Supportive= Strength of supportive responses; Non-supportive= strength of non-supportive responses; CTS=Conflict Tactics Scale; Client Post TX= client report post treatment; Psych Agg = Psychological Aggression; Partner post tx = partner report post treatment; Partner F/U= partner report 6 months after treatment; n's are reflective of the number of clients who had completed data on the given scale

Table 6

Therapist Means, Standard Deviations, and Sample Size for KI Statement Variables

	Late			Change		
	M	*sd*	*n*	*M*	*sd*	*n*
PT1	3.68	2.91	14	2.29	2.71	14
PT2	2.08	2.07	25	-0.68	2.93	25
PT3	1.47	1.43	38	-0.57	2.39	38
PT4	4.71	2.96	12	1.21	3.43	12
PT5	3.50	3.56	7	-0.79	2.46	7
PT6	3.07	2.86	7	-1.07	1.81	7

Note: KI Statements =Key Intervention Statements; Late=Late session; Change = change from early to late session; n's are reflective of the number of clients with completed data for the scale

Table 7

Therapist Means, Standard Deviations, and Sample Size for Client Response Variables

	Overall			Supportive			Non-Supportive		
	M	*sd*	*n*	*M*	*sd*	*n*	*M*	*sd*	*n*
PT1	2.59	0.98	13	2.25	1.13	13	1.12	1.10	13
PT2	2.86	1.59	19	2.04	1.33	19	1.83	0.50	19
PT3	2.17	162	25	1.66	1.37	25	0.58	1.08	25
PT4	2.01	1.54	12	1.54	0.89	12	0.57	0.47	12
PT5	1.90	1.23	7	1.02	1.26	7	0.75	1.88	7
PT6	2.69	1.41	7	2.21	1.92	7	0.54	0.80	7

Note: Global = general response of group members; Supportive= Strength of supportive responses; Non-supportive= strength of non-supportive responses; n's are reflective of the number of clients with completed data for the scale

Table 8

Therapist Means, Standard Deviations, and Sample Size for CTS Variables

	Psychological Aggression			Physical Assault			Injury		
	M	*sd*	*n*	*M*	*sd*	*n*	*M*	*sd*	*n*
Client Post Tx									
PT1	1.00	1.18	14	-1.64	0.93	14	-1.55	0.89	14
PT2	2.67	2.14	24	-1.50	1.01	24	-1.66	0.92	24
PT3	2.80	2.58	35	-1.71	0.84	35	-1.85	0.64	35
PT4	3.17	2.82	12	-1.50	1.17	12	-1.53	1.11	12
PT5	3.43	2.23	7	-1.65	0.94	7	-2.00	0.00	7
PT6	2.71	1.29	7	-1.67	0.87	7	-1.71	0.76	7
Partner Post Tx									
PT1	1.75	1.06	12	0.32	0.59	12	0.12	0.17	12
PT2	2.37	1.30	19	0.18	0.43	19	0.13	0.39	19
PT3	1.75	1.41	32	0.33	0.68	32	0.20	0.53	38
PT4	2.70	1.25	10	0.60	0.84	10	0.28	0.59	10
PT5	3.40	0.55	5	0.60	0.55	5	0.80	0.64	5
PT6	2.20	0.84	5	0.00	0.00	5	0.00	0.00	5
Partner F/U									
PT1	1.25	0.96	4	0.00	0.00	4	0.00	0.00	4
PT2	2.40	1.06	15	0.28	0.59	15	0.09	0.37	15
PT3	1.30	1.34	30	0.03	0.18	30	0.06	0.32	30
PT4	2.60	1.51	10	0.88	0.83	10	0.56	0.74	10
PT5	2.60	0.89	5	0.68	0.65	5	0.28	0.63	5
PT6	1.60	1.14	5	0.00	0.00	5	0.00	0.00	5

NoteCTS=Conflict Tactics Scale; Client Post TX= client report post treatment; Psych Agg = psychological Aggression; Partner post tx = partner report post treatment; Partner F/U= partner report 6 months after treatment; Physical Assault and Injury means and standard deviations are based on transformed variables; n's are reflective of the number of clients with completed data for the scale

Hypothesis Testing

Hypothesis 1

Hypothesis 1: Clients' rate of KI, response to KI statements and post-treatment IPV behaviors would differ significantly among therapists.

Hypothesis 1A: Significant differences would be found among therapists in rate of client KI statements in late sessions and average rate of change in amount of KI statements from early to late sessions.

Hypothesis 1B: Significant differences would be found among therapists in group members' overall level of verbal support of KI statements and in the strength of supportive and non-supportive responses of group members to KI statements in late sessions.

Hypothesis 1C: Significant differences would be found among therapists in clients' post treatment reports and client's partner report at post-treatment and 6-month follow-up of IPV behaviors.

A one-way between subjects ANOVA was conducted to compare the effect of primary therapists on each of the outcomes. The initial step in the ANOVA interpretation was to determine if the homogeneity of variance assumption was violated, which has been common for an unbalanced design (Field, 2013). Whether this assumption was violated was determined by running a Leven's test in SPSS for each outcome. Several outcome variables were found to violate the assumption. The recommendation for managing the violation of this assumption would be to transform the data (Field, 2013). As this has already been done, the second recommendation was utilized, which was to use Welch's *F* to interpret the findings. Welch's *F* was calculated by creating a weight based on sample size and variance, adjusting the means to grand centered means, and altering the residual degrees of freedom in the calculation of the F test

(Field, website). Based on research by Tomarken and Serlin (1986), Welch's *F* provides the best approach to reducing Type I error when there is an unbalanced design ANOVA and a violation of the assumptions homogeneity of variance. In several instances, the Leven's test was significant, but the Welch's *F* test could not be calculated due to zero variance in the outcome variable for one or more groups. In examining the data for each of these instances, there were valid data points but no variation in the data. The data were re-analyzed with the Kurskal-Wallis test, a non-parametric test that did not assume the variances are equal. These analyses were consistent with the results of the ANOVAs for all outcome variables. The ANOVA results have been reported below. The standard approach to ANOVA was reported where Welch's *F* was not necessary or able to be utilized. Means and standard deviations were reported in Tables 5 through 8 above.

Key intervention statements. The one-way ANOVA for individual rates of KI statements, Welch's $F(5, 23.43) = 3.96$, $p = .01$, and for mean change in individual's rates of KI statements from early to late, $F(5, 97) = 3.51$, $p = .01$, demonstrated statically significant differences among the six primary therapists.

Client responses. A one-way ANOVA demonstrated no statistically significant differences among the six primary therapists for overall group response to individual's KI statements, $F(5, 77) = 1.02$, $p = .41$, for strength of supportive responses, $F(5, 77) = 1.27$, $p = .28$, or for strength of non-supportive responses, $F(5, 77) = 0.72$, $p = .61$.

Client post-treatment CTS. A one-way ANOVA demonstrated no statistically significant differences among the six primary therapists for client's post-treatment report on the CTS Psychological Aggression sub-scale, $F(5, 93) = 1.72$, $p = .14$, CTS Physical Assault, $F(5, 93) = 0.18$, $p = .97$, and CTS Injury, $F(5, 93) = 0.62$, $p = .68$.

Partner post-treatment CTS. A one-way ANOVA demonstrated statistically significant differences among the six primary therapists for partner's post-treatment report on the CTS Psychological Aggression sub-scale, $F(5, 77) = 2.36$, p .05. Partner's post-treatment report on the CTS Physical Assault, F (5, 77) = 1.089, p = .373, and the CTS Injury sub-scale, $F(5, 77) = 1.96$, p = .09, demonstrated no statistically significant differences among the six primary therapists.

Partner follow-up CTS. A one-way ANOVA for partner's six-month follow up report on the CTS Psychological Aggression sub-scale, $F(5, 63) = 3.02$, p = .02, the CTS Physical Assault sub-scale, $F(5, 63) = 6.37$, p = .00, and the CTS Injury sub-scale, $F(5, 63) = 2.50$, p = .04, demonstrated statically significant differences among the six primary therapists.

Hypothesis 2

Hypothesis 2: Clients' rate of KI statements, group member response to KI statements, and post-treatment IPV behaviors would be significantly associated with therapists' verbal response style.

Overview of HLM. Hierarchical Linear Modeling (HLM) was a statistical approach, which relaxed the rules for independence, allowing observations to be correlated. It was expected that individuals in a group are more likely to have scores similar to one another, than to those in other groups.

The initial step in HLM was to determine whether the theoretical hierarchy or nesting is statistically warranted. This was determined with the unconditional model, referred to as the null model, which assessed whether there is an effect of the grouping variable on the intercept of the level one outcome variable. This was similar to a one-way ANOVA, with some adjustments to account for the non-independence of observations. The unconditional model had a single outcome entered at level one (client) and did not include predictor values at any level. This model determined if the mean value of the dependent variable was significantly different

between groups (Garson, 2013). In a three-level model, three variances were reported; the first level (individual), the second level (treatment group), and the third level (primary therapist; Luke, 2004). The variance components were then used to calculate the Intraclass Correlation Coefficient (ICC), which could be translated into the percentage of variance related to the outcome situated in level two and in level three. In addition to the ICC, a chi-square (χ^2) statistic was reported for level two and level three variances. The chi-square indicated whether the variance attributed to the respective level was statistically significant. The ICC and χ^2 were used to determine which levels are appropriate for model testing (Luke, 2004).

The next step was to develop models that include predictors at the appropriate levels. At this point decisions regarding centering of predictor variables were made. For this study, the predictors were scored such that zero was meaningful. Therefore, predictor variables were not centered (Luke, 2004).

Next, the type of model needed to be determined. The model chosen for this study was a random intercept and a fixed slope with a restricted estimate of maximum likelihood (REML). This model assumed that the outcome would vary by therapist but the effect of the PT response style on the outcome would be equivalent among all therapists (Garson, 2013). REML was use due to the small sample size. This would reduce the potential for type 1 errors and allowed for less biased estimated of smaller sample sizes. The following hypothesis testing results have been organized by outcome with the null model being reported first. If the null model was significant, a full model was analyzed, if it was not significant a bivariate Pearson correlation was reported.

Hypothesis 2A: *Rate of individual late session KI statements and client's average rate of change from early to late sessions would be significantly associated with early session therapist response styles.*

Late session individual KI statements were entered into an unconditional model. Treatment group did not significantly contribute to the model (χ^2 = 9.45, (8, *N* = 14), *p* = .31) and yielded an ICC of .01 accounting for less than 1% of the variability in late session KI statements. Primary therapist significantly contributed to the model (χ^2 = 26.39, (5, *N* = 6), *p* = .00) and yielded an ICC of .15, indicating that 15% of the variability was attributable to the primary therapist. This indicated there was an effect of primary therapist on individual late session KI statements.

A two-level unconditional model was specified to determine the amount of variance attributable to primary therapist. Primary therapist significantly contributed to the model (χ^2 = 28.73, (5, *N* = 6), *p* = .00) and yielded an ICC of .19, indicating 19% of the variance was attributable to primary therapist. All subsequent analyses for late session KI statements utilized a two-level model with primary therapist as the level two grouping variable.

Full multilevel models yielded no significant associations between early session therapist response styles and late session individual KI statements (Table9).

The average rate of change from early to late sessions of individual KI statements was entered into a three-level unconditional model. Treatment group did not significantly contribute to the model (χ^2 = 7.05, (8, *N* = 14), *p* > .50) and yielded an ICC of .00 accounting for less than 1% of the variability in individual KI statements change. Primary therapist significantly contributed to the model (χ^2 = 17.79, (5, *N* = 6) , *p* = .00) and yielded an ICC of .12, indicating that 12% of the variance was attributable to the primary therapist.

Table 9

Summary of Random Intercept Model for 2-Level Model of Late Session KI Statements with Primary Therapist as the Level 2 Grouping Variable

				HD			FD			HS			FS		
	Null			Full			Full			Full			Full		
	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio
Intercept	3.00	0.51	5.90	1.53	1.64	0.94	7.49	5.90	1.27	2.39	0.72	3.31*	5.25	3.44	1.52
Predictor				2.14	2.28	0.94	-3.22	4.23	-0.76	8.53	58	1.13	-2.22	3.38	-0.66
Est. Parameters	2			2			2			2			2		
Deviance	478.78			4.72.57			471.65			469.80			472.25		

Notes: HD = Hostile-Dominant; FD = Friendly-Dominant; HS = Hostile-Submissive; FS = Friendly-Submissive; Est. parameters = number of Restricted Estimated Maximum Likelihood parameters; PE = Parameter Estimate; SE = Standard Error of the parameter estimate; Null=Null Model; Full = Full Model
*p < .05; **p < .01

A two-level unconditional model was specified to determine the amount of variance in individual KI statements change that was attributable to the PT. Primary therapist significantly contributed to the model (χ^2 = 17.82, (5, *N* = 6), *p* = .00) and yielded an ICC of 0.15, indicating that 15% of the variance in the outcome was attributable to primary therapist. All subsequent analyses for individual KI statements change utilized a two-level model with primary therapist as the level two grouping variable.

Full multilevel models yielded significant associations for Individual KI Change (Table 10). Therapist early session Hostile-Dominant and Hostile-Submissive behaviors were significantly associated with a change in the average rate of client KI statements from early to late session.

Hypothesis 2B: *Group members overall level of verbal support to KI statements in late sessions and the strength of supportive and non-supportive group member responses would be significantly associated with early session therapist response style.*

The general group response was entered in a three-level unconditional model. Treatment group did not significantly contribute to the model (χ^2 = 11.84, (8, *N* = 14), *p* = .16) and yielded an ICC of .05, indicating that 5% of the variance was attributable to treatment group. Primary therapist did not significantly contribute to the model (χ^2 = 4.53, (5, *N* = 6), *p* > .50) and yielded an ICC of .00, indicating less than 1% of variability was attributable to the primary therapist.

An unconditional two-level model with primary therapist at the level two grouping variable was analyzed to ensure primary therapist did not contribute to the outcome. Primary therapist did not significantly contribute to the model (χ^2 = 5.76, (5, *N* = 6), *p* = .33) and yielded an ICC of 0.02, indicating that slightly more than 1% of the variance was attributable to the primary therapist. Based on the results of the unconditional model, HLM was not warranted.

Table 10

Summary of Random Intercept Model for 2-Level Model of Change in Rate of KI Statements with Primary Therapist as the Level 2 Grouping Variable

				HD			FD			HS			FS		
	Null			Full			Full			Full			Full		
	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio
Intercept	0.09	0.88	0.16	-2.76	1.04	-2.63	-5.07	6.49	-0.78	-1.29	0.39	-3.25*	-0.57	4.00	-0.14
Predictor				4.22	2.79	2.79*	3.71	4.65	0.80	18.86	4.55	4.14**	0.65	3.92	0.17
Est. Parameters	2			2			2			2			2		
Deviance	501.79			492.86			494.43			484.69			595.45		

Notes: HD = Hostile-Dominant; FD = Friendly-Dominant; HS = Hostile-Submissive; FS = Friendly-Submissive; Est. parameters = number of Restricted Estimated Maximum Likelihood parameters; PE = Parameter Estimate; SE = Standard Error of the parameter estimate; Null=Null Model; Full = Full Model
*p < .05; **p < .01

A Bivariate Pearson correlation yielded no significant associations between therapist response style and the general group response (Table 11).

The strength of client supportive responses was entered into a three-level unconditional model. Treatment group did not significantly contribute to the model (χ^2 = 5.81, (8, *N* = 14), *p* > .50) and yielded an ICC of .00, indicating that less than 1% of the variance was attributable to treatment group. Primary therapist did not significantly contribute to the model (χ^2 = 6.46, (5, *N* = 6), *p* = .26) and yielded an ICC of .00, indicating that a less than 1% of the variability was attributable to the primary therapist.

An unconditional two-level model with primary therapist as the level two grouping variable was analyzed to ensure primary therapist did not contribute to the outcome. Primary therapist did not significantly contribute to the model (χ^2 = 6.42, (5, *N* = 6), *p* = 0.27) and yielded an ICC of .01, indicating that about 1% of the variance was attributable to the primary therapist. Based on the results of the unconditional model, HLM was not warranted.

A Bivariate Pearson correlation yielded no significant associations between therapist response style and the strength of supportive responses (Table 12).

Strength of client non-supportive responses was entered into a three-level unconditional model. Treatment group did not significantly contribute to the model (χ^2 = 10.21, (8, *N* = 14), *p* = .25) and yielded an ICC of 0.07, indicating that 7% of the variance was attributable to treatment group. Primary therapist did not significantly contribute to the model (χ^2 = 4.10, (5, *N* = 14), *p* > 0.50) and yielded an ICC of 0.000, indicating that primary therapist accounted for essentially none of variability in the outcome.

An unconditional two-level model with primary therapist as the level two grouping variable was analyzed to ensure primary therapist did not contribute to the outcome. Primary therapist did not significantly contribute to the model (χ^2 = 4.68, (5, *N* = 6), *p* > 0.50) and yielded an ICC of 0.00, indicating that less than 1% of the variance was attributable to the primary therapist. Based on the results of the unconditional model, HLM was not warranted.

A Bivariate Pearson correlation yielded no significant associations between therapist response style and the strength of non-supportive responses (Table 10).

Table 11
Pearson Correlations between Therapist Response Style and Client Responses

	HD	FD	HS	FS
Supportive	-.12	-.03	-.13	-.08
Non-Supportive	.18	.22	-.17	-.22
Client Response	-.07	.01	-.21	-.07

Notes: HD = Hostile-Dominant; FD = Friendly-Dominant; HS = Hostile-Submissive; FS = Friendly-Submissive; ; Supportive= Strength of supportive responses; Non-supportive= strength of non-supportive responses; n = 59 for all correlations; *p<.05; **p<.01

Hypothesis 2C: *Clients' report of post-treatment IPV behaviors and partner's report of post-treatment and 6-month follow up of IPV behaviors and would be significantly associated with early session therapist response style.*

Client post treatment report. For the Psychological Aggression sub-scale, level two treatment group did not significantly contribute to the model (χ^2 = 10.62, (8, *N* = 14), *p* = 0.22) and yielded an ICC of .05, indicating that 5% of the variance was attributable to treatment group. Primary therapist did not significantly contribute to the model (χ^2 = 6.29, (5, *N* = 6), *p* = .28) and yielded an ICC of .00, indicating that less than 1% of the variance was attributable to the primary therapist.

An unconditional two-level model with primary therapist as the level two grouping variable was analyzed to ensure primary therapist did not contribute to the outcome. Primary therapist did

not significantly contribute to the model (χ^2 = 8.49, (5, *N* = 6), *p* = .13) and yielded an ICC of .05, indicating that 5% of the variability was attributable to the primary therapist. Based on the results of the unconditional models, HLM was not warranted.

Correlation analyses yielded significant associations for client report of Psychological Aggression (Table 12). Early session therapist Hostile Dominant and Friendly Dominant response styles were significantly associated with Client Post-treatment Report of Psychological Aggression.

For the Physical Assault sub-scale, treatment group did not significantly contribute to the model (χ^2 = 12.28, (8, *N* = 14), *p* = .14) and yielded an ICC of .00 indicating that less than 1% of the variance was attributable to treatment group. Primary therapist did not significantly contribute to the model (χ^2 = 0.93, (5, *N* = 6), *p* > .50) and yielded an ICC of .00, indicating less than 1% of the variance was attributable to the primary therapist.

A two-level unconditional model with primary therapist as the level two grouping variable was analyzed to ensure to primary therapist did not contribute to the model. Primary therapist did not significantly contribute to the model (χ^2 = 0.93, (5, *N* = 6), *p* > .50) and yielded an ICC of .00, indicating less than 1% of the variance was attributable to primary therapist. Based on the results of the unconditional model, HLM was not warranted.

Client Post-treatment report of Physical Assault was not significantly associated with therapists early session response styles (Table 12).

For the Injury sub-scale, treatment group did not contribute significantly to the model (χ^2 = 5.35, (8, *N* = 14), *p* > .50) and yielded an ICC of .00, indicating that less than 1% of the variance was attributable to the treatment group. Primary therapist did not significantly contribute to the

model (χ^2 = 3.21, (5, *N* = 6), *p* > .50) and yielded an ICC of .00, indicating that less than 1% of the variance was attributable to the primary therapist.

A two-level unconditional model with individual nested within therapist was examined to ensure no effects were missed. Primary therapist did not significantly contribute to the model (χ^2 = 3.18, (5, *N* = 6), *p* > 0.50) and yielded an ICC of .00, indicating that less than 1% of the variance was attributable to primary therapist. Based on the results of the unconditional models, HLM was not warranted.

Client Post-treatment report of Injury was not significantly associated with therapists early session response styles (Table 12).

Table 12
Pearson Correlations between Therapist Response Style and Client Post Treatment CTS Sub-scales

	HD	FD	HS	FS
Psychological	-.23**	-.35**	-.18	.02
Physical	-.11	-.06	-.07	.21
Injury	-.07	-.02	-.03	.11

Notes: HD = Hostile-Dominant; FD = Friendly-Dominant; HS = Hostile-Submissive; FS = Friendly-Submissive; Psychological = Psychological Assault; Physical = Physical Assault; n = 70 for all correlations; *p<.05; **p<.01

Partner post-treatment CTS. For the Psychological Aggression sub-scale, treatment group did not significantly contribute to a three-level model (χ^2 = 3.94, (8, *N* = 14), *p* > .50) and yielded an ICC of .00, indicating that less than 1% of the variance was attributable to treatment group. Primary therapist significantly contributed to the three-level model (χ^2 = 12.39, (5, *N* = 6), *p* = .03) and yielded an ICC of .07, indicating that 7% of the variance was attributable to the primary therapist.

A two-level null model with primary therapist as the level two grouping variable was examined to ensure a two-level model was appropriate. Primary therapist significantly contributed to the model (χ^2 = 12.73, (5, *N* = 6), *p* = .03) and yielded an ICC of 0.09, indicating

that 9% of the variance was attributable to the primary therapist. Based on the results of the unconditional model, a two-level model was appropriate for analyses.

Full multilevel models yielded significant associations for Psychological Aggression (Table 13). Early session therapist Friendly-Dominant and Friendly-Submissive styles were significantly associated with partner reports of psychological aggression post-treatment.

For the Physical Assault sub-scale, treatment group did not significantly contribute to the model (χ^2 = 3.22, (8, *N* = 14), *p* > .50) and yielded an ICC of .00, indicating that less than 1% of the variance was attributed to treatment group. Primary therapist did not significantly contribute to the model (χ^2 = 5.48, (5, *N* = 6), *p* = .36) and yielded an ICC of .00, indicating that less than 1% of the variance was attributable to primary therapist.

A two-level unconditional model with primary therapist as the level two grouping variable was examined to ensure no effects were missed. Primary therapist did not significantly contribute to the model (χ^2 = 5.41, (5, *N* = 6), *p* = .37) and yielded an ICC of .00, indicating that less than 1% of the variance was attributable to the primary therapist. Based on the results of the unconditional models, HLM was not warranted.

Bivariate correlation analyses yielded no significant associations between therapist early session responses styles and Partner post-treatment report of Physical Assault (Table 13).

For the injury sub-scale, treatment group did not significantly contribute to the model (χ^2 = 4.69, (8, *N* = 14), *p* > 0.50) and yielded an ICC of .00, indicating that less than 1% of the variance was attributable to the treatment group. Primary therapist did not significantly contribute to the model (χ^2 = 9.37, (5, *N* = 6), *p* = .09) and yielded an ICC of .00, indicating that less than 1% of the variance was attributable to the therapist.

Table 13

Summary of Random Intercept Model for 2-Level Model of Partner Post-treatment Psychological Aggression with Primary Therapist as the Level 2 Grouping Variable

				HD			FD			HS			FS		
	Null			Full			Full			Full			Full		
	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio
Intercept	2.26	0.23	9.83**	0.85	0.85	2.81*	7.09	1.61	4.41**	2.47	0.37	6.61**	5.02	0.44	11.34**
Predictor				-0.14	1.18	-0.12	-3.49	0.59	-3.09**	-2.77	3.88	-0.71	-2.74	0.36	-7.63**
Est. Parameters	2			2			2			2			2		
Deviance	280.20			279.98			273.02			277.03			274.87		

Notes: HD = Hostile-Dominant; FD = Friendly-Dominant; HS = Hostile-Submissive; FS = Friendly-Submissive; #parameters = number of Restricted Estimated Maximum Likelihood parameters; PE = Parameter Estimate; SE = Standard Error of the parameter estimate; Null=Null Model; Full=Full Model
*p < .05; **p < .01

A two-level null model therapist as the level two grouping variable was examined to ensure no effects were missed. Primary therapist did not contribute significantly to the model (χ^2 = 9.27, (5, *N* = 6), *p* = .09) and yielded an ICC of .01, indicating that about 1% of the variance was attributable to the therapist. Based on the results of the unconditional models, HLM was not warranted.

Bivariate correlation analyses yielded no significant associations between therapist early session responses styles and Partner post-treatment report of Injury (Table 14).

Table 14
Pearson Correlations between Therapist Response Style and Partner Post Treatment CTS Sub-scales

	HD	FD	HS	FS
Physical	.16	.06	-.08	-.13
Injury	.16	.17	-.03	-.22

Notes: HD = Hostile-Dominant; FD = Friendly-Dominant; HS = Hostile-Submissive; FS = Friendly-Submissive; Physical= Physical Assault; n =61 for all correlations; *p<.05; **p<.01

Partner follow-up CTS. For the Psychological Aggression sub-scale, treatment group did not significantly contribute to the model (χ^2 = 5.49, (7, *N* = 13) *p* > .50) and yielded an ICC of .00, indicating that less than 1% of the variance was attributable to treatment group. Primary therapists significantly contributed to the model (χ^2 = 17.06, (5, *N* = 6), *p* = .01) and yielded an ICC of 0.12, indicating that 12% of the variance was attributable to the primary therapist.

A two-level null model with primary therapist as the level two grouping variable was examined to ensure a two-level model was appropriate. Primary therapist significantly contributed to the model (χ^2 = 17.11, (5, *N* = 6), *p* = .01) and yielded an ICC of .15, indicating that 15% of the variability was attributable to primary therapist. Based on the results of the unconditional model, HLM was warranted for subsequent analyses.

Full multilevel models yielded significant associations (Tables 15). Early session therapist Friendly-Dominant style was significantly associated with partner 6-month follow-up report of Psychological Aggression.

For the Physical Assault sub-scale, treatment group did not significantly contribute to the model (χ^2 = 4.19, (7, *N* = 13), *p* > .50) and yielded an ICC of 0.00 indicating that less than 1% of the variance was attributable to treatment group. Primary therapist significantly contributed to the model (χ^2 = 33.11, (5, *N* = 6), *p* = .00) and yielded an ICC of .30, indicating that 30% of the variance was attributable to the primary therapist.

A two-level model with primary therapist as the level two grouping variable was analyzed to ensure a two-level model was appropriate. Primary therapist significantly contributed to the model (χ^2 = 33.14, (5, *N* = 6), *p* = .00) and yielded an ICC of .35, indicating that 35% of the variance was attributable to the primary therapist. Based on the results of the unconditional model, HLM was warranted for subsequent analyses.

Full multilevel models yielded significant associations (Tables 16). Early session therapist Friendly-Dominant style was significantly associated with partner 6-month follow-up report of Physical Assault.

For the Injury sub-scale, treatment group did not significantly contribute to the model (χ^2 = 5.65, (7, *N* = 13), *p* > .50) and yielded an ICC of 0.00, indicating that less than 1% of the variance was attributable to treatment group. Primary therapist significantly contributed to the model (χ^2 = 12.75, (5, *N* = 6), *p* = .03) and yielded an ICC of .10, indicating that 10% of the variability was attributable to the primary therapist.

A two-level null model with primary therapist as the level two grouping variable was examined to ensure a two-level model was appropriate. Primary therapist significantly

Table 15

Summary of Random Intercept Model for 2-Level Model of Partner Follow-up Psychological Aggression with Primary Therapist as the Level 2 Grouping Variable

				HD			FD			HS			FS		
	Null			Full			Full			Full			Full		
	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio
Intercept	1.95	0.28	6.95**	2.17	1.04	2.08	8.85	1.79	4.94**	2.09	0.45	4.67**	5.01	1.34	3.75**
Predictor				-0.32	1.52	-0.21	-4.99	1.27	-3.94**	-2.13	5.18	-0.41	-2.99	1.28	-2.35
Est. Parameters	2			2			2			2			2		
Deviance	234.09			233.27			225.41			230.68			229.95		

Notes: HD = Hostile-Dominant; FD = Friendly-Dominant; HS = Hostile-Submissive; FS = Friendly-Submissive; #parameters = number of Restricted Estimated Maximum Likelihood parameters; PE = Parameter Estimate; SE = Standard Error of the parameter estimate; Null=Null Model; Full= Full Model
*p < .05; **p < .01

Table 16

Summary of Random Intercept Model for 2-Level Model of Partner Follow-Up Physical Assault with Primary Therapist as the Level 2 Grouping Variable

				HD			FD			HS			FS		
	Null			Full			Full			Full			Full		
	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio
Intercept	0.32	0.14	2.21	0.33	0.59	0.56	3.96	0.68	5.86**	0.30	0.25	1.19	1.59	0.94	1.69
Predictor				-0.02	0.59	-0.04	-2.61	0.46	-4.18**	0.17	2.79	0.06	-1.26	0.92	-1.37
Est. Parameters	2			2			2			2			2		
Deviance	102.07			98.87			92.33			96.43			96.74		

Notes: HD = Hostile-Dominant; FD = Friendly-Dominant; HS = Hostile-Submissive; FS = Friendly-Submissive; #parameters = number of Restricted Estimated Maximum Likelihood parameters; PE = Parameter Estimate; SE = Standard Error of the parameter estimate; Null=Null Model; Full= Full Model
*p < .05; **p < .01

Table 17

Summary of Random Intercept Model for 2-Level Model of Partner Follow-up Injury with Primary Therapist as the Level 2 Grouping Variable

				HD			FD			HS			FS		
	Null			Full			Full			Full			Full		
	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio	PE	SE	t-ratio
Intercept	0.17	0.09	1.86	0.21	0.35	0.59	2.08	0.73	2.83*	0.12	0.14	0.88	0.61	0.65	0.95
Predictor				-0.06	0.51	-0.12	-1.36	0.52	-2.63*	0.69	1.67	0.41	-0.43	0.62	-0.69
Est. Parameters	2			2			2			2			2		
Deviance	84.39			82.14			77.36			79.55			81.21		

Notes: HD = Hostile-Dominant; FD = Friendly-Dominant; HS = Hostile-Submissive; FS = Friendly-Submissive; #parameters = number of Restricted Estimated Maximum Likelihood parameters; PE = Parameter Estimate; SE = Standard Error of the parameter estimate; Null=Null Model; Full= Full Model
*p < .05; **p < .01

contributed to the model (χ^2 = 12.79, (5, N = 6), p = .03) and yielded an ICC of .14 indicating that 14% of the variance was attributable to primary therapist. Based on the results of the unconditional model, HLM was appropriate for subsequent analyses.

Partner 6-month report of Injury was not significantly associated with any therapist response style (Table 17).

Discussion

The primary goal of this research study was to determine whether therapists had a unique influence on group treatment for IPV offenders, and if so, to determine whether this influence can be explained in part by therapist's interpersonal response style during treatment sessions. IPV has been a long-standing social issue with more than one-third of women in the United States reporting abuse by a partner (Black et al., 2011; Breiding et al., 2014). Often offenders have been ordered to attend treatment programs, however, research has indicated that most IPV offender treatment has only a modest impact in reducing IPV behaviors (Babcock et al., 2004; Feder & Wilson, 2005). Examining key issues influencing IPV offender treatment is essential in efforts to reduce the prevalence and negative impact of IPV.

A working hypothesis for the current study is that the therapist is a principal player in the group treatment process for partner abusive men. The rise of evidence-based approaches focused on technique and content has resulted in a marginalization of the therapist, in research and training, (Beutler, 1997; Blow et al., 2007; Garfield, 1997; Okiishi, Lambert, Nielson, & Ogles, 2003). This marginalization has left the research field focusing on the content of therapist interactions (i.e. technique) versus the process (i.e. interpersonal style) of these interactions. Nevertheless, previous research suggested that therapist communication behaviors play an

integral role in group therapy, influencing group member interactions and changes in client thinking and beliefs (Barlow et al., 1982; Marshall, 2008; Nicholas, 1977; Nicholas & Taylor, 1975; Sandahl et al., 2000; Watson, Daffern, & Thomas, 2017). The current study aimed to examine the influence of the therapist and their communication behaviors in IPV group settings with the hope of informing both treatment approaches and therapist training to enhance the efficacy of IPV treatment in reducing recidivism among offenders.

Overview of Study Findings

The first hypothesis was that several important client outcomes would differ significantly among therapists. If supported, this hypothesis would provide a foundation for exploring differences in therapist behavior that might explain differences in client outcomes. The first sub-hypothesis (1A) was that there would be significant differences among therapists in the average level of KI statements made by participants during group sessions late in treatment, as well as in the average amount of change in KI client statements from early to late sessions. This hypothesis (1A) was fully supported through the finding of significant differences among therapists in rates of late-session KI statements and rate of change in KI statements from early to late treatment sessions.

The second sub-hypothesis (1B) was that there would be significant differences among therapists in the group members' responses to KI statements, specifically the extent to which other group members supported or challenged KI statements. This hypothesis (1B) was not supported, as there were no significant differences found among therapists on group members' responses to KI statements.

The third sub-hypothesis (1C) was that differences among therapists would be found for client and partner reports of IPV behaviors, specifically Psychological Aggression, Physical

Assault, and Injury. This hypothesis (1C) was partially supported, as differences among therapists were demonstrated on partner reports of post treatment CTS Psychological Aggression and six-month follow-up partner reports of Psychological Aggression, Physical Assault, and Injury. However, there were no significant differences among therapists on client post-treatment CTS reports of Physical Assault, Psychological Aggression, or Injury, or partner post-treatment reports of Physical Assault or Injury. Overall, the findings are congruent with previous research findings of differences among therapists on client outcomes (Blatt et al., 1996; Brown et al., 2005; Crits-Cristoph et al., 1991; Dinger et al., 2008; Luborsky et al., 1997).These findings provide considerable evidence that important client outcomes differ among therapists. These findings support the need for subsequent analyses to identify the therapist behaviors that may explain difference in client outcomes.

The second hypothesis was that therapist interpersonal response style when responding to KI statements would influence outcomes. The therapist interpersonal response styles consisted of Friendly-Dominant, Friendly-Submissive, Hostile-Dominant, and Hostile-Submissive categories.

The first sub-hypothesis (2A) was that therapist interpersonal response style would influence rates of late session KI and changes in the mean rate of KI from early to late session. This hypothesis (2A) was partially supported.

In an attempt to understand which therapist variables might be influencing KI statements, therapist interpersonal response styles were examined. Findings indicated that responses with higher rates of Hostile-Dominant and Hostile-Submissive styles were related to changes in the rate of KI statements from early to late sessions. Therapist 1 had the highest mean ratings of Hostile-Dominant and Hostile-Submissive items in comparison to the other therapists in early sessions. Individuals in that therapist’s groups had an increase in mean rate of KI verbalizations

from early to late sessions. The data for Therapists 3 and 6, who had the lower mean ratings of Hostile-Dominant items in comparison to the other therapists in early sessions, indicated that clients in these treatment groups had a reduction in KI statements over time.

The second sub-hypothesis (2B) was that therapist interpersonal response style would be associated with group members' support or non-support of KI statements and the intensity of group members' responses. This hypothesis (2B) was not supported, as no early session therapist interpersonal response style was associated with client overall response style or intensity of responses to KI statements.

The third sub-hypothesis (2C) was that therapist interpersonal response style would be associated with client and partner reports of IPV behaviors. This hypothesis (2C) was partially supported. Client post-treatment report of Psychological Aggression was associated with higher mean rate of early session Hostile-Dominant and Friendly-Dominant items. When examining the data, Therapist 1 had a higher mean score for Hostile-Dominant and Friendly-Dominant items compared to the other therapists. The clients in this therapist's groups reported the lowest rates of Psychological Aggression at the end of treatment. However, there was no indication that therapists with lower mean ratings compared to the other therapists on the Hostile-Dominant and Friendly-Dominant items had clients with higher rates of reported Psychological Aggression. Client's post-treatment reports of Physical Assault and Injury were not associated with therapist interpersonal response style.

Partner post-treatment reports of Psychological Aggression were associated with early session of Friendly-Dominant and Friendly-Submissive scales. Therapists 1 and 3 had the highest mean rates on the Friendly Dominant scale compared to the other therapists, and Therapist 3 had the highest mean rates on the Friendly Submissive scale compared to other

therapists, with Therapist 1 having the third highest mean rates on the Friendly-Submissive scale compared to the other therapists. Partners of clients in these groups reported the lowest rates of Psychological Aggression. Therapist 5 had the lowest mean rate on the Friendly-Dominant and Friendly-Submissive scales compared to the other therapists. Partners of clients in those groups reported the highest rates of Psychological Aggression. However, as with client reports, partner post-treatment reports of Physical Assault and Injury were not associated with therapist scores on the CLOPT-R scales.

Partner follow-up reports of Psychological Aggression, Physical Assault and Injury were associated with therapist early session mean rates on the Friendly-Dominant scale. Therapist 1 and 3 had the highest mean score on the Friendly-Dominant scale compared to the other therapists. Partners with clients in Therapist 1's groups reported the lowest rates of abuse on all three IPV behavior scales. Therapist 3's groups had the second lowest rates of Psychological Aggression and the third lowest rates of Physical Assault and Injury. Therapists 4 and 5 have the lowest mean rates for early session on the Friendly-Dominant scale and the highest rates of partner reported IPV behaviors at the follow-up assessment. These patterns indicate that Friendly-Dominant scale scores were related to more favorable client IPV outcomes after treatment.

Interpretation of Findings

Findings from the current study provided evidence that therapists did influence specific facets of IPV group treatment, and that specific therapist interpersonal response styles influenced important treatment outcomes. These findings are consistent with prior psychotherapy research showing that there are differences in client outcomes among therapists (Blatt et al., 1996; Dinger

et al., 2008; Luborsky et al., 1997; Nissen-Lie et al., 2016), which are influenced by the therapist's interpersonal style.

Key Intervention Statements: A primary focus of IPV treatment has been to address the underlying cognitions and beliefs that develop and maintain IPV behaviors (Murphy & Eckhardt, 2005). In this study, these cognitions and beliefs were assessed indirectly through client KI statements. These statements were reflective of negative beliefs about women and relationships, as well as negative perceptions of treatment. The former beliefs were viewed as maintaining and contributing to IPV behaviors, and the latter might negatively influence treatment engagement. The verbalizations of these cognitions provided insight into client's beliefs and allowed the therapist to address these beliefs more directly. This study found significant differences among therapists in regards to changes in rate of KI statements from early to late treatment sessions, as well as frequency of late session KI statements. While it was not possible to assert that cognitions and beliefs were indeed changed, as KI statements were an observational proxy measure of cognitions, the current results are consistent with the idea that some therapists were more successful than others at altering client vocalization of thoughts and beliefs. It might be that the client actually altered their thinking patterns related to women, relationships, and aggression or alternately, they might have learned to modify their vocalization of these beliefs. These findings are consistent with previous research findings that the therapist plays a unique role in the therapeutic process. HLM models suggested that therapists accounted for 19% of the variance in rates of late session KI statements and 15% of the variance in changes in rate of KI statement from early to late sessions. These findings highlight the critical role therapist plays in treatment process.

In an effort to understand, what therapist factors were influential, therapists interpersonal style was examined. Findings indicated that mean rates on Hostile-Dominant and Hostile-Submissive scales were related to changes in the rate of KI statements from early to late sessions. These findings are consistent with the expectation that higher mean rates on Hostile-Dominant and Hostile-Submissive scales compared to other therapists early in treatment may be counter-productive to changing cognitions and beliefs.

Hostile-Dominant and Hostile-Submissive responses styles shared Hostile behaviors, which included responding in a confrontational and harsh manner. This confrontational style has been found in previous research to be detrimental to the treatment process. Marshall's (2005) research on sex offender treatment found that when therapists were confrontational this resulted in less change in victim blaming beliefs and less ownership of responsibility for the offending behaviors by clients, thus suggesting that confrontational therapist behaviors can inhibit the treatment process. These findings, as well as Marshall's (2005) results, were consistent with the assertions of Taft and Murphy (2007) regarding the negative impact of confrontational behaviors by the therapist in group treatment.

It is possible in the sample for this current study that hostile behaviors were negatively affecting the therapeutic alliance. It might be that confrontational behaviors negatively influenced therapeutic alliance, which in turn inhibited the effectiveness of treatment on changing the key underlying cognitions of IPV behaviors. There has been evidence that poor working alliance negatively affected IPV treatment outcomes (Taft, Muprhy, King, Musser, & DeDeyn, 2003). While it was not addressed in this study, Taft and Murphy asserted in their literature review of working alliance and confrontational behaviors in IPV treatment that confrontational behavior by a therapist negatively influenced the working alliance. This assertion

was consistent with research by Watson and colleagues (2017) findings that when therapist behavior was perceived as less hostile (i.e. friendlier) by the client, there was a more positive therapeutic alliance.

Another mechanism that may have been at work with KI statements and therapist interpersonal style was modeling of behaviors. In previous research, it was found that group members' verbal and interpersonal behaviors tended to be similar to the therapist (Barlow et al., 1982; Sandhal et al., 2000). This modeling was seen in Keisler and Goldston's (1998) research utilizing the CLOPT-R. In their study, they referred to this as complementarity of interactions. They found that when the therapist's behaviors were deemed hostile, the client's behaviors were also deemed hostile and conversely friendlier therapist behaviors were met with friendlier client behaviors.. Considering the increase in KI statements from early to late sessions was associated with higher levels of hostile response behaviors in early sessions, it is possible that clients were responding in a more hostile manner. As KI statements reflect negative and hostile beliefs, it is also possible the therapists, by behaving in a hostile manner, may be reinforcing this way of communicating, and may inadvertently reinforce these problematic beliefs. Conversely, lower levels of hostile behaviors in early sessions were associated with fewer negative statements by clients in later sessions, potentially due to a modeling of communication and beliefs that are more supportive and less hostile.

Client Response. Peer contagion has also been explored as a potential inhibitor of treatment progress in IPV groups. Meis (2009) found that IPV groups in which individuals consistently and strongly supported KI statements tended to have lower rates of decline in verbalization of these beliefs from early to late sessions. Additionally, Lloyd and colleagues (2014) had similar findings. They found that incarcerated individuals engaged in treatment where effected by the

negative behaviors of their peers, especially in treatment for Family Violence and Sex Offending. These findings that group members appeared to influence one another raises questions about the potential role of the therapist in altering group member interactions. A primary role of group facilitators would be to guide group norms and member engagement.

The current study found that the therapist in general did not appear to play a significant role in group member responses to KI statements, nor did any specific therapist interpersonal style appear to influence group member responses to KI statements. This was counter to other research (Barlow et al., 1982; Gilstein et al., 1977; Li et al., 2016; Romeo et al., 2014; Sandahl et al., 2000; Shoemaker, 1987), which suggested that therapists influenced group member verbalizations and interactions, such as the content of information shared, amount of verbalizations, group alliance, and level of client collaboration during treatment groups.

There could be several possible explanations for the lack of therapist influence on group interactions in the current study. One possible explanation might be that in IPV treatment groups, therapists did not influence client interactions, for example because clients had deeply ingrained beliefs about relationships and the use of coercive relationship strategies. However, this idea was not consistent with the findings regarding differences among therapists with respect to the change in KI statements over time and some abusive behavior outcomes.

A second possible explanation for the lack of findings involved the measurement of group interactions for the current study. This study examined whether the group as a whole responded in support or not in support of KI statements, along with the intensity of supportive and non-supportive responses. However, this study did not explore whether frequency and intensity of support and non-support by group members changed from early to late session, and whether the therapist influenced changes in group member responding. As we saw with KI statements, rates

of KI statements in late sessions were not impacted by therapists, however changes in rates of KI statements were different among therapists and influenced by therapist interpersonal style. Examining therapist influence on change in group member responding over the course of treatment might be an avenue of inquiry for future studies.

Third, the study did not address several other variables that relate to group member responding, such as the timing of group member responses compared to therapist responses, or relational qualities. If a therapist responded to a KI statement before any group members, that could alter group member responding to be more in line with therapist responses. Alternatively, if a group member responded first, that response may set the tone for subsequent group member responses, and may reduce the impact of subsequent therapist responses. This seemed a likely avenue of consideration as Barlow and colleagues (1982) found that when group members responded after the therapist, the group members' responses were more similar to the therapists' responses. Group members' relational communication may also be influencing outcomes. A group member may respond to a KI statement with harsh confrontational non-supportive statements or may respond with a "soft confrontation." When the response was harsh and confrontational this may have created a defensive response in the KI speaker, and conversely, if the response was presented in a warm and supportive tone (i.e. soft confrontation) the KI speaker may be less defensive and more open to alternate ideas. Although the current study did not find evidence of therapist influence on group members' responses, previous research suggests that continued exploration of this topic is warranted, particularly given that group member support appears to affect the subsequent rate of KI statements.

CTS. Key outcomes in IPV research have been post-treatment IPV behaviors, with the greatest emphasis given to victim partner reports of continued abuse. Previous research found

that individuals receiving treatment had a 40% likelihood of remaining non-violent, whereas individuals who did not receive treatment had a 35% likelihood of remaining non-violent (Babcock et al., 2004),which suggested that treatment had a minor impact on reducing IPV behaviors (Babcock et al., 2004; Feder & Wilson, 2005). Thus examining the therapist impact on IPV behaviors was an important part of this study. If the therapist and/or specific therapist interpersonal styles influenced post-treatment IPV behaviors, this could help shape training programs for IPV treatment providers. In addition, understanding the influence of the therapist on IPV recidivism would allow those researching and developing treatment to attend to the therapist behaviors in treatment development beyond specific techniques.

This study found differences among therapists in some important post-treatment outcomes; however, these findings were not consistent across reports (client and partner) or time (immediately at the end of treatment and 6-months after treatment). In particular, significant differences among therapists were found for partner reports of post treatment psychological aggression, and partner follow up reports of psychological aggression, physical assault, and injury. HLM analyses indicated that therapist accounted for 9% of the variance in partner post treatment psychological aggression reports, 15% of the variance in partner follow up report for psychological aggression, 35% of the variance for partner follow up report of physical assault, and 14% of partner follow up report of injury. These findings of differences among therapists on treatment outcomes was consistent with previous research (Blatt et al., 1996; Brown et al., 2005; Crits-Christoph et al., 1991; Dinger et al., 2008; Luborsky et al., 1997; Nissen-Lie et al., 2016; Saxon & Barkman, 2012; Wampold & Brown, 2005). These findings were particularly important, as a primary target of treatment has been sustained change in IPV behaviors. These

findings suggested that therapists uniquely affected IPV behaviors even six (6) months after treatment has ended.

To ascertain which therapist characteristics were meaningful, therapists interpersonal response style was examined. Findings suggested that therapist interpersonal response style was significantly associated with IPV outcomes. This finding was consistent with previous research on therapist influence in group treatment in general (Barlow et al., 1982; Gilstein et al., 1977; Nicholas, 1977; Nicholas & Taylor, 1975; Romeo et al., 2014; Sandahl et al., 2000; Shoemaker, 1987), and specific to forensic populations, (Bowen, 2010; Marshall, 2005; Watson et al., 2017).

Responses that were more Friendly-Dominant and Hostile-Dominant during early treatment sessions were associated with client post treatment reports of Psychological Aggression. Partner post-treatment reports found that responses that were more Friendly-Dominant and Friendly-Submissive were associated with outcomes on Psychological Aggression that were more favorable. In regards to partner 6-month follow-up reports, responses that were more Friendly-Dominant were found to be associated with lower reported rates of Psychological Aggression, Physical Assault, and Injury.

A primary interpersonal domain associated with client post-treatment reports and partner reports was Dominant responses, such as offering suggestions, taking charge of the conversations, and providing advice or instruction. It may be that more dominant responses, which could be interpreted as directive or assertive in nature, accounted for part of the association between interpersonal style and client reported IPV outcomes. This directive quality may explain the association between higher dominant responses and lower levels of IPV outcomes. This finding was consistent with Marshall's (2005) research on treatment with sexual offenders, which found that therapists with directive behaviors tended to have clients with more

positive outcomes that included less victim blaming, and increased empathy. One possibility would be that therapists were providing feedback specific to abusive behaviors that are voiced via KI statements, and through providing advice and instruction gave clients an alternate set of beliefs and behavior options. It may be possible that therapists in these groups offered suggestions and advice that targeted the behaviors and beliefs associated with victim blaming and empathy.

Another mechanism that may have been at play with directive behaviors was norm setting. An important responsibility of the group therapist would be the setting and reinforcement of norms (Bogers & Koeing, 1983; Riva et al., 2004; Yalom & Leszcz, 2005). This would be in line with Tuckman's (1965) group development theory positing that the therapist needed to be directive in early sessions to establish expectations regarding behaviors and an environment that was conducive to change. . By using directive approaches, such as guiding the conversation and providing advice, in response to KI statements, therapists may be helping create a group environment wherein it has been established that group members could openly discuss negative cognitions and beliefs, and provide one another prosocial and change oriented responses as a result of modeling therapist responses. This interpretation would be consistent with research suggesting that group member's verbalizations resembled those of the therapist (Barlow et al., 1982; Sandahl et al., 2000).

Another shared interpersonal domain across client and partner reports was Friendly. Friendly behaviors consisted of warm, empathetic, and validating. In general, for this current study, friendlier responses were associated with lower rates of reported IPV behaviors. This finding was congruent with Marshall's (2005) findings that sexual offender clients engaged in less victim blaming and displayed a greater degree of empathy for those they victimized when

they had warm and empathetic therapists. This finding was also congruent with Strupp and Anderson's (1997) research. In that study, a single therapist was trained to deliver the same content in two different interpersonal styles, either a warm and empathetic style or a cool and clipped style. The findings suggested that clients with the warm and empathetic therapist style had outcomes that were more positive and benefited more from treatment than those with the cool and clipped therapist style. One of the mechanisms may be that a warm and empathetic environment provided greater avenues for change, as clients may have felt less defensive and experienced a greater level of support, which in turn enhanced their willingness to change.

Another mechanism in IPV groups may be therapists modeling. A study conducted by Barlow and colleagues (1982) trained sets of co-facilitators in different interaction styles and examined group members interaction behaviors. The study found that group members had different verbal behaviors among the groups, with group members engaging in verbal behaviors similar to their assigned co-facilitators. Sandhal and colleagues (2000) also examined group member behaviors in the context of therapist verbal behaviors, where CBT and Analytically oriented therapists were assigned to facilitate treatment groups. That study found that differences in client verbal behaviors emerged among groups, and that group member verbalizations matched the assigned therapist's verbal behaviors. Yalom asserted that the group environment was a microcosm of the client's environment (1985; 2005). Following this logic, Goldberg and Hoyt (2015) conducted research to examine this hypothesis. This study addressed the hypothesis that the group environment would be a social microcosm that mimics the real world; in particular, the interpersonal behaviors of the group members would be a reflection of their behaviors outside of the group therapy setting (Goldberg & Hoyt, 2015). Overall, the researchers found that group members' interpersonal style in treatment group matched their typical style, as reported pre-

treatment, outside of the group context. This study provided support for the social microcosm theory (Goldberg & Hoyt, 2016). For this current study, the same modeling behaviors seen in previous research could be occurring, and taking Goldberg & Hoyt's (2015) findings into consideration, it may have been possible for the therapist to influence group members' interpersonal style. It may be that therapists were modeling a warmer and gentler communication style, which clients then adopted in their own interactions, especially when therapists were responding to KI statements, which can be viewed as negative. In essence, the therapist provided a model for communication behaviors in response to potentially confrontational statements, and in this case friendlier responses which contained] warmth and empathy, which provided clients with a set of communication skills to implement in their own potentially confrontational interactions outside of group.

The styles found to be associated with cognitions and outcomes was similar to that promoted by Murphy and Eckhardt (2005) with the concept of soft confrontations, in which the therapist challenges clients' cognitions, and controlling and abusive behaviors in an empathic fashion by helping clients identify inconsistencies between their actions and their own goals and values. This was along the same lines as other researchers' encouragements to provide challenges that were gentle, warm, and empathetic (Derlega et al., 1991; Gellar, 2005; Van Denburg & Kiesler, 2002) and without criticism and judgment (Brown & Keller, 1973).

Limitations and Strengths

As with all studies, there were limitations to the methods and findings of this study. First, the number of level 2 clusters (therapists; n=6) was quite small and the number of observations (individual clients) varied with some therapists having a small number of clients (n=8). With such a small sample, there might be the possibility of overestimated point estimates (McNeish &

Stapleton, 2014), which could indicate a larger effect than was true or indicated an effect when there was none. While the utilization of REML in part mitigates this overestimation, the sample size may limit the reliability of the statistics and therefore interpretations should be made with caution.

The generalizability of this study was limited by three main factors; the small sample size, the fact that the therapists were primarily white males, and the use of only a single site and sample. The results of this study should be interpreted cautiously and not extrapolated to other populations.

In addition, multiple therapist variables were not accounted for in this study, which may be related to the outcome variables and may provide "third-variable" explanations of the observed associations. These included, but were not limited to, therapist sex, education status, previous training experiences, number of groups facilitated prior to the coded groups, therapeutic orientation, years of experience, familiarity with the material (manual), and personal beliefs concerning intimate partner violence. Some of these variables may be associated with interpersonal style, for example, a therapist who has a personal history of witnessing or experiencing intimate partner violence may be more confrontational and less warm, than a therapist who did not have those experiences. In addition, research found that therapists' clinical orientation in treatment settings impacted outcomes, specifically therapists who approached treatment from a psychological perspective (i.e. environment, behaviors, etc.) versus a biological (i.e. genetics, neurological issues, etc.) had more positive client outcomes (Blatt et al., 1996). It has also been found that with manualized treatment, a greater level of adherence to the manual accounts for some of the variance attributed to the therapist in outcomes (Cris-Christoph et al., 1991). While the reason for this was not explored, it is possible that therapists had a greater focus

on the material and worked on skills development. These are important therapist variables to consider, however, it was beyond the scope of this study to investigate them.

Another concern was that several therapist communication behaviors were not addressed. These included frequency of responding, duration of response, order of responders (i.e. therapist first versus group member first), and who the response was directed towards (i.e. original speaker, group as a whole, another group member, or co-therapist). Barlow and colleagues (1982), research suggested that timing of responses and order of responders influences group processes. In terms of responding to the co-therapist, it was noted during the coding process for this study that therapist dyads varied in their level of collaboration and the relational aspects of their interactions. It could be possible that a therapist would be friendly to clients, but have a clipped or cool manner with their co-facilitator, which might influence the group dynamics and outcomes.

Several client characteristics were also unaccounted for in this study. Readiness to change, personality characteristics (i.e. antisocial tendencies), drug and alcohol use, and having a new partner during or after treatment might contribute in unique ways to the findings. For example, in accordance with Meis' (2009) findings, individuals who were more ready to change may have exhibited more cooperative behaviors in treatment than those less ready to change, and thus therapists might respond in a friendlier manner to these individuals. This would suggest that that therapist interpersonal style was a byproduct of clients' behaviors and client willingness to alter their behaviors. In addition, these client variables were not compared among therapists, and therefore it remains possible that such differences could have influenced the observed results.

There were also measurement issues. First, it would be important to note that the period of reported behaviors on the post-treatment CTS scales were reflective of IPV behaviors that

occurred during the course of treatment. It was unclear if the IPV behaviors reported by clients and partners occurred early in treatment, late in treatment, or both. Therefore, caution should be exercised when interpreting the effect of therapist behaviors on these posttreatment outcomes, as some of the reported behaviors may have occurred in the earliest stages of treatment before the therapeutic relationship was built, and prior to any effect of treatment. Second, CLOPT-R interpersonal profiles for this study had overlapping items, for example, Friendly-Dominant and Hostile-Dominate shared items labeled Dominant, making it difficult to parse out specific therapist behaviors, which affected outcomes. Third, the therapist's style varied somewhat across their groups and a potentially more complicated picture was simplified by using therapists' mean scores across all groups. It may be beneficial to examine the interpersonal style from a group level versus a therapist level in future studies with larger samples of therapists and groups.

Another concern was the limited number of coders for KI statements and the CLOPT-R. For both coding passes, there was a primary coder and a reliability coder. In both instances, the primary coder trained the reliability coder. Therefore, coders were likely to have coded similarly, which might have led to higher interrater reliability, and while positive for this study, might limit the replicability of the study. In addition, for both coding passes the coders were white females. There could be some inherent subjectivity when making determinations about the intent of someone's statements, be it their contextual or relational meaning, which the primary coder would pass on to the reliability coder. Other individuals might interpret KI statements or therapist verbal responses differently, thus potentially attaining a different set of results.

An additional issue with the CLOPT-R was the low rate of observations for the Hostile-Submissive domain. For example, one therapist displayed no behaviors that mapped on to this domain. The low rate of these behaviors in general could have affected findings for this domain.

In addition, the inter-rater agreement for the CLOPT-R coding was consistently high for three quadrants, but somewhat lower for the Friendly-Submissive quadrant. It may be that submissive behaviors were more challenging to code to their subjective nature. For example, submissive behaviors could be considered the absence of assertive behaviors. However, for this study, if a therapist did not engage in an assertive behavior, it was not assumed the intent was submissiveness. One of the items that mapped on to the submissive domain was "finds it difficult to take the initiative." If a therapist did not take initiative, it was not assumed it was because they found it difficult, and this item would not be coded. A clear behavior needed to be present to have this item coded, for example a therapist would have to attempt or start to speak then stop if talked over by a client or stopped speaking if they were contradicted. These types of behavior were observed less frequently than other behaviors. The lower inter-rater reliability and the lower occurrence of these behaviors may have reduced the ability to observe results for submissive behavior.

While there were limitations to this study, there were also several strengths. The sample population, while a limitation to generalizability, can also be viewed as a strength. All the therapists were trained at the same graduate program, utilized a manualized treatment, and received supervision and feedback from a single supervisor. These commonalities may have minimized some of the variance in therapist influence by eliminating differences in training, supervision approaches, and treatment modality, thus strengthening the confidence in the findings for interpersonal style.

An additional strength would be the excellent inter-rater reliability on the CLOPT-R. Given the subjective nature of the observations, gaining a reasonable reliability would be challenging.

The ability to achieve a good reliability on the CLOPT-R enhances the confidence of the findings for interpersonal behaviors.

Implications for Practice and Training

Findings from this study are consistent with previous research regarding the importance of therapist role in treatment (Blatt et al., 1996; Brown et al., 2005; Crits-Christoph et al., 1991; Dinger et al., 2008; Luborsky et al., 1997; Nissen-Lie et al., 2016; Saxon & Barkman, 2012; Wampold & Brown, 2005), and in particular therapists' interpersonal behaviors in treatment (Barlow et al., 1982; Gilstein et al., 1977; Nicholas, 1977, Nicholas & Taylor, 1975; Sandahl et al., 2000; Shoemaker, 1987), and extend these past findings to IPV group treatment. The lessons learned from this study may provide direction for future efforts to train therapists, develop IPV treatments, and revise relevant social policies such as state guidelines for the training and implementation of IPV interventions.

In the development of legislation and treatment programs careful consideration should be given to the role of the therapist. Legislation should encourage and utilize treatment research to aid in decisions regarding therapist training and qualifications for IPV treatment. Further, program development should attend to therapist selection, training, and supervision in order to improve the efficacy of IPV treatment.

Particular consideration should be given to therapists' interpersonal behaviors in treatment. This study provided evidence for the influence of interpersonal behaviors in changes of cognitions (i.e. KI statements) and sustained changes in IPV behaviors (i.e. CTS partner 6 month follow up reports). Legislation should rely on continued research to make thoughtful decisions regarding treatment approaches, therapist training, and treatment requirements to aid in improving implementation of effective treatments. Graduate training programs and IPV

treatment programs should consider implementation of interpersonal behaviors into training and supervision. In the delivery of group treatment for IPV, the interpersonal behaviors of a therapist should be viewed as malleable, as evidenced by Marshall's (2005) research, with appropriate and specific feedback in training programs. Strupp and Anderson (1997) were able to train a single therapist in varying relational styles as part of their research. Both of these studies provided evidence of the importance of therapist interpersonal style, and the ability to train therapists to attend to and alter their interpersonal behaviors. This type of training and feedback may be difficult to provide as therapy sessions likely occur without the supervisor present, and without audio or video recordings. Training programs should consider enhancing therapist effectiveness through monitored sessions to allow feedback on the technique as well as the interpersonal behaviors of the therapist. The challenge would be to define clearly the interpersonal behaviors that can enhance treatment efficacy. The current study utilized a scale that provided some direction, but still relied heavily on the interpretation of the observer. Research could continue to address these interpersonal behaviors and aid in the development of clear operational definitions and examples, which may then be incorporated into therapist training programs.

In terms of treatment development, it might be helpful to incorporate into treatment manuals direction for the interpersonal behaviors found to be most beneficial, as previous research indicated when holding content constant differences were found in client outcomes based on therapist interpersonal style in delivering treatment (Derlega et al., 1991). This current study suggested that a Friendly-Dominant set of behaviors provided an effective approach for therapists to adopt for IPV group treatments. Further efforts to operationalize and incorporate this response style into treatment manuals and program policies may enhance the efficacy of IPV treatment programs.

Future Research Directions

This study was considered an initial effort to examine the influence of therapist's influence, and therapists' interpersonal behaviors, in IPV group treatment. The findings highlighted the need for continued and more refined research into therapists' role in the IPV treatment process, and in particular the role of therapist interpersonal behaviors. There could be several avenues of future exploration.

Of importance in IPV group treatment would be the co-therapist interactions and the influence of both therapists. Over the course of this study, it was noted that the dynamics between the therapists varied. Several dyads appeared to have positive and collaborative relationships. In another dyad, the therapists appeared to have a contentious relationship and often seemed to be bickering. In yet another dyad, it appeared that the male therapist took on a protective role with the female therapist, and inserted himself into interactions when it appeared a client was being disrespectful to the female therapist, essentially "rescuing" her. These varied dynamics and interactions likely influenced the group process. In groups with a higher level of collaborative and respectful interactions between therapists, we might anticipate a greater level of respectful interactions by group members. Alternately, if therapists had contentious relationships, we might see an increase of negative statements directed towards therapists. Coding and analyzing the therapists' interactions with one another were beyond the scope of this current study, and may require larger samples of treatment groups and therapist dyads

Another consideration for future research might be to examine the therapists' responses from the client's perspective. Observational methods have been beneficial, as they removed certain confounds, such as client's beliefs about treatment or client's readiness to change, and allow for a theoretical examination of the therapist's behaviors. However, it should be

recognized and acknowledged that the client's feelings about being in treatment, motivation to change, and many other variables may influence the ways in which the client viewed and responded to the therapist, and in turn the extent to which the therapist can influence the client. It may be important to explore further the client's perspective on the therapist interpersonal behaviors and the impact on outcomes.

Finally, this study looked only at KI statements that were reflective of negative cognitions and beliefs viewed as maintaining IPV behaviors. It would be helpful to understand if the therapist influenced not merely a lessening of these thoughts and beliefs, but an increase in positive cognitions and beliefs about women and relationships.

Conclusion

Overall, this study answered the primary question of whether the therapist influenced client behaviors and provided evidence of the importance of the therapist role in IPV group treatment. Cognitions and beliefs that maintained IPV behaviors and the IPV behaviors themselves have been identified as the primary targets for change in IPV treatment. This study provided support regarding the fundamental role of the therapist in altering these cognitions beyond the delivery of a manualized technique. In addition, a principal finding was the difference among therapists in rates of IPV behaviors at 6-month follow up. An important measure of treatment success was the sustainability of change in IPV behaviors. This result highlighted the integral role of therapists in the process of change. These findings provided a positive avenue to develop and improve treatment approaches for IPV programs.

The relational aspects of the therapist's communication behaviors had an important role in the facilitation of change, as well. Evidence suggested that hostile therapist behaviors could inhibit individuals' desire and/or ability to alter cognitions and beliefs that maintain IPV

behaviors. Moreover, a warm and direct therapist style provided a therapeutic environment that encouraged changes in IPV behaviors.

This research could guide future studies, and might inform treatment training and practices. Much less is known about how to enhance interpersonal behaviors of therapists than about training therapists to provide treatment based on manualized content and techniques. It may be possible to mold therapists' interpersonal styles, as Marshall (2005) found with his sexual offender treatment research and therapists' ability, in that case, to eliminate confrontational behaviors. Given the high recidivism rates observed for current treatment approaches to IPV, this study provided preliminary direction to develop research examining the therapist's role, and to enhance treatment delivery by focusing on therapist training from a more holistic perspective that is inclusive of interpersonal style.

Appendix A
CTS-2

RELATIONSHIP BEHAVIORS

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please circle how many times you did each of these things in the past six months. If you or your partner did not do one of these things in the six months, but it has happened before that, circle "7."

HOW OFTEN HAS THIS HAPPEN

1 = Once in the past 6 months
2 = Twice in the past 6 mo.
3 = 3-5 times in the past 6 mo.
4 = 6-10 times in the past 6 mo.
5 = 11-20 times in the past 6 mo.
6 = More than 20 times in the past 6 mo.
7 = Not in the past 6 mo., but it did happen before
0 = This has never happened

Psychological Aggression

CTS2: 5. I insulted or swore at my partner. 1 2 3 4 5 6 7 0
HCTS 11. I insulted or swore at my partner. 1 2 3 4 5 6 7 0
CTS2: 6. My partner did this to me. 1 2 3 4 5 6 7 0
HCTS 12. My partner did this to me 1 2 3 4 5 6 7 0

CTS2: 49. I stomped out of the room, house, or yard during a disagreement. 1 2 3 4 5 6 7 0
HCTS 15. I stomped out of the room, house, or yard. 1 2 3 4 5 6 7 0
CTS2: 50. My partner did this to me. 1 2 3 4 5 6 7 0
HCTS 16. My partner did this to me. 1 2 3 4 5 6 7 0

CTS2: 67. I did something to spite my partner. 1 2 3 4 5 6 7 0
HCTS 17. I did or said something to spite my partner 1 2 3 4 5 6 7 0
CTS2: 68. My partner did this to me. 1 2 3 4 5 6 7 0
HCTS 18. My partner did this to me. 1 2 3 4 5 6 7 0

CTS2: 69. I threatened to hit or throw something at my partner. 1 2 3 4 5 6 7 0
HCTS 19. I threatened to hit or throw something at my partner. 1 2 3 4 5 6 7 0
CTS2: 70. My partner did this to me. 1 2 3 4 5 6 7 0
HCTS 20. My partner did this to me. 1 2 3 4 5 6 7 0

Omitted:
CTS2: 25. I called my partner fat or ugly . 1 2 3 4 5 6 7 0
CTS2: 26. My partner called me fat or ugly . 1 2 3 4 5 6 7 0
CTS2: 35. I shouted or yelled at my partner. 1 2 3 4 5 6 7 0
CTS2: 36. My partner did this to me. 1 2 3 4 5 6 7 0

CTS2: 65. I accused my partner of being a lousy lover. 1 2 3 4 5 6 7 0
CTS2: 66. My partner did this to me. 1 2 3 4 5 6 7 0
CTS2: 29. I destroyed something belonging to my partner. 1 2 3 4 5 6 7 0
CTS2: 30. My partner did this to me. 1 2 3 4 5 6 7 0
HCTS 13. I sulked or refused to talk about an issue. 1 2 3 4 5 6 7 0
HCTS 14. My partner sulked or refused to talk about an issue. 1 2 3 4 5 6 7 0
HCTS 21. I threw or smashed or hit or kicked something. 1 2 3 4 5 6 7 0
HCTS 22. My partner threw or smashed or hit or kicked something. 1 2 3 4 5 6 7 0
8 items

Physical Assault
CTS2: 7. I threw something at my partner that could hurt. 1 2 3 4 5 6 7 0
HCTS 23. I threw something at my partner. 1 2 3 4 5 6 7 0
CTS2: 8. My partner did this to me. 1 2 3 4 5 6 7 0
HCTS 24. My partner did this to me. 1 2 3 4 5 6 7 0

CTS2: 17. I pushed or shoved my partner. 1 2 3 4 5 6 7 0
CTS2: 45. I grabbed my partner. 1 2 3 4 5 6 7 0
HCTS 25. I pushed, grabbed, or shoved my partner 1 2 3 4 5 6 7 0
CTS2: 46. My partner did this to me. 1 2 3 4 5 6 7 0
CTS2: 18. My partner did this to me. 1 2 3 4 5 6 7 0
HCTS 26. My partner did this to me. 1 2 3 4 5 6 7 0

CTS2: 53. I slapped my partner. 1 2 3 4 5 6 7 0
HCTS 27. I slapped my partner 1 2 3 4 5 6 7 0
CTS2: 54. My partner did this to me. 1 2 3 4 5 6 7 0
HCTS 28. My partner did this to me. 1 2 3 4 5 6 7 0

CTS2: 27. I punched or hit my partner with something that could hurt. 1 2 3 4 5 6 7 0
CTS2: 73. I kicked my partner. 1 2 3 4 5 6 7 0
HCTS 29. I kicked, bit, or hit my partner with a fist. 1 2 3 4 5 6 7 0
CTS2: 74. My partner did this to me. 1 2 3 4 5 6 7 0
CTS2: 28. My partner did this to me. 1 2 3 4 5 6 7 0
HCTS 30. My partner did this to me. 1 2 3 4 5 6 7 0

CTS2: 43. I beat up my partner. 1 2 3 4 5 6 7 0
HCTS 33. I beat my partner up. 1 2 3 4 5 6 7 0
CTS2: 44. My partner did this to me. 1 2 3 4 5 6 7 0
HCTS 34. My partner did this to me. 1 2 3 4 5 6 7 0

CTS2: 33. I choked my partner. 1 2 3 4 5 6 7 0
HCTS 35. I choked my partner. 1 2 3 4 5 6 7 0
CTS2: 34. My partner did this to me. 1 2 3 4 5 6 7 0
HCTS 36. My partner did this to me. 1 2 3 4 5 6 7 0

CTS2: 21. I used a knife or gun on my partner. 1 2 3 4 5 6 7 0
HCTS 39. I used a knife or a gun. 1 2 3 4 5 6 7 0
CTS2: 22. My partner did this to me. 1 2 3 4 5 6 7 0
HCTS 40. My partner did this to me 1 2 3 4 5 6 7 0

Omitted
CTS2: 37. I slammed my partner against a wall[a]. 1 2 3 4 5 6 7 0
CTS2: 38. My partner did this to me. 1 2 3 4 5 6 7 0
CTS2: 9. I twisted my partner's arm or hair. 1 2 3 4 5 6 7 0
CTS2: 10. My partner did this to me. 1 2 3 4 5 6 7 0
CTS2: 61. I burned or scalded my partner on purpose. 1 2 3 4 5 6 7 0
CTS2: 52. My partner did this to me. 1 2 3 4 5 6 7 0
HCTS 37. I threatened my partner with a knife or gun. 1 2 3 4 5 6 7 0
HCTS 38. My partner did this to me. 1 2 3 4 5 6 7 0
HCTS 31. I hit or tried to hit my partner with something. 1 2 3 4 5 6 7 0
HCTS 32. My partner did this to me. 1 2 3 4 5 6 7 0
14 items
Injury
CTS2: 71. I felt physical pain that still hurt the next day because of a fight with my partner. 1 2 3 4 5 6 7 0
HCTS 49. I felt physical pain that still hurt the next day because of a fight with my partner. 1 2 3 4 5 6 7 0

CTS2: 72. My partner still felt physical pain the next day because of a fight we had. 1 2 3 4 5 6 7 0
HCTS 50. My partner felt physical pain that still hurt the next day because of a fight with me. 1 2 3 4 5 6 7 0

CTS2: 11. I had a sprain, bruise, or small cut because of a fight with my partner. 1 2 3 4 5 6 7 0
HCTS 47. I had a sprain bruise, or small cut because of a fight with my partner. 1 2 3 4 5 6 7 0

CTS2: 12. My partner had a sprain, bruise, or small cut because of a fight with me. 1 2 3 4 5 6 7 0
HCTS 48. My partner had a sprain, bruise, or small cut because of a fight with me. 1 2 3 4 5 6 7 0

CTS2: 41. I needed to see a doctor because of a fight with my partner, but I didn't. 1 2 3 4 5 6 7 0
HCTS 53. I needed to see a doctor because of a fight with my partner but I didn't. 1 2 3 4 5 6 7 0

CTS2: 42. My partner needed to see a doctor because of a fight with me, but didn't. 1 2 3 4 5 6 7 0
HCTS 54. My partner needed to see a doctor because of a fight 1 2 3 4 5 6 7 0

with me, but didn't

CTS2: 23. I passed out from being hit on the head by my partner in a fight. 1 2 3 4 5 6 7 0
HCTS 51. I passed out from being hit on the head by my partner in a fight. 1 2 3 4 5 6 7 0

CTS2: 24. My partner passed out from being hit on the head in a fight with me. 1 2 3 4 5 6 7 0
HCTS 52. My partner passed out from being hit on the head by me in a fight. 1 2 3 4 5 6 7 0

CTS2: 31. I went to a doctor because of a fight with my partner. 1 2 3 4 5 6 7 0
HCTS 55. I went to a doctor because of a fight with my partner. 1 2 3 4 5 6 7 0
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CTS2: 32. My partner went to a doctor because of a fight with me. 1 2 3 4 5 6 7 0
HCTS 56. My partner went to a doctor because of a fight with me. 1 2 3 4 5 6 7 0

CTS2: 55. I had a broken bone from a fight with my partner. 1 2 3 4 5 6 7 0
HCTS 57. I had a broken bone from a fight with my partner. 1 2 3 4 5 6 7 0

CTS2: 56. My partner had a broken bone from a fight with me. 1 2 3 4 5 6 7 0
HCTS 58. My partner had a broken bone from a fight with me. 1 2 3 4 5 6 7 0
12 items – None omitted

Appendix B

Group Therapy Interaction Patterns (GTIP) Among Partner Violent Men

Coding System Training Manual

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OVERVIEW

The Group Intervention Project….

Standard interventions for intimate partner violence (IPV) offenders involve criminal justice sanctions and group therapy; however, research suggests these interventions have only limited effectiveness. This project takes a closer look at the role of certain group interactions during psychotherapy sessions. Specifically, we are interested in the impact of "counter-therapeutic talk". While similar projects have been conducted examining aggressive behavior in antisocial adolescents, this is the first study, to the best of our knowledge, to explore these processes in adult IPV perpetrators.

Counter-therapeutic talk (CT) refers to statements made during therapy sessions that support aggressive and antisocial behavior, encourage destructive relationship tactics, or promote hostile beliefs about women. Each of these categories of CT talk will be identified by coders during initial viewing of video-taped sessions (i.e., the "first pass"). During this first pass, episodes of CT talk will be identified and their intensity rated. The first pass will be traditionally conducted by graduate coders.

Group members' and therapists' responses to others' CT talk will be coded during a second review of the therapy sessions by trained undergraduate coders (i.e., the "second pass"). During this pass through the session recording, the group response to the CT events identified during the first pass will be rated further.

Four group sessions for each group will be coded. Two from the beginning and two from the end of group.

The data source….

Previously, group therapy sessions were video-recorded for two different research projects. The previously recorded video-tapes from both of these research projects will be used for the present study. The first project compared a supportive group therapy intervention to cognitive-behavioral group therapy. For the second project, all participants received the same manualized group intervention; however, participants received either a standard intake into to the program or a motivational enhancement intake.

For all of the groups that were video-recorded, the treatment they received was a 16-week group intervention, with two group therapists and each session lasting 2 hours. Most clients (roughly 80-90%) referred to treatment were court-ordered or presented to treatment with pending court-cases for violence against a romantic partner.

The Coders' responsibilities….

All the materials for the project are located in the research team's lab at UMBC. Your work will involve required weekly meetings with all undergrad coders and the principal investigators. The purpose of this meeting is for training, maintaining reliability, and maintaining adherence to the coding manual. Additionally, you will be required to attend periodic meetings with the larger group of undergraduates and Dr. Murphy. The rest of your time would be devoted to reviewing and coding group session tapes, individual supervision of your coding, and related data management tasks.

Through this project you'll be exposed to the practice of conducting cognitive-behavioral group therapy sessions, a wide variety of therapist techniques, and positive and negative patterns of group interaction among partner-violent men.

The training process….

Training will consist of multiple phases. Initial training will involve direct instruction through review of the training manual and examples of previously coded interactions. Secondly, coders will code previously scored practice tapes and each coder's ratings will be compared with the previously generated rating key. Group meetings will be devoted to reviewing practice tapes and discussing coding. Each coder's ratings will be evaluated until a minimal reliability rating is reached (kappa of at least .60). Those coders with kappas at or above .60 on this tape may begin coding for the study.

As the training process can be extensive, we are eager to extend invitations for coders who attain minimal reliability ratings to continue on the project beyond the fall semester and to gain additional experience. This can be negotiated throughout the semester.

At the same time, it is possible that some individuals may not be capable of reaching reliability cutoffs. If this occurs, these individuals will be assigned different duties for the Group Therapy Interactions Patterns (GTIP) Project or may transfer to a different project in Dr. Chris Murphy's lab, depending upon lab needs.

CODING INSTRUCTIONS FOR FIRST PASS: IDENTIFYING CT EVENTS

Purpose of this Pass:

➢ To identify episodes of Counter-therapeutic Talk (CT Events) for coding during Pass 2 and conduct global ratings of individual behavior and group interactions.

Materials: You will need the following materials when coding…

1. A video from an un-coded group therapy session
2. Forms: Session Map, CT Events
3. Data tracking form to keep track of which tapes you have coded

Coding Steps

1. Fill out Form identifiers in the header and footer (date coded, coder, session number, group number, etc)
2. Fill out the Session Map form with identifiers as a short-hand for identifying group members
    a. Label each group member in the room with an identifier that can be used to keep the participants straight for coding during this and the second pass
    b. Examples: “black hat”, “blonde hair”, “green jacket”, etc.
    c. Write these on the group map
    d. This will be done by graduate student and advanced coders only
3. Code CT Talk Events
    a. View the tape from 15 minutes until one hour and 15 minutes into the session, identifying CT talk episodes, their type/category, and their intensity
    b. Each event for a session is recorded on the same form and in the order it occurred
    c. Record time of the event
    d. Transcribe the verbalization that begins the event
    e. Transcribe verbalizations at the end of the event
4. Record on tracking sheet what you coded
5. File completed forms

Instructions

1. **Identifying the end of a CT event…**
    a. When the group conversation shifts away from the specific CT comments the speaker made, the event ends
    a. For an event to end, the focus of the entire group must shift (not just the therapists') to either a different topic or to a different speaker
    b. Events can end quickly, like when a therapist changes the subject and the group follows this new line of topic, or may take longer as group members make comments about the speaker's talk
    c. The comment made directly before the group focus shifts mark the end of the event
    d. Events may overlap: See below for description of overlapping events
2. **If you can't hear what's being said on the video…**
    a. Keep rewinding and turning it up until you hear what they are saying.
    b. If you still cannot be certain of what is said, consult with the principal investigators and review it with one of them. You need to understand what's being said to identify all events that can be coded.
    c. Ultimately, if neither you nor those you consult with can understand what is being said, that verbalization cannot be coded as an event.
3. **Terminology: For ease of explanation the following short-hand will be used throughout the manual:**
    a. An individual who says a counter-therapeutic comment beginning a CT event = speaker
    b. An individual who responds to what the CT speaker said = responder

Coding Counter-Therapeutic Talk

Counter-therapeutic talk (CT Talk): treatment interfering behavior or comments falling into 6 categories – coded using CT Events form

- When determining whether or not to code a statement, ask yourself: Is this counter-therapeutic (against the goals of treatment – supporting behavior or attitudes that are resistant, illegal, aggressive, destructive to one's relationship, hostile towards women, or aggressive towards women).
- If so, then determine which category it falls into
- It must be both counter-therapeutic AND fit into a category.

Hierarchy:

- ➢ If an event meets criteria for multiple types of CT talk, first double-check that the speaker's comments constitute a single event rather than 2 events (consult a study investigator if you are uncertain).
- ➢ If it is truly a single event and can still be coded as more than one type of CT talk, code the type of talk that is the most counter-therapeutic – that is, the most directly counter the target of treatment (i.e., reducing physical and emotional abuse in intimate relationships).
- ➢ Order from least to most counter-therapeutic:

1. Hostile Resistance to Treatment
2. Illegal activities
3. Aggressive
4. Destructive Relationship
5. Hostile Talk About Women
6. Physical Aggression Toward Women

Endorsement:

- ➢ In order for an event to be coded as counter-therapeutic, the speakers must believe their counter-therapeutic attitudes or think their counter-therapeutic behaviors were justified or right.
- ➢ The speaker is NOT endorsing the behavior if he states he doesn't feel that way anymore or if he states he would not act on his CT thoughts – when in doubt if he is endorsing the counter-therapeutic beliefs, code it as if he is.
- ➢ When in doubt if he is endorsing his previous behaviors that were counter-therapeutic:
  - If he is relaying the events of what brought him to the center in a direct manner, without placing blame or justifying his behavior, it is NOT counter-therapeutic.
  - If he justifies his behavior, rationalizes his behavior, or blames his partner for his behavior, it IS counter-therapeutic

- E.g.: "My wife hit me and I hit her back." – NOT counter-therapeutic; direct relaying of events
- E.g., "My wife hit me and I defended myself." – justifying his behavior: counter-therapeutic
- E.g., "My wife hit me first so I just pushed her back." – justifying his behavior and blaming his partner: counter-therapeutic

Six Types of CT Talk

1. **Hostile Resistance to Treatment:**
   - Belittling, undermining, or otherwise negative comments about treatment or specific interventions (e.g., This will never work for me. It's a waste of time.) If the client says an intervention will not work for him, code it as resistant.
   - Belittling, undermining, or otherwise negative comments about their or others change
   - Verbal denial of a need to change behavior in romantic relationships
   - Arguing with or challenging the therapist - contesting their accuracy, expertise or integrity – intent is to challenge or undermine the therapist's authority
   - Contesting the integrity of the treatment agency as a whole
   - Interrupting, insulting, or maliciously making fun of the therapist (do not code if it is clearly a good natured joke shared with the therapist and not clearly harmful to the therapeutic alliance)
   - Resisting or refusing treatment or therapeutic suggestions
   - Falling asleep in group (indicates a disinterest in treatment and undermining its value or importance – if not accompanied by verbally resistant statements, score the strength as a 1, initially, as the reasons he's falling asleep are unknown, he may not necessarily think treatment is a waste of time; if he continues to fall asleep without explanation and after re-direction by the group, increase the strength score)

➢ **Examples:**
- "Counseling is a waste of time."
- "I took time outs when I was five. That will never work."
- "What do you know (to therapist)? Do you have kids?"

2. **Illegal activities**
   - Favorable talk endorsing drug-use, non-violent illegal activities, criminal lifestyle, getting into trouble with the law, or other illegal activities
   - Talk is not about violent crime or acts toward a former or current romantic partner

- Speaker must be endorsing the behavior, so do not code if he "spoils" the response with a "But" Statement that indicates he does not endorse the behavior (see example below)

➢ **Examples:**

- "Pot helps me relax. It's not like I use it every day."
- "Drinking doesn't affect my driving. I don't know what the big deal is."
- "Yeah, I've had a run in or two with the cops. We had some good times back then."
- "Dealing isn't such a bad thing. I make more money than working in a factory. I can live the lifestyle I want."

➢ **Non-Examples**

- "Pot helps me relax, but I know I need to find a healthier way to calm down."

3. Aggressive

- Favorable talk about aggressive behavior, including child abuse, violence to animals, violent crime, general violence, getting into trouble with the law for violence, and desires to behaviorally aggress against another
- Speaker must be endorsing the behavior – the speaker is NOT endorsing the behavior if he states he doesn't feel that way anymore or if he states he would not act on his aggressive thoughts
- To code child abuse as endorsement of aggressive behavior, it must meet the definition of child abuse in that the behavior they are endorsing would leave a mark or a bruise or is excessive – spanking that does not leave a mark or a bruise is not considered abusive parenting
- Jokes about violent behavior are coded – score their strength one point lower than the content would indicate due to the fact they are joking
- If aggression is towards any woman, code as physical aggression towards women

➢ **Examples:**

- "When I was a kid, my dad would use the belt if I got out of line. Kids have no respect these days."
- "Let's punch him and see what happens." (joking)
- "I teach my kids to fight back. I don't want people thinking they are weak."
- "I need to let people know I am in charge. If I fight and win then I get more respect. I like that."

➢ **Non-Examples**

- "I don't see any problem with spanking my children."

4. Destructive Relationship Talk:

➢ Always check first to make sure the statement does not meet criteria for hostile talk about women

➢ Definition includes two components

A. <u>Destructive Behaviors:</u>

- Favorable talk about behavior in a current or former romantic relationship (participant may be talking about his own relationship or someone else's) that would be clearly harmful to the relationship or emotionally abusive.
- If they verbally minimize or justify behavior that is clearly destructive to the relationship, this is also considered favorable talk about destructive relationship behavior.
  - i.e., use words like "I just called her an f-ing bitch" or "I don't see what the big deal is," "I had to cuss her out or she'd never stop" "I cussed her out because she cussed me out first"
- Behaviors that are destructive to one's relationship include but are not limited to
  - cheating, being manipulative, being dishonest,
  - controlling behavior
  - stomping out of the room house or yard in the middle of an argument
  - refusing to talk to your partner about her relationship concerns
  - looking through her things without her permission
  - Yelling, shouting at, or swearing at your partner
  - Insulting her (e.g., name-calling)
  - Criticizing her appearance
  - Accusing the other of being a lousy lover
  - Doing something spiteful
  - Destroying something belonging to your partner
  - Checking up on your partner
  - Saying or implying she is stupid
  - Laughing at one's partner or dismissing her concerns and feelings in the middle of an argument
  - Passive behavior
  - Etc...

B. <u>Destructive Attitudes:</u>

- Favorable talk about beliefs about relationships or women in general that would clearly be harmful to the relationship or emotionally abusive. ONLY the following attitudes will be coded:
  - Belittling and negative statements about one's current partner, former partner, or groups of women that do not meet criteria for hostile talk about women
  - Explicit blame of relationship problems or arguments primarily on their partner's behaviors (if he blames her for being physically abusive, code that as Physical Aggression Towards Women)
  - Statements that insult or put-down the character of one's current or former relationship partner that are not severe enough to be coded as hostile talk about women
  - Stating beliefs that one's or someone else's romantic partner's intentions are insidious or hostile
- For Destructive Attitudes, the participant may be talking about his relationship or someone else's, as long as it reflects a destructive attitude about romantic relationships or women
- Whether or not a particular belief is "destructive" to a romantic relationship can be highly subject to one's personal beliefs on relationships. In turn, we will consider only attitudes that fall into the above categories and when in doubt, do NOT code it.

➢ If the counter-therapeutic talk can be coded as both a destructive attitude and a destructive behavior:

- Destructive behavior reported by participants provides a more direct example of the ways in which participants have negatively impacted the functioning of their relationships. How an attitude will directly impact one's relationship can sometimes be less clear.
- In turn, if the CT talk can legitimately be coded as BOTH an attitude and a behavior, code it as a behavior

➢ **Examples:**

- Behaviors**:**
  - If that happened to me, I'd just stop talking to her.
  - We got into an argument at a restaurant, so I just took the car and left her there.
  - Sometimes I just don't tell my wife who I am with. She gets jealous to easily. Keeping her in the dark makes things easier.
- Attitudes:
  - All women say they want to be independent, but when it comes down to it, they are all dependent on men.

- She's evil.
- You can never trust a woman.
- What she doesn't know about can't hurt her.
- Its like you can be down, two breaths left in your body, she'll step on your hand just to see if you still can breathe.

5. Hostile Talk About Women

➢ Definition includes three components:

A. Hostile Attitudes:

- Comments indicating contempt, animosity, deep-seated ill will, or hatred towards a woman or women in general
  - This includes humiliating, degrading, contemptuous, and/or domineering comments about one's romantic partner or women in general.
  - Does not have to refer to a romantic partner
- If uncertain if comment is offensive or belittling "enough," code as destructive relationship talk

➢ **Examples:**

- She's such a bitch. It would be a happy day if I never saw her again
- She's dumb as a box of rocks
- All women are good for is cooking and cleaning
- Julie is such a moron that she…
- That social worker. Wow, she's a bitch.

➢ **Non-examples:**

- She's a liar (insulting, but not humiliating or degrading; code as destructive relationship if he's referring to a romantic partner)

B. Hostile Behavior:

- Endorsing confrontational behavior towards a partner that is intimidating, domineering, degrading, or antagonistic behavior (egging her on, picking a fight intentionally) towards one's partner or women in general
- Threatening behaviors that do not involve the threat of physical violence (if physical violence is clearly threatened, code as physical violence towards women)

➢ **Examples**

- I told her that she can't do the check book because she's just not smart enough.
- Sometimes when I have a bad day at work I pick a fight with my wife when I get home. It makes me feel better.
- If she did that to me, the argument would be on. I wouldn't stand for that!
- Oh, I'd get her back.
- We started arguing and I got up in her face. (intimidating)
- Sometimes I get so angry when we argue that I've punched walls before.
- I slammed the door in her face.

C. Inappropriate sexual comments:

- Sexually inappropriate behavior or comments towards female co-leader that are unnecessary or inappropriate for the topic of discussion
- Sexually explicit comments about one's romantic partner or all women in general that are irrelevant or inappropriate for the topic of discussion

➢ **Examples**

- (Client has been looking for a job and is sharing news during "check in"): Yep, I got an interview this week, which both me and my wife were pleased about. The interview was tough. The woman who interviewed me had a great rack. I think it went okay.
- Client to therapist, "You look nice in that dress. I love a woman in a dress."
- If she isn't willing to satisfy me then there is no problem with me getting my needs met somewhere else. (inappropriate sexual comment and threatening)

➢ **Non-examples:**

- A big issue with my partner is that I want to try new things in bed and she doesn't.
- My wife just doesn't want sex and that causes arguments.

➢ If the counter-therapeutic talk can be coded as both a hostile attitude and a hostile behavior:

D. Hostile behavior reported by participants provides a more direct example of how participants may have negatively impacted the functioning of their relationships. Whereas, how attitudes will directly impact one's relationship can be less clear.
E. In turn, if the CT talk can legitimately be coded as BOTH an attitude and a behavior, code it as a behavior

6. Physical Aggression Towards Women (Applies to Male-to-Female Aggression)

- Aggressive or violent talk about any women, with NO remorse verbalized
- Endorsing his or other's aggressive behavior
- Justifying, excusing, minimizing violent behavior
- When clients are clearly simultaneously discussing physical and emotional abuse, code with the more extreme code (i.e., physical aggression towards women)
- Included in this category is forced sex or rape

➢ **Examples:**

- "I don't blame you for grabbing her!"
- "Some women want you to hit them."
- "So, you pushed her? Sounds like she deserved it."
- "Sometimes that's all you can do to end the argument. She's so out of control you just grab her to stop it."

➢ **Non-Examples:**

- "I'm not proud of it, but I did shove her back."

Intensity Ratings

➢ CT talk is coded for the strength of the statement made on a 5 point scale ranging from 1 = A Little to 5 = Extremely
  - 1 = A Little; 2 = Somewhat; 3 = Moderately; 4 = Very; 5 = Extremely

➢ If the speakers comment is made as a joke, assess the severity of the event based solely on its content, then code the event one point lower (e.g., if the severity of event, based solely on its content would be scored as a 5, code the event as 4 if he is clearly trying to crack a joke)

➢ When deciding on an intensity rating, consider the strength their comment for the category of interest. For example, for resistant talk, assess severity based on how resistant they are; for destructive relationship, assess severity based on how destructive to their relationship their beliefs or behaviors would be, for physical aggression, assess severity based on how physically aggressive they are.

- ➢ When assigning a score, start by asking yourself, is this statement moderately (3) _____ (insert kind of CT talk)? If not, is it weaker or stronger? Is it a lot or a little stronger/weaker?
- ➢ Examples:
  - Resistance
    - Therapist: "Will you do a role play John?"
      - 5 = John: "No. It's an absolute a waste of time! I'm never going to change how I do things anyway."
      - 4 = John: "No." (no explanation and he does not participate)
      - 3 = John: "I'd really rather not" (moderately resistant; no out right refusal or belittling the intervention)
      - 2 = John: "No, not this week, it makes me nervous in front of all of these people, maybe next week" (left open the possibility he may do it)
      - 1 = John: "Do I have to?" (ultimately participates)

Overlapping Events

1. An overlapping event occurs during a CT event when a supportive responder's comments can also be coded as counter-therapeutic talk
   a. In order to be coded as a separate and overlapping event, the responder's comments must be able to be coded as counter-therapeutic talk, independently – that is, ignoring the initial CT speaker's comments, the responder's comments would still be coded as CT talk.
   b. A responders comments are NOT a new event when:
      i. The responder just agrees with the speaker without repeating the actual CT talk, no matter how strong the agreement
      ii. A responder does not endorse what the CT speaker said, for example, he just asks the speaker to clarify his statement
2. Common examples include when a responder endorses and repeats what the initial CT speaker said, adds new meaning to the original speaker's comments, or shares a personal example that supports the initial CT speaker's comments.
3. Ending overlapping events
   a. Double check that the events truly overlap – that is, that the groups focus doesn't shift entirely to the new CT speaker or a new topic – if this happens and the group never returns to the original comment made by the CT speaker, then the first event ends when the second begins
   b. Both the original and the overlapping events may end at the same time or separately.
4. See Group responses for instructions in coding responses to overlapping events

- **Examples:**
  - Original CT Event: "You can't just call the police when your girlfriend gets violent. You wind up having to

fight her just get to the phone." (Physical aggression towards women = 6)

- Overlapping CT Event: "Yea. Once my girlfriend and I got into it and I had to hold her down just to reach the receiver" (Physical aggression towards women = 6)
- Overlapping CT Event: "Yea. You had no choice. You had to fight her." (Physical aggression towards women = 6)

- Original CT Event: "Women are difficult to deal with. They say they want independence, but they constantly act dependent on men." (Blanket negative statement about all women; Destructive Relationship Talk = 4A)
- Overlapping CT Event: "Yea. They never carry their own weight in relationships. I get tired of them not picking up their end of things" (Blanket negative statement about all women; Destructive Relationship Talk = 4A)
- Overlapping CT Event: "Yea. They are dependent! My girl's always asking me to get that for her, pick that up, reach this for her."
- Overlapping CT Event: "Yeah. Women DO say they want independence, but constantly act dependent!"

- **Non-examples**
  - Original CT Event: "You can't just call the police when your girlfriend gets violent. You have to fight to just get to the phone" (Physical aggression towards women = 6)
  - Non-example: "You're absolutely right! That's the way it really is!" (no CT talk)
  - Non-example: "Yea. I've been there before." (no CT talk)
  - Non-example: "Yea. That's happened to me too!" (no CT talk)
  - Non-example: "Yea. I've been there on a couple of occasions" (no CT talk)
  - Non-example: "You have to fight her to reach the phone?" (clarifying question, no endorsement)
  - Non-example: "Yea. When my girlfriend gets violent it's really hard to get to the phone." (not counter-therapeutic, no endorsement of physical violence against one's partner)

CODING INSTRUCTIONS FOR SECOND PASS: CODING RESPONSES TO CT EVENTS

Purpose of this Pass:

➢ To identify responses to CT Events. This involves coding the group's responses for each CT Event identified in Pass 1 coding.

Materials: You will need the following materials when coding…

1. A video that has been previously coded for CT events
2. Completed Pass 1 Forms:
3. Group Map for session you are coding, completed during Pass 1 (has additional nicknames for group members)
4. Blank Pass 2 Forms: you will need one for each event identified on the CT events form (e.g., 12 events identified in the tape during pass one means you need 12 forms)
5. Data tracking form: to record what you coded

Coding Steps

1. Fill out form identifiers: in the header and footer of each Pass 2 form (date coded, coder, session number, group number, Event number, etc)
2. Identify group members:
    a. Use Group Map to familiarize yourself with who is who in the group room so you can identify speakers quickly
    b. Group members may come in late and sometimes leave for a break during the group – so make sure you stay certain of who is in the room at any given time. Rewind, fast forward, or watch as much of the tape as you need to do to be certain.
3. Fast forward to first CT Event:
    c. Code entire group response (described below)
4. Fast forward to each subsequent CT Event:
    d. Code entire group response (described below)
5. Record on tracking sheet what you coded and file completed forms

Instructions

1. If you can't hear what's being said on the video…
    a. Keep rewinding and turning it up until you hear what they are saying.
    b. If you still cannot be certain of what is said, notify your supervisor and review it with her. You need to understand what's being said to identify all events that can be coded.
    c. Ultimately, if neither you nor your supervisor can understand what is being said, that verbalization cannot be coded.
2. When possible, do not code both early and late session sessions for any single group

a. For example, if you code session 2 for group A, you may also code session 4, but when possible do not code sessions from the end of that group (session 14 & 16)
b. Or, alternately, if you code session 16 from group B, you may also code session 14, but when possible, do not code sessions from the beginning of that group (session 2 and 4)

Coding Group Response:

➢ The following things are coded
1. Global group response: Consistency of group members responses to the speakers CT talk (the global degree to which group members are supportive, non-supportive, or mixed in their responses)
2. Strength of the supportive group responses; strength of the non-supportive group responses
3. Number of people whose responses are:
   - Supportive of the speaker's comments,
   - Non-supportive of the speaker's comments, and
   - Who do not respond AT ALL or their statements are neither supportive or non-supportive
   - The number of responders who you cannot see or hear to code their responses.
   - See Pass 2 form.

Coding the Global Group Response…

➢ This code is intended to encapsulate how the group as a whole responds to the event – that is, to what degree the group-as-a-whole is supportive, non-supportive, or mixed in their response to the counter-therapeutic talk

➢ Coded on a 5-point Likert scale
- **1 =** **Non-Supportive Response:** Group members' response is entirely non-supportive of the speaker's CT comments
  That is: Most of the responders (more than half) you can see non-verbally (shake their heads) or verbally disagree with the speaker's comments the rest of the group members either do not respond or their responses are neutral
  Code is intended to capture when the response by the group as a whole is entirely non-supportive
- **2 =** **Predominately Non-Supportive Response:** Group members response is mixed with people being both supportive and non-

supportive, but the non-supportive comments are more predominant

Example: laughter from a few (1 OR 2) group members with specific verbalization of non-support from other group members

- **3 =** **Mixed Response:** Group members' response contains relatively equal parts of supportive and non-supportive reactions
  Example: specific verbalization of support and non-support from relatively equal numbers of group members
- **4 =** **Predominately Supportive Response:** Group members response is mixed with people being both supportive and non-supportive, but the supportive comments are more predominant
  Example: laughter and supportive comments from most group members with a few small comments of non-support made OR laughter from multiple group members with no specific verbalization of support or non-support
- **5 =** **Supportive Response:** Group members' response is entirely supportive of the speaker's initial CT comments
  That is: Most of the responders (more than half) you can see laugh or make verbally supportive comments the rest of the group members either do not respond or their responses are neutral
  Code is intended to capture when the response by the group as a whole is entirely supportive

- **Examples:**
  1. If 4 people snicker (supportive response) and two people are very vocally non-supportive (e.g., disagree directly with the speaker and his ideas) this would be coded as a 2 – the non-supportive speakers are more vocal and sway the general group response in the direction of non-supportive
  2. If the majority of visible responders (e.g., 3 of 4 group members) laugh (supportive response), and other group members respond neutrally, this would be coded as a 5

Special Issues…

➢ Coding responses to overlapping events:
- During the time that the events overlap, if a responder is supportive of one CT speaker, he is supportive of the other(s)
- Alternatively, if the responder is non-supportive of one CT speaker, he is non-supportive of the other(s)

➢ If you cannot fully see a responder
- Attempt to identify who is giving all verbal responses:
- If a verbal response comes from someone off camera or someone who has his back to the camera and that person makes no other responses that can be coded, consider the verbalized response that person's only response.
- If you cannot clearly determine whether laughter is coming from an off-camera "can't see" responder, a therapist, or the CT speaker himself, DO NOT code that laughter
- When in doubt that an individual is responding non-verbally as you cannot fully see him, do NOT code him as responding
- When someone does not verbally or non-verbally respond to the CT talk, but you can see his facial expressions for the majority of the time (more than 50%), code him as an "other" responder. Otherwise, code him as "can't see"
- Anytime you can see a responder's face in the one-way mirror, count him as someone you can see, given the assumption that if he were to respond, you would likely see it in the mirror's reflection

What counts as a supportive or non-supportive response?

1. **Supportive Responses:**
   a. **Laughter:**
      - Positive affective reactions, including laughter, and obvious nonverbal affective endorsements like thumbs up and discernable smiles that are in response to the CT statement
   b. **Agreement:**
      - Clear discernible nods following a speaker's CT talk, verbal agreement by other group members, other group member expands upon or intensifies negative comment
   c. **Reflections**
      i. Group member reflects the speaker's comments
      ii. Reflection can be clearly supportive or just a neutral rephrase or re-iteration of the speaker's CT statement
   d. **Attention:**
      - Positive or joking comments about the speaker himself or about what he said. These comments are not:
        - disparaging or belittling
        - disapproving
        - critical

2. **Non-Supportive Response**
   a. **Disagreement:**
      - Open disagreement by a group member with the speakers comments

- Includes non-verbal disagreement such as head shaking or agreement with non-supportive responders

b. Disapproval

- Disapproving, disparaging, berating, or critical comments about what the speaker said or the speaker himself

3. Mixed

a. Response contains both supportive and non-supportive components, e.g., the responder initially laughs, then later says he disagrees with something the CT speaker said

b. Supportive or non-supportive response contains a "spoiler": i.e., "You have a point there, BUT…." Or "I disagree with you, BUT…"

- The BUT spoils it from being a purely supportive or non-supportive response

To determine the general group response as well as the strength of the supportive and non-supportive comments:

1. Transcribe the entirety of what each group member says during the event and their non-verbal responses (e.g., nods)
2. For each group member, determine which parts of their transcription are supportive, non-supportive, or neutral for everything that is said and all non-verbal responses
3. Score overall Group Response (see below for further instructions)
4. Review supportive responses by all group members to determine the overall strength of the supportive comments made (see below for further instructions)
5. Review non-supportive responses by all group members to determine the overall strength of the non-supportive comments made (see below for further instructions)

Neutral responses

- Group members will make comments that are neither supportive nor non-supportive of CT talk in that the comments are unrelated to the CT talk, don't specifically address what the CT speaker said, or don't address the general topic
- Ultimately, we are interested in the function of group responses on the CT speaker. If a neutral comment is made, theoretically, the CT speaker will view that response as neither supportive or non-supportive of what they just said.
- When uncertain if a group members' response is related to the CT talk and should be considered as either supportive or non-supportive, consider the following:

3. Try to draw a connection between the questionable comment and either (1) the content of the CT talk or (2) the underlying reason the CT talk is counter-therapeutic (as specified in the Pass 1 form; e.g., partner blame)

4. If no connection can be made, try to trace the comment back to the CT talk through other group members' responses; that is, is the comment supportive or non-supportive of another group member/therapist who was supportive or non-supportive of the CT talk?
5. If these connections (1. or 2.) cannot be made, then the comment is neutral
6. If still uncertain, consult a supervisor
7. If all of the above fails to clarify, assume its neutral

- Examples: For the following examples, imagine the participant says that "when men are physically violent, most of the time their partner provokes them into it in some way." Responder then says:
    8. "I don't know if I agree or disagree with that." (neutral)
    9. "Cliff's not a bad person for thinking that." (Doesn't address CT talk)
    10. "What did you say?" (if responder truly didn't hear)
    11. "I had an argument with my wife, Gia, last night." (Doesn't address CT talk)

Intensity Ratings

➢ Strength of the response made by the group is coded using 2 Likert scales, ranging from
1. 1 = Very Weak
2. 2 = Weak
3. 3 = Moderate/Average
4. 4 = Strong
5. 5 = Extreme

➢ If a supportive response consists of laughter only with no explicit verbalization of support, code as a 4 or lower depending on volume and length of laughter

➢ **<u>When assigning a score, start by asking yourself; is this a moderately supportive/non-supportive (3) response? If not, is it weaker or stronger? Is it a lot or a little stronger/weaker?</u>**

➢ **<u>Below are some examples, but ultimately rely on the above rule of thumb.</u>**

➢ **Examples of supportive responses:**
1. slight giggle or chuckle
   Nods directly after response (the nod is clearly a supportive response to the statement made)
2. brief laughter and group moves on
   "I guess you've got a point."
   <u>Reflections: A brief simple reflection with no endorsement</u>
3. laughter
   "You've got a point." (Tone: matter-of-fact)

"I'd agree with that." (Tone: matter-of-fact)
Reflections: A simple reflection with endorsement (e.g., I see your point) – endorsement can be implied
Responder provides examples: An example with mild or implied agreement/endorsement: "That's happened to me." "I did that too."

4. loud brief burst of laughter and group moves on
"You're absolutely right about that." (Tone: matter-of-fact)
"Yeah it is."
Reflections: A simple reflection with strong endorsement (e.g., you're right)
Examples: An example with strong endorsement (e.g., you're right. That happened to me too.)
5. loud extended laughter
"You're absolutely right about that!" (Emphatically)
Reflections: Simple reflection with emphatic endorsement (e.g., your absolutely right)
Amplifies CT talk that also goes beyond just giving a personal example (i.e., responder expresses and endorses a similar counter-therapeutic view that is actually more extreme than was originally said and states or implies that it CT talk applies across multiple situations, not just his)

➢ **Examples of non-supportive responses**
- When participants do not support other group members CT talk, the tone used by responder is less useful as frequently, non-supportive statements are made in matter of fact tone. In turn, an emphatic statement of disagreement is not necessary to receive a high strength score. Instead, focus on the content of what the responder says. If he directly disagrees with what the speaker said, even if said in a matter of fact tone, score this as a "5"
- For the following examples, imagine the participant says that "When men are physically violent, most of the time their partner provokes them into it in some way." Responder then says:

1. Nods in agreement with someone who makes a verbal statement of non-support
2. Are there other options to violence, though? (doesn't take issue with his blanket negative statement about all women, makes it into a question rather than opposing his opinion more directly)
3. I think you do everything you can to try to keep from retaliating (doesn't take a real stand)
I don't know about that (Doesn't take a real stand)
4. I don't know about that. I think you do everything you can to try to keep from retaliating. (Has both a statement that is non-supportive and an alternative behavior that's contrary to the belief that its okay to be violent

if provoked; disagreement still indirect, but the combination of statements leads to a more of a stand than a moderate response)
But if that were true, wouldn't you be saying that none of the fights I'd had with my wife would have been my fault? (Clearly non-supportive, but indirect;
Personalized examples that are contrary to the counter-therapeutic talk, with indirect disagreement)
"But, I don't act on that provocation." (Clearly non-supportive of justifying violence through saying she provoked it, but indirect in that he only applies it to himself
5. "But we're supposed to not act on that provocation and instead find some other non-violent way of dealing with our anger." (long, clear explanation of why he's wrong in justifying his violent behavior through saying she provoked him; disagreement with the justification is direct)
"I think you're completely wrong." (Clear direct disagreement)
"I completely disagree." (Clear direct disagreement)
"My partner has never provoked me into it. If I hit her, that's my responsibility." (Clear direct disagreement)

➢ One Likert scale is used to code only the supportive comments made and the other is for coding only the non-supportive comments made – ignore responses that are neutral or those who do not respond at all

➢ For group members that provide mixed responses code the portion of their response that was supportive with the strength of supportive comments made (ignoring their non-supportive comments) – and code the portion of their response that was non-supportive with the strength of the non-supportive comments made (ignoring their supportive comments)

- If the responder begins with a very brief few words to "soften the blow" of their statement and these words do not contain any strong content, do no code it as mixed.
- Example: "Yeah but, I think you're wrong" = non-supportive
- If uncertain if the beginning comment is "enough" to make the response mixed – consult your supervisor

Count of Responders …

1. Record number of group members that…
   - Respond with support to the speakers comment (i.e., agree verbally, nod in agreement, etc.)
   - Respond non-supportively to the speakers comment (i.e., disagree verbally, shake their heads, etc.)

    - Respond with mixed feedback to the speakers comment (for example, agree or disagree with speaker but spoil the comment with a “but” statement)
    - You cannot see respond (i.e., they are off the screen, or after several attempts you cannot understand what was said)
    - Are “other responders” this includes those who do not respond at all and those who respond neutrally
2. Include id numbers beside the number of various responders to indicate who did what
3. Total up the number of people you counted for the above categories. It should equal the number of people present for group on that day. Take care that no group member is counted twice.

Pass 1: CT Talk Events:

➔ For Category Enter Appropriate Number:

1 = Resistant **3 =** Aggressive **5 = (A, B, or S)** Hostile Talk About Women (Attitudes = A; Behaviors = B; Sexually Inappropriate = S)

2 = Illegal **4 = (A or B)** Destructive Relationship **6 =** Aggression Towards Women (Attitudes = A; Behaviors = B)

➔ For Strength enter the appropriate number: 1 A Little 2 3 Moderately 4 5 Extremely

➔ Indicate an overlapping event with an "**O**" after the Category code (e.g., **1/O** or **4A/O**)

Event#	Time	ID	Begins with (verbatim)	Ends with (verbatim)	Category	Strength
1						
2						
3						
4						

Appendix B.2

Pass 2: Group Responses to CT Talk

1. Group Response:

Non-Supportive				Supportive	
1	2	3	4	5	NA
Entirely Non-supportive		MIXED		Entirely Supportive	No Response

2. Strength of Supportive Responders Statements (based solely on supportive speakers' behaviors)

1	2	3	4	5	NA
Weak		Moderate		Extreme	

3. Strength of Non-supportive Responders Statements (based solely on non-supportive speakers' behaviors)

1	2	3	4	5	NA
Weak		Moderate		Extreme	

Notes:

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Appendix C

MANUAL FOR

THE CHECK LIST OF INTERPERSONAL TRANSACTIONS-REVISED (CLOIT-R)

and

THE CHECK LIST OF PSYCHOTHERAPY TRANSACTIONS-REVISED (CLOPT-R)

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Manual for
The Checklist of Interpersonal Transactions-Revised (CLOIT-R)
and
The Checklist of Psychotherapy Transactions-Revised (CLOPT-R)

The Check List of Interpersonal Transactions (CLOIT) and its companion versions, the Check List of Psychotherapy Transactions (CLOPT), were constructed by Kiesler (1984, 1987b) to measure the interpersonal behavior of target persons on dimensions corresponding to the 16 categories of the 1982 Interpersonal Circle (Kiesler, 1983, 1985).

The 1982 Interpersonal Circle was constructed as a comprehensive taxonomy of the domain of two-dimensional interpersonal behavior by integrating and expanding the content of four major adult interpersonal measures: the Interpersonal Check List (ICL; LaForge and Suczek, 1955; Leary, 1957), the Interpersonal Behavior Inventory (IBI; Lorr and McNair, 1965, 1967), the Interpersonal Adjective Scales (IAS; Wiggins, 1979, 1981), and the Impact Message Inventory (IMI; Kiesler, Anchin, Perkins, Chirico, Kyle and Federman, 1985; Kiesler, 1987a). The sixteen 1982 interpersonal categories--labeled A to P counterclockwise around the circumference of the Circle--are: DOMinant, COMpetitive, MIStrusting, COLd, HOStile, DETached, INHibited, UNAssured, SUBmissive, DEFerent, TRUsting, WARm, FRIendly, SOCiable, EXHibitionistic, and ASSured.

CLOIT and CLOPT are rationally, in contrast to empirically, derived inventories that have identical item content. CLOPT items were derived systematically from the 1982 Circle taxonomy (Kiesler, 1983, 1985) to characterize the interpersonal behaviors of either patient or therapist in the individual psychotherapy context through use of observer ratings. CLOPT items were then translated into CLOIT form to characterize the interpersonal behaviors of dyadic interactants as perceived and rated by each, or self-reported by each.

Each check list consists of the same 96 items descriptive of overt interpersonal behaviors that are checked as present or absent by the subject, interactant, or observer. The inventory is available in five versions: three forms of CLOIT and two forms of CLOPT. The CLOIT: Self-Report version is used by subjects to describe their own typical behaviors with others. The CLOIT: Transactant version is used in the situation in which one interactant (respondent) rates the interpersonal behavior of another interactant (target person) within the context of their previous interactions. The CLOIT: Observer version is used by external observers to rate the behavior of interactants after observation of their live or transcribed transactions. The CLOPT is available in two versions for observer ratings of live or videotaped samples of psychotherapy sessions, with either the patient (CLOPT: Client Form) or the therapist (CLOPT: Therapist Form) as the target person.

All five versions have identical item content and differ only in (a) pronoun form to match the appropriate context and (b) the sentence stem listed at the top of the inventory pages --CLOIT: Self-Report Form: "When with others, I. . ."; CLOIT: Transactant Form: "When in my company, this person. . ."; CLOIT: Observer Form: "When with this interactant, person A. . ."; CLOPT: Client Form: "When with the therapist, the client. . ."; and the CLOPT: Therapist Form: "When with the client, the therapist. . .". In short, the check lists are rating instruments designed to characterize a target person's interpersonal behavior from the perspective of the target person or a particular interactant, or from the intersubjective perspective of a group of observers.

Since the CLOIT and CLOPT items are in the format of descriptions of overt interpersonal actions, the inventories are in the tradition of action (Lorr and McNair, 1965, 1967) or act-frequency (Buss and Craik, 1983), in contrast to adjective check list or descriptive (LaForge and Suczek, 1955; Leary, 1957; Wiggins, 1979, 1981), approaches to measurement of interpersonal behavior. The CLOIT-CLOPT approach also measures interpersonal actions of a target person by respondent ratings, in contrast to respondents' self-reporting of their covert engagements as used by the Impact Message Inventory (Kiesler et al., 1985; Kiesler, 1987a).

ADMINISTRATION

Depending on the nature of a particular study, one or more of the five versions of the inventory can be used. Each version consists of six pages of items and an accompanying cover sheet of instructions designed for the respective version. Respondents check (or leave blank) each of the 96 items by recording their checks either directly on the inventory or directly on its corresponding Scoring Sheet. Item checks, then, can either be hand- scored directly on the Scoring Sheet or can be entered directly into computer storage for subsequent computer scoring.

When self-reports are sought, inventories are distributed to subjects who read the instructions and then respond to the items as to whether each is an accurate representation of their typical behavior with others. For transactant ratings, an inventory is distributed to each member of the dyad who, then, separately rate each item as to whether or not the interpersonal action described was performed by the other person during their particular interaction -- either for a specified time period, such as during a particular therapy session; or over some longer period of their transactions with each other (e.g. since being married to each other, or since you first met each other).

In the case of observer ratings, a group of observers fill out the inventory after witnessing a live transaction, or some transcription (videotape, audiotape, etc.) of a transaction, between two individuals. If the transaction being observed is of a psychotherapy or clinical interview, observers fill out the CLOPT inventory (either Client or Therapist forms); if of a non-clinical transaction, they use the CLOIT: Observer Form. In studies to date of clinical transactions, observers have been presented with as little as 5 to 10 minutes of a session and as much as an entire 50-minute session.

SCORING

Scales (Sixteenths) : Each of the 16 Circle categories is measured by 6 items: 3 designated at the mild-moderate level of behavioral intensity (each receiving a score of 1 when checked), and 3 designated at an extreme level of intensity (each receiving a score of 2 when checked). The range of possible scores for each category scale is 0 (no items checked) to 9 (all 6 items checked).

In each version of the inventory the 96 items are arranged identically on 6 separate pages. Each page contains 16 items, one item for each of the 16 category scales. The order of the items on each page is the same, with category items ordered by a counterclockwise progression around the Circle with a two-category gap (i.e., A:DOM, D:COL, G:INH, J:DEF, M:FRI, P:ASS, C:MIS, F:DET, etc.) to minimize possible bias in respondents' successive responses to the items.

The six columns on the Scoring Sheet are arranged to reflect the same item order. Each column provides spaces to record checks for 16 items, with item numbers ordered by the identical counterclockwise progression around the Circle with a two-category gap. A seventh column records the sum score for each category Scale: across a given row, each check found in columns 1, 3, and 5 (mild-moderate level items) receives a score of "1"; each check found in columns 2, 4, and 6 (extreme level items) receives a score of "2." The 16 Scale sum scores, then, are obtained directly from the Scoring Sheet from the column of row sum scores at the far right of the sheet.

Profile Summary Sheets are available for depicting the 16 Scale scores of a particular individual or means scores of a group of target persons on the 1982 Interpersonal Circle. Lines drawn to connect the 16 scores provide a visual summary of the interpersonal behavior pattern which is useful for interpretation, especially in the context of psychotherapy diagnosis and treatment. The resulting linear patterns can usefully be considered as pictorial displays of the interpersonal "force field" that a particular target person "projects" in his or her interactions with others in specific contexts.

NIC : Two additional scores are routinely calculated from each subject's Scoring Sheet. Number of Items Checked

(NIC) is calculated by simply counting the number of the total 96 items that have check marks on a particular Scoring Sheet; that is, NIC records the number of items checked by a particular respondent. NIC = the sum of checks for columns one through six; or NIC = n1 + n2 (number of checked items weighted "1" + number of checked items weighted "2"). Since LaForge (1977), NIC has been interpreted as a measure of a subject's or rater's "response acquiescence": the tendency to endorse or check an item regardless of its behavioral content.

AIN : The Average Intensity of the total items checked on the Scoring Sheet is recorded as the AIN score. Since half of the 96 items are weighted "1," the other half weighted "2," the possible range of AIN is between 1.00 and 2.00. For example, if in describing himself a respondent checked only mild-moderate items (regardless of scale designation), the resulting AIN score would be 1.00. AIN = n1 + 2n2 / n1 + n2; AIN = n1 + 2n2 / NIC. Since LaForge (1977), AIN has been interpreted as a measure of a subject's or rater's "social desirability" response set: the tendency to endorse items describing an extreme, socially unacceptable level of interpersonal behavior. However, AIN is also conceptualized as a direct measure of the extremeness of the target person's overall interpersonal actions. As such, AIN can be used (a) as an indicant of the degree of psychopathology present in a particular protocol and (b) as another measure of the degree of complementarity present between two interactants (the more the complementarity in a dyad, the higher the correspondence or correlation present between the AIN scores obtained by each in a particular transaction).

Octants : The 16 Scale scores can be combined (one Scale with its adjacent Scale on either side, as represented on the circumference of the 1982 Circle) to form Octant scores. The result is two sets of eight Octant scores. Since Leary (1957), the traditional set of octants that has been used in interpersonal studies are the following eight combinations: PA, BC, DE, FG, HI, JK, LM, NO. Kiesler (1983) noted that an equally plausible set of non- traditional octants need also to be studied: namely AB, CD, EF, GH, IJ, KL, MN, OP.

Quadrants : The 16 Scale scores also can be summed to obtain separate scores for each of the four circle quadrants: hostile-dominant (HD), hostile-submissive (HS), friendly-submissive (FS), and friendly-dominant (FD). As Orford (1986) documents, previous researchers have used imprecise formulas in combining Scales to quadrants, resulting from arbitrary judgment regarding assignment of the four Scales (A, E, I, M) that anchor the circles axes. He notes that most research "has followed Leary in dividing the circle cleanly into four quadrants, assigning sector A to friendly-dominance, E to hostile-dominance, and so forth ... it is clearly inconsistent to label the quadrants of the circle as hostile-dominant, hostile-submissive, friendly-submissive, and friendly-dominant, and then to include sector A (dominant) with friendly-dominant rather than hostile-dominant, E (hostile) with hostile-dominant rather than hostile-submissive, and so on" (pp. 369, 372). The imprecise quadrant formulas are as follows: HD = B + C + D + E; HS = F + G + H + I; FS = J + K + L + M; FD = N + O + P + A. Orford recommended that future research follow the Rausch, Dittman and Taylor (1959) and Kiesler (1983) convention of dividing behavior coded at the four axis Scales equally between adjacent quadrants. This convention leads to the following Quadrant Score formulas: HD = 1/2 A + B + C + D + 1/2 E; HS = 1/2 E + F + G + H + 1/2 I; FS = 1/2 I + J + K + L + 1/2 M; FD = 1/2 M + N + O + P + 1/2 A.

Goldston (1989) changed traditional quadrant scoring to reflect the predicted trigonometric components among scale scores detailed in Figure 1. According to Goldston's derivation, quadrant score formulas that precisely reflect circle trigonometry are as follows: HD = .707 A + .924 B + C + .924 D + .707 E; HS = .707 E + .924 F + G + .924 H + .707 I; FS = .707 I + .924 J + K + .924 L + .707 M; FD = .707 M + .924 N + 0 + .024 P + .707 A. We recommend that future investigators use these more precise formulas.

Hemispheres : The 16 Scale scores can be summed to obtain separate scores for the four possible hemispheres of the circle: dominant, submissive, friendly, and hostile. Recent evidence (Henry, Schacht and Strupp, 1986; Kiesler and Goldston, 1988; Kiesler and Watkins, 1989; Orford, 1986) suggests that it is important to analyze hemisphere scores, especially friendly and hostile, when testing for complementarity in therapy transactions -- more precisely, to tease out of complementary interactions the separate contributions of the control and affiliation axes (Weinstock- Savoy, 1986). The appropriate Hemisphere score formulas, expressed in terms of their precise trigonometric counterparts, are as follows: DOM = .383 N + .707 O + .924 P + A + .924 B + .707 C + .383 D; SUB = .383 F + .707 G + .924 H + I + .924 J + .707 K + .383 L; FRI = .383 J + .707 K + .924 L + M + .924 N + .707 O + .383 P; HOS = .383 B + .707 C + .924 D + E + .924 F + .707 G + .383 H.

Axes : The 16 Scale scores can further be summed to provide scores representing a target person's overall vector on each of the axes of the circle: control (vertical axis) and affiliation (horizontal axis). Since LaForge (1977) and Leary (1957), the scores have been obtained from trigonometric weightings of the Scale scores from a given protocol using the following Axis score formulas: CONTROL = A - I + .924 (B + P - H - J) + .707 (C + O - G -K) + .383 (D + N - F - L); AFFILIA = M - E + .924 (N + L - D - F) + .707 (O + K - C - G) + .383 (P + J - B - H).

Vectors : The 16 Scale scores can be combined to obtain a vector-sum score. Scores are computed for each subject on the two principal components (axes) that define that subject's interpersonal behavior space. These scores for the two axes are combined using the theorem of Pythagoras to arrive at the magnitude of the vector sum; the direction is determined by the arctangent of the affiliation to control score ratio, with the signs of each component preserved. The result is the angle of deviation of the sum score from the control (dominant) axis -- equivalent to the point of intersect that occurs when perpendicular lines are drawn from the score-points on the control and affiliation axes.
As LaForge (1977, p. 7) points out, a subject's interpersonal behavior pattern may be summarized as one point on the circumplex in terms of its distance and direction from the center. To examine for group differences in mean vector-sum scores (Alden & Phillips, 1990), investigators can follow the procedure outlined by Watson & Williams (1956) and Mardia (1972).

Ipsatized Scores : Finally, any investigator has the option of using all of the above scores (with the exception of NIC and AIN) as derived from the raw Scale scores or from ipsatized Scale scores (Berzins, 1977; Block, 1957; Cattell, 1944; Paddock, Potts, Kiesler and Nowicki, 1986). The conceptual distinction is between "ipsative" and "normative" measurement. In the former, "the set of scores ... are weighted or ordered relative to that individual's own personal mean;" in the latter, "each score for an individual is evaluated relative to the mean score of a group of individuals" (Block, 1957, p. 50). Cattell (1944) suggested that ipsative measurement, treated normatively, provides results different from those derived by direct normative measurement (p. 296). Block (1957), in an important methodological paper, demonstrated that nomothetic and ipsative scaling of personality attributes are not interchangeable and that each involves a somewhat different kind of appraisal. He concluded that ipsative ratings, normatively treated, "offer the possibility of providing more stable interrelationships among variables than has usually been the case" (p. 53).

To ipsatize sector scores, one simply normalizes a given subject's sixteen scores around that subject's overall mean score (mean of all 16 Scales or mean of all inventory items), resulting in 16 positive and negative z-scores. Although infrequently used in interpersonal studies, ipsative scores seem the conceptual choice for many tests of interpersonal propositions, especially those addressing interpersonal complementarity (Kiesler, 1987). That is, for many interpersonal predictions it seems crucial to determine the strongest component (profile peak) within the interpersonal "force field" emitted by a particular person, regardless of the normative level (compared to other persons) of that strongest component or peak -- an ipsative determination. If, for example, friendly-dominance is the predominant pattern of an individual's interpersonal behavior, it is likely that friendly-dominance will be prepotent in elicitation of reactions from others even if the individual's level of intensity is only moderate in comparison to levels found in some normative sample. In other instances, especially determination of psychopathology, a normative comparison (using unconverted raw scores) of the strength or intensity of an individual's "force field" seems both indicated and crucial; likewise, in dyadic transactions an investigator might seek to evaluate the transactional outcome of a given mix of relative strengths or intensities of friendly-dominance present for the interactants. In sum, while normative scores, based on raw Scale scores, clearly have a place in empirical analyses, it seems important that researchers give much greater attention to possibilities of ipsative scoring (based on ipsatized Scale scores) of interpersonal data.

Summary . Obviously a large number of possible scores can be obtained from any single inventory protocol. On the one hand, univariate analysis of all possible scores in any particular study inflates considerably the Type I error because of repeated sampling and interrelated scores. For this reason, LaForge (1977, p. 21) recommended that "wherever possible, statistical hypotheses should be expressed in terms of a single dependent variable" such as CONTROL, AFFILIA, AIN:TOT, or one of the Scales. Another rationale for LaForge's recommendation is that different hypotheses are targeted more precisely to different scores on the molar-molecular continuum.

On the other hand, researchers have rarely examined carefully the strengths or weaknesses of

v

arious possible inventory scores, nor have we accumulated any tradition of standard analyses or cumulative normative data. These omissions often make it an arbitrary choice as to which one or few inventory scores should serve as key dependent variables in a particular study. At this point in time, it seems most sensible for interpersonal researchers to combine both strategies within and across studies: a priori specification of a few scores for testing of specific hypotheses; wide-band, especially multivariate, analyses of many of the scores for descriptive and/or exploratory purposes. It would be an unfortunate outcome if, by solidifying score conventions prematurely, we build a corpus of findings on what turns out to be swampy terrain.

RELIABILITY OF CLOIT-R AND CLOPT-R SCORES

Internal Consistency Reliability

Five studies (Kiesler, Goldston, Paddock and Van Denburg, 1986; Kiesler, Heffner, Larus and Radecki-Bush, 1989; Kiesler, Paddock, Goldston and Schmidt, 1988; Kiesler, Schmidt and Larus, 1988, 1989) report Cronbach alpha coefficients for the 16 scales of the CLOIT versions.

Kiesler, Goldston, Paddock and Van Denburg (1986) used the 1984 CLOIT: Transactant Form for a study in which 325 undergraduates rated the interpersonal behavior of same gender acquaintances. For the 16 CLOIT scales they report alpha coefficients ranging from .43 to .81 (median of .63), with only two of the coefficients below .50. They also report alphas for quadrants (HD = .89, HS = .71, FS = .88, FD = .69) and for hemispheres (DOM = .81, SUB = .81, FRI = .87, HOS = .86).

Kiesler, Heffner, Larus and Radecki-Bush (1989) had clinical interviewers in a mental health setting use the 1984 CLOIT: Transactant Form to rate the intake interview behavior of 117 male and female outpatients. Internal consistency coefficients for the sample ranged from .24 to .68 (median of .50, with eight coefficients below .50.

Kiesler, Paddock, Goldston and Schmidt (1988) used the 1984 CLOIT: Transactant Form in a study in which 425 undergraduates rated the interpersonal behavior of same gender close friends who, in turn, rated the behavior of the 425 undergraduates. Internal consistency coefficients were calculated on the combined undergraduates and close friends samples (N = 850). Resulting alphas obtained for the 16 scales ranged from ..39 to .65 (median of .51), with eight coefficients below .50. Alpha coefficients for the traditional octants ranged from .49 to .73 (median of .62).

Kiesler, Schmidt and Larus (1988) used the 1987 CLOIT-R: Self-Report Form in a study in which 167 undergraduates characterized their own typical interpersonal behaviors with others. They found alpha coefficients for the 16 scales ranging from .44 to .64 (median of .55), with only one coefficient below .50.

Kiesler, Schmidt and Larus (1989) had 196 undergraduates characterize their typical interpersonal behavior at two time points (n = 126 at retest) using the 1987 CLOIT-R: Self-Report Form. Internal consistency coefficients calculated for the octant scores were as follows: at time one, rs ranged from .63 to .74 (median of .72) for traditional octants, while ranging from .67 to .73 (median of .70) for nontraditional octants; at time two, rs ranged from .53 to .80 (median of .72) for traditional octants, while ranging from .65 to .75 (median of .73) for nontraditional octants. Traditional octants are PA, BC, DE, FG, HI, JK, LM, NO; nontraditional octants are AB, CD, EF, GH, IJ, KL, MN, OP.

Interrater Agreement

Indexes of interrater reliability are obtained from studies in which more than one observer view live or videotaped samples of interpersonal behavior taken from interview sessions or other dyadic interactions.

After viewing each sample, observers independently rate the behavior of the designated target person (patient, therapist, interviewer, etc.) using the CLOPT versions of the inventory. Intraclass reliability coefficients are then calculated across the n observers for each of the 16 CLOPT scales.

Three studies (Kiesler, Van Denburg, Sikes-Nova, Larus and Goldston, 1990; Van Denburg, 1988; Weinstock-Savoy, 1986) have reported intraclass coefficients for the CLOPT scales.

Kiesler, Van Denburg, Sikes-Nova, Larus and Goldston (1990) had 22 graduate students sequentially observe four 9-minute videotapes of cases of DSM-III personality disorders. After viewing each case, observers independently rated the behavior of the patient using the 1984 CLOPT: Client Form. Ebel intraclass coefficients were calculated for their ratings, albeit on a very small sample (N = 4 tapes). The estimated average reliabilities for all pairs of the 22 raters (r_{11}) ranged from -.024 to .899, with a median r_{11} of .238. Any pair among the 22 graduate raters, then, yielded very unreliable CLOPT ratings. In contrast, the reliabilities of the scale score averages obtained from all 22 judges (r_{kk}) ranged from .000 to .995, with a median r_{kk} of .873. Eleven of the 16 scales obtained r_{kk} coefficients above .800, while only four were less than .488 (these four were for scales used very infrequently to characterize the patient cases with a resulting minimal variance for the scores). In sum, the average graduate student CLOPT scale ratings for the four patients were highly reliable for all but five (COL, HOS, TRU, WAR, FRI) of the 16 scales.

In Van Denburg's (1988) study, two interviewers were trained to portray two different styles of interpersonal behavior: friendly-dominant and hostile-submissive. The interviewers then conducted high and low stress interviews with experimental subjects. As an experimental check on the validity of the interviewers' style portrayals, three observers viewed a sample of 20 videotaped interview samples and independently filled out 1984 CLOIT: Observer Forms on the interviewers' behavior. To assess the interjudge reliability of the CLOIT ratings completed on the interviewers, Cronbach alphas were calculated for each of the 16 scale scores from the 3 observers. Five scales (DOM, MIS, UNA, SUB, ASS) were bypassed in the analyses because of zero variance as a result of too few items being endorsed by the raters on these scales. For the remaining 11 scales, standardized item alphas ranged from .33 to .97, with a median coefficient of .68. Five coefficients were .74 or higher, while only four (COM, INH, DEF, TRU) were below .50.

Weinstock-Savoy (1986) had 26 subjects rate patients' behavior using 1984 CLOPT: Client Forms after viewing four videotapes of role-played clinical interviews. A regression analysis computed on the CLOPT octant scores revealed a moderate to high level of agreement between observers: the mean r^2 across the octants was .69 (ranged from .56 to .83). She also correlated individual rater scores for a given octant with the mean octant scores given by all raters who saw a particular tape, across all four tapes. This resulted in high correlations between individual observer and mean scores (a) for octants (rs ranged from .70 to .90, with a mean of .82), (b) for quadrants (HD = .74, HS = .89, FS = .89, FD = .72), and for axis scores (CONTROL = .85, AFFILIA = .88).

In a separate study, Weinstock-Savoy (1986) had pairs of raters fill out 1984 CLOPT: Client Forms on 39 outpatients after viewing videotaped segments of an early therapy session. Modified intraclass coefficients revealed moderate levels of reliability for the CLOPT axis scores (.62 for both axes), but the quadrant scores were variable (coefficients ranged from .15 to .73) and the CLOPT octant scores were even more variable (coefficients ranged from .00 to .72, with a median of .37). Since an equivalent pattern of coefficients was obtained for Wiggins's (1981) Interpersonal Adjective Scales octants, which have considerable evidence of high reliability, these lower and more variable reliability values likely reflect the judge-by-target-person interactive effects that are maximized when only two judges are used for interpersonal ratings (see also Kiesler, 1987).

Interobserver Agreement for CLOPT Profiles

Another estimate of interobserver agreement is possible when groups of observers rate the same target person from live or videotaped interactional samples. These estimates characterize the stability or generalizability of the mean profile of 16 CLOPT scale scores obtained for a particular ratee by (a) constituting split-half samples of the observer group, (b) calculating Pearson correlations between the two sets of 16 mean

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cores, and (c) then correcting the obtained r value by Spearman-Brown formula to arrive at a coefficient representative of the entire group of observers.

Three studies (Heffner, 1988; Kiesler, Van Denburg, Sikes-Nova, Larus and Goldston, 1990; Weinstock-Savoy, 1986) have reported these profile stability indexes.

In Heffner's (1988) study, a male interviewee was trained to portray a submissive hemisphere pattern of interpersonal behavior, using behavioral descriptors from the mild-moderate range, with emphasis on the Inhibited, Submissive, and Trusting scales, from the Acts Version of the 1982 Interpersonal Circle (Kiesler, 1985). After viewing the videotaped simulated interview, each of four groups of subjects (n = 24 in each group) rated the submissive interviewee using the 1987 CLOIT-R Transactant version. The means of the 16 scales, calculated for each of the four groups, constituted four separate CLOIT-R profiles. Each of the 16-scale profiles was then correlated with each of the other three group profiles, with the resulting six rs ranging from .97 to .98. These values represent strong evidence for the profile reliability of the 16 CLOIT-R scales.

Kiesler, Van Denburg, Sikes-Nova, Larus and Goldston (1990) had 22 graduate student clinical trainees sequentially view videotapes of 4 cases of DSM-III personality disorder. Also 8 separate groups of undergraduates (N = 30 each) viewed the same 4 cases plus 4 additional personality disorder patients. After viewing a particular case, all observers rated the patient's behavior using the 1984 CLOPT: Client Form. Since MANOVA analyses had revealed no significant sex effects on the CLOPT ratings for graduate observers and only minimal effects for the undergraduates, one easily calculated split-half estimate resulted from intercorrelating the mean profile of 16 scores obtained for male observers with the mean profile obtained for females. For both graduate and undergraduate observers, split-half samples were constituted by dividing each group by gender (approximately a 50-50 ratio in all cases). The CLOPT profiles obtained for each patient were highly reliable. The 12 corrected r values are all above .925 with only two exceptions: antisocial (for graduates) at .847, schizoid (for undergraduates) at .763. Hence, using gender as one the many possible splits of observer groups into halves yields very high reliabilities of the 8 patients' CLOPT profiles.

A second split-half estimate of interobserver agreement was obtained by intercorrelating the mean profiles of the graduate and undergraduate observers for each of the four cases rated by both groups. The mean profile of the sixteen CLOPT scores obtained for 22 graduate observers for each of the four vignettes was correlated with the mean profile obtained for the 30 undergraduate observers. The resulting Pearson rs were .640 ($p < .005$) for compulsive, .906 ($P < .0001$) for schizotypal, .973 ($p < .0001$) for narcissistic, and .945 ($p < .0001$) for antisocial. These figures represent impressive evidence of generalizability of CLOPT ratings for personality disorders between clinically naive undergraduates and clinically-trained graduate observers.

Weinstock-Savoy (1986) had 26 subjects rate patients' behavior using the 1984 CLOPT: Client Form after viewing four videotapes of role-played clinical interviews. She intercorrelated the octant profiles obtained by all observers who rated a given tape; she obtained mean rs for the 4 tapes of .74, .97, .67 and .60.

Summary

Most of the reliability studies reported above were conducted using the earlier 1984 CLOIT and CLOPT versions of the inventory; only a few more recent studies have been conducted for the 1987 CLOIT-R and CLOPT-R revisions. However, since the item content of the 1984 and 1987 versions has substantial overlap, reliabilities obtained for either version should be mostly comparable.

The findings reveal the following conclusions. (1) Studies yield internal consistency coefficients approximating .55 for sixteenths, .65 - .70 for octants, .70 - .90 for quadrants, and .80 - .90 for both hemisphere and axis scores. (2) Interrater agreement findings reveal clearly that the level of reliability obtained is a function of the number of judges used for a particular study. Ratings from only two judges can vary across the entire coefficient range depending on scales, sixteenths or octants, and contexts; ratings from twenty plus judges reveal very high levels of interjudge agreement. Although an exact satisfactory cutoff number has not been determined to date, data suggest that 5 or 6 judges ordinarily are necessary to establish high intersubjective agreement (by canceling out the

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diosyncratic variance that can result from judges' own interpersonal styles). (3) With a sufficiently large number of judges for observer or transactant ratings, the CLOIT-R and CLOPT-R profiles (for sixteenths or octants) that emerge for individuals or for groups show very high levels of interjudge agreement.

The upshot is that CLOIT-R and CLOPT-R inventories, in their various versions, obtain adequate levels of reliability when scored for octants, quadrants, hemispheres, or axes. When scored for sixteenths, the resulting reliabilities are much more variable and more often less than satisfactory. Routine applications of the inventories, then, should restrict themselves to the octant scores.

EMPIRICAL FINDINGS

Concurrent Validity

Available evidence for concurrent validity comes from Weinstock-Savoy's (1986) two studies in which both the 1984 CLOPT: Client Form and Wiggins's (1981) IAS were used to rate the same data sets. For her first study, correlations between patient CLOPT and IAS scores revealed moderate to high levels of correlations for the octants (rs ranged from .46 to .80, all significant at $p < .05$ or better); quadrant rs ranged from .62 to .81; while axis scores were highly correlated (rs were .86 and .88). Her second study of 39 outpatients in psychotherapy also revealed moderate to high correlations between the two measures; rs for octants ranged from .18 to .86 (median of .55); quadrants ranged from .33 to .79; rs for axes were .54 and .88. Also, for this second study which used only pairs of judges for ratings, only two octants (BC and JK) were not significantly correlated across the two measures. Weinstock-Savoy concludes that "the IAS and CLOPT displayed a high but not complete degree of overlap. While the IAS had better circumplex structure and was quicker to administer, the CLOPT appeared somewhat more sensitive to therapist hostility and was more often successful in predicting outcome" (1986, p. 136).

Kiesler, Schmidt and Larus (1989) administered the CLOIT-R Self-Report and the Interpersonal Adjective Scales (IAS; Wiggins, 1979) to a sample of 326 undergraduates (86 males, 223 females). Intercorrelations were calculated between the CLOIT-R traditional octants and both Wiggins' IAS and IAS-R octants. For the total sample octant intercorrelations ranged from .00 to .54 for IAS (PA = .38, BC = .29, DE = .31, FG = .54, HI = .49, JK = .00, LM = .35, NO = .20) and from .00 to .57 for IAS-R (PA = .45, BC = .24, DE = .32, FG = .47, HI = .57, JK = .00,
LM = .31, NO = .20). These values suggest that there is minimal to only moderate relationship between the octant scales of the two measures.

Predictive Validity

Evidence for predictive validity comes from several studies (Kiesler and Goldston, 1988; Kiesler and Watkins, 1988; Kiesler, Van Denburg, Sikes, Larus and Goldston, 1988; Van Denburg, 1988; Weinstock-Savoy, 1986).

Kiesler and Goldston (1988) found that 1984 CLOPT: Client Form and 1984 CLOPT: Therapist Form ratings by groups of undergraduate observers (ns ranged from 9 to 15 in the six groups) significantly differentiated the interpersonal behavior of three prominent therapists (Rogers, Perls, Ellis) who interviewed the same patient (Gloria), and also significantly differentiated Gloria's behavior with each of the therapists. Findings for the three therapists showed that on the control dimension Rogers was more unassured with Gloria than were both Perls and Ellis, and more submissive than Ellis; Perls and Ellis were equally dominant, and both were more dominant, competitive, and mistrusting than Rogers. On the affiliation dimension, the CLOPT findings showed that Perls and Ellis could not be differentiated in terms of hostility but that both were more hostile than Rogers, while Perls was also colder than Rogers. In sum, Rogers was characterized as friendly-submissive, Ellis as dominant- neutral, and Perls as hostile-dominant.

Findings for Gloria revealed that on the control dimension Gloria was more competitive and mistrusting with Perls than with both Rogers and Ellis, more dominant with Perls than with Rogers, and equivalently submissive with Rogers and Ellis. On the affiliation dimension, Gloria was less warm and friendly (and remarkably more cold, hostile, and detached) with Perls than with both Rogers and Ellis. In sum, Gloria was friendly - submissive with both Rogers and Ellis but hostile-dominant with Perls.

Analyses of the fit of CLOPT profiles between Gloria and each therapist showed that Gloria's actual behavior with all three therapists departed from the perfect complementary predictions. Axes analyses showed that Gloria's behavior on the control dimension was complementary (reciprocal) only to Ellis (Ellis, dominant; Gloria, submissive) but markedly nonreciprocal to both Rogers (Rogers, submissive; Gloria, submissive) and to Perls (Perls, dominant; Gloria, dominant). On the affiliation dimension, Gloria's behavior was, in contrast, complementary (correspondent) to both Rogers (Rogers, friendly; Gloria, friendly) and to Perls (Perls, hostile; Gloria, hostile) but was not correspondent to Ellis (Ellis, neutral; Gloria, friendly).

Findings for the 16 CLOPT scales clarified more specifically the obtained departures from complementarity. In all, 6 scales showed noncomplementary fit for Gloria with both Rogers and Ellis; 9 with Perls -- 21 violations out of the total 48 scale comparisons for the three therapists. Of the 21 violations, 11 scales were located on the hostile half of the 1982 Interpersonal Circle, 4 were neutral (i.e. fall exactly at either pole of the dominant-submissive axis), and only 6 were located on the friendly half. In sum, most of the fit to complementarity occurred on the friendly half of the circle; most of the violations occurred on the hostile half, among scales loading more heavily on either pole of the control axis than on the hostile pole of the affiliation axis.

Kiesler and Watkins (1989) examined, on a sample of 36 outpatient psychotherapy dyads, the relationship between the working alliance and patient-therapist complementarity during early therapy sessions. Patients and therapists independently recorded their perceptions of the alliance on Working Alliance Inventories (WAIs; Horvath, 1981; Horvath and Greenberg, 1986); interpersonal complementarity was derived from patients and therapists' ratings of each other's interpersonal behavior on the 1984 CLOIT: Transactant Form. Both sets of measures were obtained at the end of the third therapy session.

Results showed that when a patient-therapist complementarity score was calculated from CLOIT scales within the hostile hemisphere of the 1982 Interpersonal Circle, a significant relationship emerged between complementarity and patients' perceptions of the working alliance. The closer the dyadic fit to perfect complementarity, the stronger was the therapeutic alliance perceived by the patient. The same relationship was found for therapists' perceptions of the working alliance and a complementarity score obtained from both the hostile and friendly Circle h emispheres. The authors conclude that these findings indicate that in the psychotherapy context the valence of interpersonal behaviors from the hostile versus friendly hemispheres is not equivalent. How patient and therapist match on the hostile half of the Circle seems important for development of a positive working alliance. How they match on the friendly half seems relatively irrelevant, at least during early therapy sessions.

Results also revealed that the extremeness of the patient's hostile-side behavior was significantly related to both patients' and therapists' perceptions of the working alliance. The more extreme a patient's behavior within the hostile half of the Circle, the less positive is the working alliance perceived by that patient. A similar pattern emerged for therapists' WAI scores, except that therapists' perceptions of the alliance were related to extremeness of patient behavior on both halves of the Circle. The authors conclude that both patients and therapists perceive a stronger helping alliance when the patient's hostile-side interpersonal behavior is less extreme. In contrast, extremeness of the therapist's interpersonal behavior is essentially unrelated to either the patient's or the therapist's perceptions of the working alliance.

Kiesler, Van Denburg, Sikes, Larus and Goldston (1990) set out to provide empirical interpersonal descriptions for seven of eleven DSM-III personality disorder patients as a test of the a priori classifications of these diagnostic categories on the 1982 Interpersonal Circle that were offered by Kiesler (1986). A sample of eight videotaped patient interviews was obtained from two psychiatric training tape series which had been produced to exemplify DSM-III Axis I and Axis II disorders. The eight vignettes represented seven personality disorders: histrionic (two cases), passive-aggressive, schizoid, schizotypal, compulsive, antisocial, and narcissistic. Independent checks on the training tape diagnoses were obtained from a panel of 10 professional trainees who viewed the eight vignettes and independently recorded DSM-III diagnoses. Interpersonal characterizations of the

interview behavior of the eight patients were obtained from 1984 CLOPT: Client Form ratings by 240 undergraduates (30 per each vignette) and 22 graduate psychology students (who sequentially rated 4 of the 8 tapes).

A moderately conservative test of Kiesler's (1986) predictions was obtained by ascertaining whether the predicted peak scale(s) actually occurred among the top-five highest ranked scales for each of the 8 patients, as rated by the undergraduates and graduates. Results showed that predictions were clearly confirmed for two cases (narcissistic, schizoid) and mostly confirmed for two others (compulsive, schizotypal). In contrast, for one disorder (antisocial) predictions were clearly not confirmed; for the remaining 3 cases (passive-aggressive, histrionic A, histrionic B) confirmations were partial (one peak scale confirmed, the other not). Inspection of the top-five ranked CLOPT scales for each case showed that, rather than one or two predicted peak scales, combinations of larger numbers of Circle segments seem necessary both to define a particular disorder and to differentiate disorders. Inspection also revealed that core interpersonal behaviors for a particular disorder often were located in more than one Circle quadrant. For example, the schizotypal patient's pattern centered in the hostile-submissive quadrant (detached, unassured, inhibited), but contained components also from the hostile-dominant (cold, mistrusting) quadrant.

Multivariate analyses of variance of the 16 CLOPT scales revealed significant differentiations of the interpersonal behavior of the eight cases. Observer sex had minimal effects on the CLOPT ratings. Sex made a difference only for the undergraduate observers, for only the Trusting and Warm scales. Women rated the patients' behavior as more trusting and warm than did the men. On the other hand, level of observer clinical training significantly affected the CLOPT ratings in a very consistent pattern. In all cases where significant differences existed, regardless of scale location on the 1982 Circle undergraduates rated more intense or extreme levels of the patients' interpersonal behaviors than did graduates.

The panel of clinicians achieved good agreement that seven of the eight cases (all except histrionic A) had a principal diagnosis on Axis II. Also, the panel confirmed, with high interjudge agreement, the training series' diagnoses for four of the eight cases (compulsive, schizotypal, narcissistic, antisocial). The CLOPT profiles for these four cases likely provide valid interpersonal characterizations of these disorders, although the profiles need to be replicated on samples larger than N = 1.

The authors conclude that systematic interpersonal ratings can provide statistically reliable discriminations of the interpersonal behavior of patients assigned a principal diagnosis of personality disorder; that prototypic interpersonal profiles for the various personality disorders seem to be more complex and subtle than previous a priori translations, which focused on octant patterns, suggest; that quite brief (5 to 9 minutes long) videotaped patient vignettes seem to provide reliable and valid ratings of patients' interpersonal behavior; that observer sex had inconsequential effects on the interpersonal ratings of the study; and that level of clinical training contributed important effects to the intensity or extremeness of interpersonal ratings of patient behavior, although simultaneously yielding highly generalizable profiles or patterns.

Van Denburg (1988) sought empirical support for a core interpersonal assumption which he labeled the "principle of transactional escalation", according to which an individual's typical interpersonal behavior will become rigid and extreme under stressful interpersonal conditions. A sample of 30 undergraduates was selected, all of whom received peak scores in the friendly-submissive quadrant of the 1982 Circle as determined by 1984 CLOIT: Transactant forms filled out on each subject by 3 acquaintances. Half (N = 15) of the subjects were randomly placed in a low-stress structured interview; half (N = 15) were placed in a high-stress condition. In the first half of the interview, which was identical for both groups, the interviewer assumed a complementary (friendly-dominant) posture, and asked questions designed to elicit low-intimacy responses (Taylor and Altman, 1966). In the second half of the interview for the low-stress group, the interviewer maintained the identical conditions; for the high-stress group, the interviewer's style changed to the anticomplementary position (hostile-submissive), and the questions asked of the interviewee had a significantly higher intimacy ratings. A group of 10 female raters viewed 10-minute samples of the first and second halves of each interview in such a manner that each sample was rated by 5 judges using the CLOPT forms.

Results provided strong support for the hypothesis that subjects' interpersonal behavior, under the stressful condition, indeed became more extreme. Analyses of subjects' friendly-submissive behaviors (SUB, DEF, TRU, WAR, FRI) showed significant increases in the SUB, DEF, and TRU scales in the second half of the interview for

high-stress subjects only. A second hypothesis stated that subjects' interpersonal behavior would also become more rigid in the high-stress condition--i.e. not only should the FS quadrant scores increase, but the other three quadrant scores (FD, HD, HS) should also decrease. Results showed the predicted pattern for the high-stress subjects' HD quadrant score only; it was not found for the HD quadrant score, and the opposite pattern (escalation) was found for the HS quadrant score.

Van Denburg concluded that his study was the first to provide empirical support for the interpersonal principle of transactional escalation. Results demonstrated that an individual's typical interpersonal behavior became more extreme during a stressful interview situation; partial support was found for the prediction that the subject's behavior would also become more rigid under stress. A third hypothesis, that a subject's self-reportable level of anxiety would increase during the stressful interview condition was not supported.

Weinstock-Savoy's (1986) first study of psychotherapy patients' behavior showed that both the CLOPT and the IAS octants significantly differentiated four role-played therapy interactions designed to represent the quadrants of the Interpersonal Circle. Her second (clinical outcome) study demonstrated that high patient- therapist complementarity, as measured by both CLOPT and IAS, during initial sessions was positively associated with successful patient outcome. Outcome was assessed by post-treatment evaluations by the patient, therapist, and independent raters as well as by change in target problem behaviors. Her finding, however, was related primarily to complementarity that occurred on the friendly-hostile axis.

Other Studies. Other validity studies which used one or another versions of the CLOIT-R or CLOPT-R inventories include Campbell and Brown (1990), Carson and Shapiro (1985), Chewning (1990), Golden (1988), Goldston (1989), Gonick (1987), Heffner (1988, 1992), Kiesler, Goldston, Paddock and Van Denburg (1986), Kiesler, Heffner, Larus and Radecki-Bush (1989), Kiesler, Paddock, Goldston and Schmidt (1989), Kiesler, Schmidt and Larus (1988, 1989), Kivlighan and Mullison (1986), Mahalik, Hill and Thompson (1990), Pollock (1990), Schmidt (1989), Thompson, Hill and Mahalik (1989), Whiffen, Dudley & Sasseville (1990), Wilkie (1987), and Wilkie and Conway (1988).

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MANUAL FOR THE CHECKLIST OF INTERPERSONAL TRANSACTIONS-REVISED (CLOIT-R) AND CHECKLIST OF PSYCHOTHERAPY TRANSACTIONS-REVISED (CLOPT-R): A 2004 UPDATE

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Measure

The Check List of Interpersonal/Psychotherapy Transactions-Revised (CLOIT-R/ CLOPT-R; Kiesler, 1987; Kiesler, Goldston, & Schmidt, 1991) measures overt interpersonal actions. A rationally derived interactional (CLOIT-R) and observational (CLOPT-R) rating system comprising 16 scales of interpersonal behavior, it is conceptually rooted in the 1982 interpersonal circumplex model of interpersonal behavior (Kiesler, 1983, 1996). Each of the 16 circle categories is measured by 6 items, 3 keyed at the mild-moderate level of behavioral intensity (each receiving a score of 1 when checked), and 3 designated at an extreme level of intensity (each receiving a score of 2 when checked). The range of possible scores for each category scale is 0 to 9. The CLOIT-R respondent (dyadic interactants) makes a “yes” or “no” judgment as to whether the interpersonal action described by a particular item was enacted by the target person (e.g., a friend or acquaintance) during their previous transaction(s). The CLOPT-R respondent (an observer judge) makes a "yes” or “no” judgment as to whether the interpersonal action described by a particular item was enacted by the target person (e.g., psychotherapist, physician, patient) in the live or recorded sample of interaction (e.g., therapy/medical consultation) the judge observed. The CLOIT-R/CLOPT-R, thus, measures a target’s dyadic interpersonal behavior using interactant or observer ratings, in contrast to the Impact Message Inventory (Kiesler, Anchin, Perkins, Chirico, Kyle, & Federman, 1985; Kiesler & Schmidt, 1993) which measures a target’s dyadic behavior using respondents’ reports of their own covert engagements.

The CLOIT-R/CLOPT-R inventories produce 16 interpersonal behavior scores: dominant (DOM), competitive (COM), mistrusting (MIS), cold (COL), hostile (HOS), detached (DET), inhibited (INH), unassured (UNA), submissive (SUB), deferent (DEF), trusting (TRU), warm (WAR), friendly (FRI), sociable (SOC), exhibitionistic (EXH), and assured (ASS). Because studies have revealed variable internal consistency (Cronbach alpha) and interobserver (intraclass) reliabilities (Kiesler, Goldston, & Schmidt, 1991), it is recommended that the 16 scales be routinely combined into more reliable pairs to produce the following octant scores: Dominant (ASS+DOM), Hostile-Dominant (COM+MIS), Hostile (COL+HOS), Hostile-Submissive (DET+INH), Submissive (UNA+SUB), Friendly-Submissive (DEF+TRU), Friendly (WAR+FRI), and Friendly-Dominant SOC+EXH). For most studies it is recommended that investigators use at least (a) the octant scores and (b) the axes scores (which are calculated by combining

the circumplex vector values for each of the 16 scales into summary scores for Affiliation and Control). This choice represents the range of liberal (axes) and conservative (octant) tests of hypotheses using scores having both good internal consistency and interobserver reliabilities.

In the case of testing more limited or precise hypotheses, observers may prefer to use one or more of the 16 original scales that have demonstrated high reliabilities. For example, Newton and colleagues (Newton & Bane, 2001; Newton, Bane, Flores, & Greenfield, 1999; Newton & Sanford, 2003) have pursued a program of research examining the association of interpersonal dominance and hostility with cardiovascular reactivity during marital and other mixed gender interactions. While their 1999 study measured dominance and hostility using trait questionnaires, Newton and Bane (2001) and Newton and Sanford (2003) instead used 3 observers who coded two (DOM, HOS) of the 16 CLOPT-R interpersonal circumplex scales to assess behavioral dominance and hostility of participants during dyadic discussions. The 2001 study averaged the coding of 3 independent observers across three 1-minute samples of videotaped problem-solving discussions of previously unacquainted mixed-gender dyads. The 2003 study average the codings of 3 independent observers across seven 2-minute samples of videotaped problem-solving discussions between marital partners. For each study, coders made a yes-no judgment as to whether each of the 6 DOM and 6 HOS items accurately described the target person's behavior during the sample observed. In the 2001 and 2003 studies respectively, Cronbach alphas found were .86 and .81 for DOM and .78 and .88 for HOS; intraclass coefficients were .87 and .88 for DOM and .80 and .89 for HOS.

The CLOIT-R/CLOPT-R has recently been modified into a 48-item Four-Octant Brief Version (Kiesler, 2004). The Brief Version measures the 4 octants that anchor the two axes (Control, Affiliation) of the 1982 Interpersonal Circumplex (Kiesler, 1983) using four of the eight octants: DOM (Assured + Dominant), HOS (Cold + Hostile), SUB (Unassured + Submissive), FRI (Warm + Friendly). Each of the four octants is thus measured using 12 items – a total of 48 items. The four octant scores are combined to obtain Control (DOM minus SUB) and Affiliation (FRI minus HOS) axis scores that are used in subsequent analyses.

CLOPT-R observers do not code the act-by-act behaviors of interactants resulting in frequency counts of particular behaviors. Although CLOPT-R coders check (or do not check) whether specific overt behaviors of interactants occurred (at least once) or not, these judgments are made after some elapsed period of focused observation -- in previous studies ranging from one to fifteen minutes of live or taped interactions. Even with relatively brief time lapses (e.g., 1 or 2 minutes), CLOPT-R coders still (a) base their judgments regarding the 16 categories on short-term memory, (b) do not restrict their focus to only one or two interpersonal behaviors, instead make judgments about 16 different behavior categories, and (c) do not provide item frequency counts for each of the 16 scales. These factors add to CLOPT-R judgments unknown amounts of selective attention and inaccurate recall that can introduce bias and into resulting scores. The CLOPT-R rating task, thus, falls somewhere along a continuum between one pole of more molecular, act-by-act codings and its opposite pole of more molar ratings based on the entire history of

one's previous transactions
with the target person. CLOIT-R/CLOPT-R codings based on brief (1-3 minute samples) fall much closer to the act-by-act pole of traditional behavioral codings.

Analyzing for Interpersonal Complementarity

In addition to calculating sixteenth, octant, and axis scores, researchers also can combine CLOIT-R/CLOPT-R scores to calculate indices of interpersonal complementarity (Kiesler, 1983) for subsequent statistical analyses. Many unique aspects of contemporary interpersonal analysis result from simultaneous administration of the same circumplex measure (e.g., CLOIT-R/CLOPT-R) to both participants of a dyad, such as physician-patient, therapist-client, husband-wife, mother-son. Possession of paired protocols permits analyses, not only of the separate control and affiliation behaviors of each participant, but also of the degree of complementarity or fit (Kiesler, 1983) of the pair's control and affiliation behaviors. According to the principles of complementarity, on the interpersonal circumplex person A's friendly-dominant behaviors pulls for friendly-submissive behavior from person B (and vice versa); person A's hostile-dominant behaviors tends to evoke hostile-submissive behavior from person B (and vice versa). Precise mathematical formulas (derived by Wagner, in Kiesler Schmidt, & Wagner, 2001) are available that permit routine analysis of the degree of complementarity present between the interpersonal behavior patterns of any two interactants. The formulas provide 3 complementarity measures: for the control and affiliation dimensions separately, as well as for their interactive combination. In one application, Auerbach, Clore, Kiesler, et al. (2002) found that diabetic patients' metabolic control was worse when there was poor complementarity between physician and patient on the control dimension. Thus, a characteristic of the physician-patient dyad itself (poor complementarity or match between their control behaviors) -- not the patient's control behavior or the physician's control behavior separately -- was predictive of an undesirable medical outcome. In another study, France (2002) found that oral surgery patients who had greater overall (Control+Affiliation) complementarity with their surgeons reported more participation in their medical decision-making process.

Training of CLOPT-R Coders

The CLOPT-R respondent (an observer) makes a "yes" or "no" judgment as to whether the interpersonal action described by a particular item was enacted by the target person (e.g., physician or patient) in the sample of interaction observed. Previous studies have used 3-5 coders in a particular study: all coders observe live or recorded interview interactions (e.g. of psychotherapy interviews or medical consultations), then independently fill out the CLOPT-R items on one of the interactants. Samples of psychotherapy or consultation sessions have ranged in length from 1-15 minutes, with optimal reliabilities being obtained for samples between 1-3 minutes in length. In error

preparation for their study CLOPT-R codings observers do not need systematic training, although it is desirable that they rate several (perhaps 5 or more) observation samples to familiarize themselves with the CLOPT-R items and the rating task.

Availability of CLOIT-R/CLOPT-R Materials

(1) Copies of the various forms of the CLOIT-R/CLOPT-R, scoring sheets, manual, and other materials can be printed as Adobe Reader (.pdf) files by accessing the following internet site: http://www.vcu.edu/sitar/publications.htm. The CLOIT-R/ CLOPT-R files can be found at the very beginning of this SITAR web page.

(2) Copies of the 24-item Short Form of the CLOIT-R/CLOPT-R can be obtained by e-mailing the following address: dkiesler@mail1.vcu.edu . In reply, Microsoft Word files will be e-mailed that provide questionnaires, scoring sheets, and other related materials.

(3) Procedures for calculating Wagner's complementarity formulas (Kiesler, Schmidt, & Wagner, 2001) for both the regular length and 24-item Short Form versions can be obtained by e-mailing the following address: dkiesler@mail1.vcu.edu . In reply, Microsoft Word files will be e-mailed that provide the respective axis score and complementarity formulas.

(4) An annotated bibliography of empirical studies that used the CLOIT/CLOPT or CLOIT-R/CLOPT-R can also be printed as an Adobe Reader (.pdf) file by accessing the internet site: http://www.vcu.edu/sitar/publications.htm . The annotated bibliography file can be found at the very beginning of this SITAR web page.

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CHECK LIST OF PSYCHOTHERAPY TRANSACTIONS

(Therapist Rating Form: R)

DIRECTIONS. The following pages contain lists of actions that can occur in psychotherapy sessions. Your task is to check each item which accurately describes an action exhibited by the therapist whom you have just observed.

Make your judgments about occurrence of therapist actions solely on the basis of the sample of psychotherapy you just observed. Check only those items which describe therapist actions that occurred "live" in the session.

In order to receive a check, the action described by a particular item must have occurred at least once during the sample you observed, but it need not occur more than once. If an item describes an action that did not occur in the sample you observed, leave that item blank.

WHEN WITH THE CLIENT, THE THERAPIST. . .

_____1. is quick to take charge of the conversation or discussion, or to offer suggestions about what needs to be done

_____2. is hesitant to express approval or acceptance of the client

_____3. is careful not to let his or her feelings show clearly; or speaks undemonstratively, with little variation in tone or manner

_____4. finds it difficult to take the initiative; or looks to the client for direction or focus; or shows a desire to do "whatever you want"

_____5. is receptive and cooperative to the client's requests, directions, appeals, or wishes; or is quick to assist or work together with the client

_____6. expresses pleasure in self; or comments on own accomplishments, awards, or successes

_____7. scans carefully to detect any of the client's reactions, evaluations, or motives that might have a harmful intent

_____8. shows little attention, interest, curiosity, or inquisitiveness about the client's personal life, affairs, feelings, or opinions

_____9. waits for or follows the client's lead regarding topics or issues to discuss, directions or actions to pursue

_____10. is quick to express approval or acceptance of the client

_____11. speaks or acts emotionally or melodramatically, or with much variation in tone or manner

_____12. shows an intense task focus or desire to "get down to business"; or suggests directions or objectives

_____13. is quick to resist, not cooperate, or refuse to comply with the client's requests, directions, appeals, or wishes

_____14. makes self-critical statements; or expresses low self-worth; or apologizes frequently

_____15. gazes at the client in an open, receptive, trusting, or non-searching manner

_____16. inquires into or expresses attention, interest, or curiosity about the client's personal life, affairs, feelings, or opinions

WHEN WITH THE CLIENT, THE THERAPIST. . .

_____17. dominates the flow of conversation, or changes the topic, or interrupts and "talks down"

_____18. avoids at any cost showing affection, warmth, or approval

_____19. endlessly prefaces or qualifies statements to the place where points being made get lost, or views or positions are unclear or ambiguous

_____20. goes out of way to give the client credit for contributions, or to admire or praise the client for good ideas or suggestions

_____21. inconveniences self or sacrifices to contribute, help, assist, or work cooperatively with the client

_____22. is cocky about own positions or decisions; or makes it abundantly clear s/he can do things by self; or avoids any hint that the client can help

_____23. expresses doubt, mistrust, or disbelief regarding the client's intentions or motives

_____24. refrains at all costs from close visual or physical contact or direct body orientation with the client

_____25. finds it almost impossible to take the lead, or to initiate or change the topic of discussion

_____26. constantly expresses approval, affection, or effusive warmth to the client

_____27. makes startling or "loaded" comments; or takes liberties with facts to embellish stories

_____28. works hard to avoid giving the client credit for any contribution; or implies or claims that good ideas or suggestions were his/her own

_____29. is openly antagonistic, oppositional, or obstructive to the client's statements, suggestions, or purposes

_____30. is hesitant or embarrassed to express his or her opinions; or conducts self in an unsure, unconfident, or uneasy manner

_____31. responds openly, candidly, or revealingly to the point of "telling all"

_____32. continually stands, sits, moves or leans toward the client to be physically close

WHEN WITH THE CLIENT, THE THERAPIST. . .

_____33. expresses firm, strong personal preferences; or stands up for own opinions or positions

_____34. acts in a stiff, formal, unfeeling, or evaluative manner

_____35. finds it difficult to express his or her thoughts simply or without qualifications; or works hard to find precise words to express his or her thoughts

_____36. is content, unquestioning, or approving about the focus or direction of a given topic of discussion or course of action; or is quick to follow the client's lead

_____37. expresses appreciation, delight, or satisfaction about the client, their situation, or their task

_____38. prefers to rely on own resources to make decisions or solve problems

_____39. claims that the client misunderstands, misinterprets, or misjudges his/her intents or actions

_____40. remains aloof, distant, remote, or stand-offish from the client

_____41. claims s/he doesn't have an opinion, preference, or position, or that "it doesn't matter," "whatever you want," "I don't know," etc.

_____42. acts in a relaxed, informal, warm, or nonjudgmental manner

_____43. makes comments or replies that "pop out" quickly and energetically

_____44. questions or expresses reservation or disagreement about the focus or direction of the conversation or course of action

_____45. grumbles, gripes, nags, or complains about the client, the situation, or their task

_____46. readily asks the client for advice, help, or counsel

_____47. communicates that the client is sympathetic or fair in interpreting or judging his/her intents or actions

_____48. is absorbed in, attentive to, or concentrates intensely on what the client says or does

WHEN WITH THE CLIENT, THE THERAPIST. . .

_____49. states preferences, opinions, or positions in a dogmatic or unyielding manner

_____50. has absolutely no room for sympathy, compromise, or mercy regarding the client's mistakes, weaknesses, or misconduct

_____51. "talks around" or hedges on evaluations of the client, events, or objects; or constantly minimizes expressions of his or her feelings

_____52. makes statements that are deferentially, softly, or carefully presented as if s/he desperately wants to avoid any implication of disapproval, criticism, or disagreement

_____53. seems always to agree with or accommodate the client; or seems impossible to rile

_____54. brags about achievements, successes, or good-fortune; or "puts on airs" as if in complete control of his/her life

_____55. expresses harsh judgment, "never forgetting," or no forgiveness for the client's mistakes, weaknesses, or injurious actions

_____56. seems constantly uncomfortable with the client, as if s/he wants to leave or be by self

_____57. expresses own preferences hesitantly or weakly; or yields easily to the client's viewpoints; or backs down quickly when the client questions or disagrees

_____58. goes out of way to understand or be sympathetic towards the client, or to find something about the client to approve of, endorse, or support

_____59. constantly overstates evaluations of the client, events, or objects; or exaggerates expression of his/her feelings

_____60. makes comments that avoid sharing credit with the client for good happenings or joint accomplishments; or "plays up" own contributions

_____61. argumentatively challenges or refutes the client's statements or suggestions; or "tells the client off," "lets the client have it" when disagrees

_____62. claims s/he is a constant failure, or is helpless, witless, or at the mercy of events and circumstances

_____63. expresses unbending sympathy, understanding, or forgiveness for the client's hurtful or injurious actions

_____64. finds it difficult to leave the client; or goes out of way to secure more and more of the client's company

WHEN WITH THE CLIENT, THE THERAPIST. . .

_____65. seizes opportunities to instruct or explain things, or to give advice

_____66. expresses stringent, exacting, rigorous standards or expectations of the client

_____67. delays giving clear answers or postpones decisions; or deliberates carefully before speaking or acting

_____68. makes comments that give the client credit for any good happenings or joint accomplishments; or points out the client's contributions while "playing down" his or her own

_____69. is attentive to, considerate or solicitous of the client's feelings, or sensitive to pressures or stresses in the client's life

_____70. expresses his or her opinions with conviction and ease; or conducts self in a confident, assured, and unruffled manner

_____71. in response to the client's inquiries or probings, acts evasively as if hiding important secrets

_____72. is slow to respond or speak to the client; or seems distracted by own thoughts

_____73. is quick to agree with the client's opinions or to comply with the client's directions or preferences

_____74. expresses lenient, soft-hearted, or compassionate standards or expectations of the client

_____75. makes hasty decisions; or jumps into new activities with little premeditation

_____76. challenges or disputes the client's ideas or statements; or attempts to get the better of the client or put the client down

____77. ignores, overlooks, or is inconsiderate of the client's feelings; or disregards pressures or stresses in the client's life

_____78. urgently solicits the client's advice, help, or counsel even for everyday troubles or difficulties

_____79. shows trust in or reliance upon the client's good intentions or motives; or casts the client's behavior in the best possible "light"

_____80. is careful to acknowledge and be responsive to the client's statements and actions

WHEN WITH THE CLIENT, THE THERAPIST. . .

_____81. overwhelms or "steamrolls" the client by his/her arguments, positions, preferences, or actions

_____82. expresses severe, inflexible, or uncompromising expectations for the client's conduct

_____83. endlessly avoids or delays clear answers, decisions, actions, or commitment to positions

_____84. makes flattering or glowing comments about the client, their situation, or their joint task

_____85. makes unconditionally supportive, encouraging, endorsing, comforting, or bolstering comments to the client

_____86. acts as if excessively "full of self," or as feeling special or favored, or as cocksure of his/her future

_____87. is bitterly accusatory, suspicious, or disbelieving of the client

_____88. seems totally unmoved, unaffected, or untouched by the client's comments or actions

_____89. seems unable to assert what s/he wants, or to stand up to the client, or to take any opposing position

_____90. is unwaveringly tolerant, patient, or lenient in regard to his/her expectations for the client's conduct

_____91. seems compelled to act out feelings with the client, or impulsively to jump into new actions or activities

__92. makes critical, demeaning, snide, or derisive statements about the client, their situation, or their joint task

_____93. swears at the client; or makes abusing, disparaging, damaging, or crude comments to the client

_____94. is constantly dissatisfied with self, guilty or depressed; or feels hopeless about the future

_____95. shows blind faith or polyannish trust in the client; or believes almost anything the client says

_____96. seems totally engrossed in the client; or is constantly moved, affected, or responsive to the client's comments or actions

CHECK LIST OF PSYCHOTHERAPY TRANSACTIONS

(Client Rating Form: R)

DIRECTIONS. The following pages contain lists of actions that can occur in psychotherapy sessions. Your task is to check each item which accurately describes an action exhibited by the client whom you have just observed.

Make your judgments about occurrence of client actions solely on the basis of the sample of psychotherapy you just observed. Check only those items which describe client actions that occurred "live" in the sessions with the therapist.

In order to receive a check, the action described by a particular item must have occurred at least once during the sample you observed, but it need not occur more than once. If an item describes an action that did not occur in the sample you observed, leave that item blank.

WHEN WITH THE THERAPIST, THE CLIENT. . .

_____1. is quick to take charge of the conversation or discussion, or to offer suggestions about what needs to be done

_____2. is hesitant to express approval or acceptance of the therapist

_____3. is careful not to let his or her feelings show clearly; or speaks undemonstratively, with little variation in tone or manner

_____4. finds it difficult to take the initiative; or looks to the therapist for direction or focus; or shows a desire to do "whatever you want"

_____5. is receptive and cooperative to the therapist's requests, directions, appeals, or wishes; or is quick to assist or work together with the therapist

_____6. expresses pleasure in self; or comments on own accomplishments, awards, or successes

_____7. scans carefully to detect any of the therapist's reactions, evaluations, or motives that might have a harmful intent

_____8. shows little attention, interest, curiosity, or inquisitiveness about the therapist's personal life, affairs, feelings, or opinions

_____9. waits for or follows the therapist's lead regarding topics or issues to discuss, directions or actions to pursue

_____ 10. is quick to express approval or acceptance of the therapist

_____ 11. speaks or acts emotionally or melodramatically, or with much variation in tone or manner

_____ 12. shows an intense task focus or desire to "get down to business"; or suggests directions or objectives

_____ 13. is quick to resist, not cooperate, or refuse to comply with the therapist's requests, directions, appeals, or wishes

_____ 14. makes self-critical statements; or expresses low self-worth; or apologizes frequently

_____ 15. gazes at the therapist in an open, receptive, trusting, or nonsearching manner

_____ 16. inquires into or expresses attention, interest, or curiosity about the therapist's personal life, affairs, feelings, or opinions

WHEN WITH THE THERAPIST, THE CLIENT. . .

_____ 17. dominates the flow of conversation or changes the topic, or interrupts and "talks down" the therapist

_____ 18. avoids at any cost showing affection, warmth, or approval

_____ 19. endlessly prefaces or qualifies statements to the place where points being made get lost, or views or positions are unclear or ambiguous

_____ 20. goes out of way to give the therapist credit for contributions, or to admire or praise the therapist for good ideas or suggestions

_____ 21. inconveniences self or sacrifices to contribute, help, assist, or work cooperatively with the therapist

_____ 22. is cocky about own positions or decisions; or makes it abundantly clear s/he can do things by self; or avoids any hint that the therapist can help

_____ 23. expresses doubt, mistrust, or disbelief regarding the therapist's intentions or motives

_____ 24. refrains at all costs from close visual or physical contact or direct body orientation with the therapist

_____ 25. finds it almost impossible to take the lead, or to initiate or change the topic of discussion

_____ 26. constantly expresses approval, affection, or effusive warmth to the therapist

_____ 27. makes startling or "loaded" comments; or takes liberties with facts to embellish stories

_____28. works hard to avoid giving the therapist credit for any contribution; or implies or claims that good ideas or suggestions were his/her own

_____ 29. is openly antagonistic, oppositional, or obstructive to the therapist's statements, suggestions, or purposes

_____ 30. is hesitant or embarassed to express his or her opinions; or conducts self in an unsure, unconfident, or uneasy manner

_____ 31. responds openly, candidly, or revealingly to the point of "telling all"

_____ 32. continually stands, sits, moves or leans toward the therapist to be physically close

WHEN WITH THE THERAPIST, THE CLIENT. . .

_____ 33. expresses firm, strong personal preferences; or stands up for own opinions or positions

_____ 34. acts in a stiff, formal, unfeeling, or evaluative manner

_____ 35. finds it difficult to express his or her thoughts simply or without qualifications; or works hard to find precise words to express his or her thoughts

_____ 36. is content, unquestioning, or approving about the focus or direction of a given topic of discussion or course of action; or is quick to follow the therapist's lead

_____ 37. expresses appreciation, delight, or satisfaction about the therapist, their situation, or their task

_____ 38. prefers to rely on own resources to make decisions or solve problems

_____ 39. claims that the therapist misunderstands, misinterprets, or misjudges his/her intents or actions

_____ 40. remains aloof, distant, remote, or stand-offish from the therapist

_____ 41. claims s/he doesn't have an opinion, preference, or position, or that "it doesn't matter," "whatever you want," "I don't know," etc.

_____ 42. acts in a relaxed, informal, warm, or nonjudgmental manner

_____ 43. makes comments or replies that "pop out" quickly and energetically

_____ 44. questions or expresses reservation or disagreement about the focus or direction of the conversation or course of action

_____ 45. grumbles, gripes, nags, or complains about the therapist, their situation, or their task

_____ 46. readily asks the therapist for advice, help, or counsel

_____ 47. communicates that the therapist is sympathetic or fair in interpreting or judging his/her intents or actions

_____ 48. is absorbed in, attentive to, or concentrates intensely on what the therapist says or does

WHEN WITH THE THERAPIST, THE CLIENT. . .

_____ 49. states preferences, opinions, or positions in a dogmatic or unyielding manner

_____ 50. has absolutely no room for sympathy, compromise, or mercy regarding the therapist's mistakes, weaknesses, or misconduct

_____ 51. "talks around" or hedges on evaluations of the therapist, events, or objects; or constantly minimizes expressions of his or her feelings

_____ 52. makes statements that are deferentially, softly, or carefully presented as if s/he desperately wants to avoid any implication of disapproval, criticism, or disagreement

_____ 53. seems always to agree with or accommodate the therapist; or seems impossible to rile

_____ 54. brags about achievements, successes, or good-fortune; or "puts on airs" as if in complete control of his/her life

_____ 55. expresses harsh judgment, "never forgetting," or no forgiveness for the therapist's mistakes, weaknesses, or injurious actions

_____ 56. seems constantly uncomfortable with the therapist as if s/he wants to leave or be by self

_____ 57. expresses own preferences hesitantly or weakly; or yields easily to the therapist's viewpoints; or backs down quickly when the therapist questions or disagrees

_____ 58. goes out of way to understand or be sympathetic towards the therapist, or to find something about the therapist to approve of, endorse or support

_____ 59. constantly overstates evaluations of the therapist, events, or objects; or exaggerates expression of his/her feelings

_____ 60. makes comments that avoid sharing credit with the therapist for good happenings or joint accomplishments; or "plays up" own contributions

_____ 61. argumentatively challenges or refutes the therapist's statements or suggestions; or "tells the therapist off," "lets the therapist have it" when disagrees

_____ 62. claims s/he is a constant failure, or is helpless, witless, or at the mercy of events and circumstances

_____ 63. expresses unbending sympathy, understanding, or forgiveness for the therapist's hurtful or injurious actions

_____ 64. finds it difficult to leave the therapist; or goes out of way to secure more and more of the therapist's company

WHEN WITH THE THERAPIST, THE CLIENT. . .

_____ 65. seizes opportunities to instruct or explain things, or to give advice

_____ 66. expresses stringent, exacting, rigorous standards or expectations of the therapist

_____ 67. delays giving clear answers or postpones decisions; or deliberates carefully before speaking or acting

_____ 68. makes comments that give the therapist credit for any good happenings or joint accomplishments; or points out the therapist's contributions while "playing down" his or her own

_____ 69. is attentive to, considerate or solicitous of the therapist's feelings, or sensitive to pressures or stresses in the therapist's life

_____ 70. expresses his or her opinions with conviction and ease; or conducts self in a confident, assured, and unruffled manner

_____ 71. in response to the therapist's inquiries or probings, acts evasively as if hiding important secrets

_____ 72. is slow to respond or speak to the therapist; or seems distracted by own thoughts

_____ 73. is quick to agree with the therapist's opinions or to comply with the therapist's directions or preferences

_____ 74. expresses lenient, soft-hearted, or compassionate standards or expectations of the therapist

_____ 75. makes hasty decisions; or jumps into new activities with little premeditation

_____ 76. challenges or disputes the therapist's ideas or statements; or attempts to get the better of the therapist or put the therapist down

_____ 77. ignores, overlooks, or is inconsiderate of the therapist's feelings; or disregards pressures or stresses in the therapist's life

_____ 78. urgently solicits the therapist's advice, help, or counsel even for everyday troubles or difficulties

_____ 79. shows trust in or reliance on the therapist's good intentions or motives; or casts the therapist's behavior in the best possible "light"

_____ 80. is careful to acknowledge and be responsive to the therapist's statements and actions

WHEN WITH THE THERAPIST, THE CLIENT. . .

_____ 81. overwhelms or "steamrolls" the therapist by his/her arguments, positions, preferences, or actions

_____ 82. expresses severe, inflexible, or uncompromising expectations for the therapist's conduct

_____ 83. endlessly avoids or delays clear answers, decisions, actions, or commitment to positions

_____ 84. makes flattering or glowing comments about the therapist, their situation, or their joint task

_____ 85. makes unconditionally supportive, encouraging, endorsing, comforting, or bolstering comments to the therapist

_____ 86. acts as if excessively "full of self," or as feeling special or favored, or as cocksure of his/her future

_____ 87. is bitterly accusatory, suspicious, or disbelieving of the therapist

_____ 88. seems totally unmoved, unaffected, or untouched by the therapist's comments or actions

_____ 89. seems unable to assert what s/he wants, or to stand up to the therapist, or to take any opposing position

_____ 90. is unwaveringly tolerant, patient, or lenient in regard to his/her expectations for the therapist's conduct

_____ 91. seems compelled to act out feelings with the therapist, or impulsively to jump into new actions or activities

_____ 92. makes critical, demeaning, snide, or derisive statements about the therapist, their situation, or their joint task

_____ 93. swears at the therapist; or makes abusing, disparaging, damaging, or crude comments to the therapist

_____ 94. is constantly dissatisfied with self, guilty or depressed; or feels hopeless about the future

_____ 95. shows blind faith or polyannish trust in the therapist, or believes almost anything the therapist says

_____ 96. seems totally engrossed in the therapist; or is constantly moved, affected, or responsive to the therapist's comments or actions

CHECK LIST OF PSYCHOTHERAPY
TRANSACTIONS CHECK LIST OF
INTERPERSONAL TRANSACTIONS Donald
J. Kiesler, Ph.D

Transfer the check marks fro m a particular protocol onto this sheet by checking the corresponding item numbers listed below. Arrive at a sum score for each of the 16 interpersonal categories by summing across each row. Give 1 point to each check falling in columns 1, 3, and 5; give 2 points to each check falling in columns 2, 4, and 6.

Example:
1. __x__ 17. _____ 33. __x__ 49. _____ 65. __x__ 81. __x__ = A:DOM _____

(1 + 0 + 1 + 0 + 1 + 2) = A:DOM = 5

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1 + 2 + 1 + 2 + 1 + 2 = TOTAL

1. _____	17.	33.	49.	65.	81.	A:DO ____
2	18	34	50	66	82	D·COL
3	19	35	51	67	83	G·INH
4	20	36	52	68	84	I·DEF
5	21	37	53	69	85	M·ERI
6	22	38	54	70	86	P·ASS
7	23	39	55	71	87	C·MIS
8	24	40	56	72	88	F·DET
9	25	41	57	73	89	I·SUB
10	26	42	58	74	90	L·WAR
11	27	43	59	75	91	O·EXH
12	28	44	60	76	92	B·COM
13	29	45	61	77	93	E·HOS
14	30	46	62	78	94	H·UNA
15	31	47	63	79	95	K·TRU
16	32	48	64	80	96	N·SOC

Rater _____ Ratee _____

M F Age _____ M F Age __ Date: ____

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