

TREATMENT OF PSYCHIATRIC INPATIENTS WITH RELATIONSHIP
DYSFUNCTION USING A SHORT TERM COGNITIVE INTERPERSONAL
INTERVENTION: A PILOT STUDY

by

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Liberty University

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ABSTRACT

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Relationship conflict for the psychiatric patient can have significant detrimental effects. There are specific types of interactions that can increase conflict and predict the potential for relapse; these have been identified by research and designated as components of Expressed Emotion (EE). Cognitive Behavioral Therapy (CBT) and Interpersonal Therapy (IPT) have been very effective when targeting specific psychiatric diagnoses, but less effective when addressing relationship conflict. The majority of studies addressing relationship conflict have taken place in an outpatient, long-term setting. There is limited research that utilizes an inpatient short-term intensive therapy with relationship conflict as its sole focus, targeting areas known to contribute to relapse. This research was designed to address whether a short-term intensive inpatient Cognitive Interpersonal Therapy intervention, which specifically addresses these important components of

relationship conflict, can impact relationship satisfaction, emotion regulation, destructive thought processes, and rehospitalization at six weeks after discharge, when compared to a treatment as usual group.

Keywords: Cognitive Intensive Therapy, relationship dysfunction, inpatients.

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CHAPTER ONE: THE PROBLEM

Individuals suffering from psychiatric disorders often experience a significant degree of relationship dysregulation (Burge, Daley, Davila, Hammen & Paley, 1995; Borkovec, Lytle, Newman & Pincus, 2002; Gross, 1998). Research has shown that relationship conflict strongly predicts relapse for psychiatric populations even when they are fully compliant with medication regimens (Butzlaff & Hooley, 1998; Chambliss & Steketee, 1999; Hooley, Orley, & Teasdale, 1986; Hooley & Teasdale, 1989; Kwon, Lee, Lee, & Bifulco, 2006). Expressed Emotion (EE) research, which explores family relationships, has provided evidence that demonstrates how communication in families plays a pivotal role in the clinical course of individuals suffering with psychiatric illnesses (Butzlaff & Hooley, 1998). In particular, Canetto, Feldman and Lupei (1989) note that suicidal behaviors, which are often the precipitant of psychiatric hospitalizations, tend to occur in the context of difficult interpersonal relationships. This study was designed to examine the effects of a short term intervention for the hospitalized patient that is designed to specifically target relationship disturbances in close interpersonal relationships.

Cognitive Therapy (CT) and Interpersonal Therapy (IPT) have been shown to reduce relapse rates using long term interventions with outpatient psychiatric populations (De Mello, Mari, Bacaltchuk, Verdeii & Neugebauer, 2005; Fava, Rafanelli, Grandi, Conti, Belluardo, 1998; Paykel, et al., 1999). There have been short term interventions on inpatient units utilizing Cognitive Behavioral Therapy (Bach & Hayes, 2002; Durrant, Clark, Tolland & Wilson, 2007; Haddock, Tarrier, Morrison et al, 1999), Dialectal Behavioral Therapy (Springer, Lohr, Buchtel & Silk, 1996), and social skills training

(Foxy, McMorrow, Bittle & Fenlon, 1985; Frisch, Elliott, Atsides, Salva & Denny, 1982; Monti, et al., 1979). There are few studies that have specifically focused on relationships in an inpatient psychiatric setting (Loomis & Baker, 1985; Waldo & Harmon, 1999). There is a paucity of research specifically targeting relationship dysfunction using a short term intensive intervention on the psychiatric inpatients.

Each of these therapies targets different elements in relationship dysregulation. Cognitive therapy primarily identifies and challenges negative beliefs (Beck, 1995), while IPT focuses upon the patient's interpersonal context (Weissman, Markowitz & Klerman, 2000). Cognitive Interpersonal Therapy (CIT) is an intervention that specifically targets relationship dysfunction by teaching patients how to deal with criticism (Burns, 2008). While CIT has been shown to be very effective when taught to therapists to use as an integrative treatment (Castonguay, et al., 2004), it has yet to be examined as a primary intervention for patients in any research. Because of the unequivocally negative impact of relationship distress on the psychiatric patient's clinical course and the limited number of studies examining short term interventions, the continued examination of efficacious and effective interventions is imperative.

Purpose

The purpose of this study was to examine whether a brief intensive CIT (ICIT) intervention, which is designed to target and reduce relationship conflict, would improve patients' ability to handle negative, highly critical interactions within their close relationships and thus decrease their vulnerability to emotion dysregulation, increase their relationship satisfaction, decrease destructive thought processes and reduce rates of

rehospitalization. This study used a pseudo-experimental controlled design. It took place on an acute care adult psychiatric inpatient unit. Before starting the research the toss of a coin determined which group (TAU or ICIT) would be the first to enroll patients. Patients who met the inclusion criteria and consented to participate were randomly assigned to the experimental group (ICIT) or a treatment as usual (TAU) control group. Both groups were given pre-treatment testing using tools designed to measure relationship satisfaction, emotion regulation, and destructive thought processes. The experimental group participated in a two day intensive CIT (ICIT) group, which took place on the weekends. The control group received treatment as usual (TAU). Six weeks after discharge the patients were contacted and appointments were made for post-treatment testing using the same pretreatment measures. For the purpose of this study relapse was defined as the recurrence or exacerbation of psychiatric symptoms requiring rehospitalization. A chart review was completed to determine rehospitalization rates.

Background and Theoretical Considerations

Dealing with relationship dysfunction is often challenging. The diversity of relationships, the vast range of relationship problems with which patients present, and the strong emotions attached to relationships contribute to this challenge. Research has shown that there is a specific population, patients who have a psychiatric diagnosis, for which relationship dysfunction presents an increased challenge (McCleod, 1994; Truant, 1994; Whisman, 2001). Snyder and Whisman (2003) concluded that the type of relationship dysfunction that presents the greatest challenge, even to a seasoned therapist, is one in which patients not only are experiencing relationship problems, but one or both

partners are also experiencing emotional, behavioral or health problems. National surveys of couple therapists reveal that treating relationship disturbances in the context of a psychiatric diagnosis is one of the most difficult problems encountered in clinical practice (Northley, 2002; Whisman, Dixon, & Johnson, 1997).

The majority of relationship dysfunction that psychiatric patients experience takes place in a specific type of family environment (Brown, Carstairs, & Topping, 1958; Butzlaff & Hooley, 1998; Hahlweg, 2005; Miklowitz, 2004). This environment is described as one that is high in Expressed Emotion (EE). Despite its somewhat inappropriate name, it is not a measure of emotional expressiveness. Expressed Emotion is best thought of as a measure of family atmosphere, reflecting the attitudes of family members toward the patient. It is assessed using the Caldwell Family Interview, which is a semi-structured interview, administered individually to relatives of the patient. The interview is scored and coded on three principal dimensions: criticism, hostility and emotional over-involvement (Vaughn & Leff, 1976). Families with high expressed emotion (HEE) put patients at risk for relapse (Butzlaff & Hooley, 1998).

Due to the increased awareness of the negative impact of relationship dysfunction on psychiatric illness, a variety of relationship-targeted therapies and interventions have been developed (Segrin, 2001). While there are numerous theories, three psychological paradigms will be reviewed: Cognitive Therapy (CT), Interpersonal Therapy (IPT) and Cognitive Interpersonal Therapy (CIT). Each of these therapies, CT, IPT and CIT, targets different elements in relationship dysregulation.

Expressed Emotion

Family relationships play a pivotal role in the clinical course of individuals suffering with psychiatric illnesses. In assessing a patient's risk of relapse based on family interactions, an important factor is expressed emotion (Butzlaff & Hooley, 1998). Expressed emotion (EE) is a measurement of the level of emotional over-involvement, criticism, and hostility toward the patient by a relative of the patient. Of these, criticism has been shown to be the most detrimental for the patient (Hooley & Teasdale, 1989). High expressed emotion is a predictor of poor outcomes across a range of psychiatric diagnoses (Butzlaff & Hooley, 1998). Research examining a family's expressed emotion (EE) confirms that interpersonal relationships can impact symptom fluctuation, relapse rates and treatment outcomes (Butzlaff & Hooley, 1998; Chambliss & Steketee, 1999; Hooley, 1998; Hooley, et al., 1986; Hooley & Teasdale, 1989; Kwon, et al., 2006). Butzlaff and Hooley (1998) found that during times of crisis, such as hospitalization, family levels of EE are reliably associated with the risk of relapse after discharge. This would indicate that it is especially important to administer psychosocial treatments that effectively address relationship conflict during the patient's hospitalization.

Cognitive Therapy and Interpersonal Therapy

The foundational premise in CT and CBT is that emotions and behaviors are influenced by perceptions and beliefs about a particular situation or event. The goal of CT is to challenge and change negative beliefs and to increase the patient's understanding of how these negative cognitions impact one's thoughts, emotions and relationships (Beck, 1995). A primary objective of the CBT approach to relationship dysfunction is

helping patients identify their beliefs and expectations and then to evaluate the validity and reasonableness of them (Baucom & Epstein, 1990; Beck, 1988; Epstein, 1986).

Unlike CT, IPT does not directly address negative cognitions, but aims to improve emotion dysregulation by addressing various relationship concerns. This approach is aimed at helping persons renegotiate their interpersonal context. The patient's relationship dysfunction is addressed in one of four relationship domains: 1) grief; 2) interpersonal role disputes; 3) role transitions; or 4) interpersonal deficits (Weissman, et al., 2000). Interpersonal Therapy addresses the way the patient feels, thinks, and acts in problematic interpersonal relationships. Unlike CBT, cognitions and behaviors are not the central focus. Cognitions and behaviors may be addressed, but only as they pertain to significant persons in the patient's life.

Cognitive Interpersonal Therapy

Dr. David Burns (1990) developed and introduced Cognitive Interpersonal Therapy (CIT) in his book, *The Feeling Good Handbook*. Burns developed this therapy based on twenty-five years of clinical experience and personal research. Cognitive Interpersonal Therapy presents an effective, but often challenging, way of addressing relationship conflict. Burns, who is a cognitive therapist, spent his career being very successful using cognitive therapy with patients with a variety of diagnoses. However, he found that patients who were angry, critical, or unreasonable often presented a unique challenge that he was determined to overcome. Burns observed that regardless of diagnosis, many of his patients presented with relationship conflict (Burns, n.d., audio recording; Burns 1990; Burns, 2008). He also observed that the cognitive techniques that

had been very successful with specific problems in depression and anxiety were not effective when dealing with angry, critical patients, or with patients who had relationship conflict. It was the ongoing challenge of working with patients with alliance ruptures and relationship conflict that prompted Burns to dissect and examine his interactions with his patients and their responses to him. It was during this time he developed and refined CIT (Burns, nd, audio recording, Castonguay, et. al., 2004).

Others also observed that there were a number of patients who did not respond to CT (Robins & Hayes, 1993). Reinforcing this concern was research that concluded that therapists' use of traditional CT techniques to address interpersonal issues such as alliance ruptures was negatively correlated with outcome (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). This finding was further examined by research that compared Burns' Integrative Cognitive Therapy for alliance ruptures (instead of traditional CT) to a Waiting List (WL) group. The Integrative treatment led to greater improvement than the WL condition. This preliminary empirical support for Burns' interventions suggests possible benefit for the proposed utilization in an inpatient population (Castonguay, et. al., 2004).

Cognitive Interpersonal Therapy: The motivational component.

Burns (2008) states that most therapies address relationship dysfunction from a "deficit" perspective, which means that relationship problems are due to the lack of interpersonal skills that are required for close relationships. With this etiological mindset for relationship dysfunction, the primary goal for any intervention, be it based on CT or IPT, is to teach the patients relationship skills they are lacking. While CIT does include

instruction on specific communication skills, its foundational premise is that relationship problems are due to motivation, not simply the lack of interpersonal skills. It is for this reason that motivation for change is addressed in depth before any instruction on interpersonal skills take place.

Assessing motivation is a crucial component of CIT. In order for CIT to be effective the patient has to be willing to: (a) acknowledge that emotional discomfort is inherent in intimate relationships; (b) determine whether he wants to leave the relationship, keep the relationship as it is, or recognize his role in creating relationship problems and work on changing himself; and lastly (c) give up blaming his partner, defined as giving up his right to get even.

The patient's recognition of his role in relationship dysfunction is vital and allows him to become aware of how his own behavior inadvertently produces the relationship problems about which he complains. Once the patient has acknowledged his personal responsibility in relationship dysfunction, the therapist does not directly challenge the patient's beliefs and negative emotions, but accepts them and empathizes with the patient, which is very different from CT or IPT. The therapist emphasizes the patient's responsibility to change his own way of communicating (Burns, 2008).

The application of Cognitive Interpersonal Therapy.

The application of CIT skills begins once the patient acknowledges his own contribution to relationship dysfunction, has agreed to give up blaming his partner, and agrees to begin to work on himself. The CIT communication skills require the patient to constantly address his motivations. The CIT intervention begins by teaching the patient to

do a situation analysis. The client is asked to identify a situation in which he felt criticized or hurt. This situation analysis helps the patient to identify the exact conversation as it took place.

The communication skills that are taught are empathy, assertiveness and respect. Empathy involves the ability to identify the thoughts and emotions of one's partner. The patient is then taught how to be assertive while being respectful. This involves the ability to identify and communicate his thoughts and feelings in a respectful, nonjudgmental manner. Each of these skills is discussed in depth, and examples are given for practical application of each. The client will then examine the conflict identified in the situation analysis and determine if he utilized any of these skills. The patient then revises his part of the interaction incorporating the CIT skills. This process is practiced and modeled throughout the CIT intervention.

Cognitive Interpersonal Therapy as mentalization.

Cognitive Interpersonal Therapy (CIT) is specifically designed to address relationship conflict and to help individuals learn how to deal with the negative emotions generated by relationship distress. CIT focuses on managing emotion dysregulation by addressing both cognitions and relationship problems. CIT could be classified as a mentalization-based treatment as described by Allen (2006), in that it works to manage emotion dysregulation by teaching patients to attend to states of mind in themselves and others. Mentalizing is an active process that takes place while one is interacting with others. During CIT the goal is to assist the patient to remain attentive to his own mental and emotional state, while holding the other person's mental and emotional state in mind

as well. It is the ability to be aware of others' emotional states that enables people to interact with others effectively. The ability to be aware of one's own thoughts and emotions (explicit mentalizing) is an essential component of interpersonal problem solving. This explicit mentalizing (self-awareness) "promotes intrapersonal problem solving, most notably, the capacity for emotion regulation" (Allen, 2006, p. 20). This process can be very challenging for several reasons, one of which is that mentalizing is fused with emotion (Allen, 2006). It is these highly emotionally charged interactions that CIT targets.

The interpersonal skill set presented in CIT teaches patients how to reduce the severity of a conflict and to repair relationship disturbances (Burns, n.d., Audio Recording; Burns, 2008). CIT challenges the patient to identify the thoughts and emotions of his partner by learning empathy, and to identify and communicate his thoughts and feelings in a respectful, nonjudgmental manner. Helping the patient learn to respond in a nonjudgmental manner is also involved in the process of mentalizing. Another important component of mentalizing is the meanings attributed to the self and other's actions, that is, "to the implicit or explicit hypotheses we use to understand why we, or another, might have thought or done such and such a thing" (Holmes, 2006, p. 32). This is an important topic addressed in CIT when assisting the patient to form respectful and nonjudgmental responses.

As previously mentioned, CIT skills are practiced with the patient using his own personal communication example, usually a situation in which the patient has been criticized. This is a crucial component of CIT since the EE research has indicated that criticism is the component that can often trigger relapse for patients (Hooley & Teasdale,

1989). The CIT skills are also being modeled by the therapist as well. This process helps promote positive attitudes as the patient begins to see how modifying his own responses could impact the outcome of the communication process, as well as working to increase the patients' attentiveness to the mentalization process. Herein lies the powerful paradox of CIT: the patient begins to learn that attempts to change his partner are futile, even counterproductive, but that changing himself leads to the sought-after changes in his partner. Burns (2008) states, "We change other people every time we interact with them, but we're just not aware of it" (p. 82). CIT helps the patient not only to become aware of it, but to observe the powerful impact he can have in his own relationships.

CIT focuses on the motivation of the patient and the process of communicating, rather than on specific content. Like other mentalization-based treatments, the goal is not to "create specific insights such as developmental origins of internal conflicts or relationship problems...Rather, the point of mentalization-based therapy is to enhance the patient's capacity to generate insight on the fly" (Allen, 2006, p. 18).

Examples of different approaches.

Each of the therapies reviewed targets different elements in relationship dysfunction. For example if a patient states, "My husband is such an awful person, he is always angry and upset, and nothing makes him happy no matter what," the Cognitive therapist would focus on and challenge the various cognitive distortions present in this statement, such as overgeneralization and focusing on the negative. The Interpersonal therapist would work with the patient to do an in-depth examination of the context in which the conflict takes place and evaluate interpersonal deficits. However, the CIT

therapist would use empathy: “I know it’s very difficult to deal with someone who is angry and upset. It is also frustrating when you feel like you cannot please him.” The therapist would then focus the patient’s attention on potential responses to her husband that would help her communicate more effectively. The therapist empathizes with and accepts the patient’s pain and anger and does not directly challenge thoughts or emotions expressed about her husband. The patient is also taught how to manage conflict through empathy and acceptance of self and others. The objective is to enhance the patient’s ability to change his own way of communicating and relating to others by: (a) helping the patient better monitor relationship events; (b) teaching the patient to assess his skillfulness in handling conflict; and (c) enhancing the patient’s interpersonal communication skill for coping with conflict more effectively (Burns, nd, audio recording; Burns, 2008).

Importance of Study and Implications

There has been much research examining the impact of relationships on the clinical course of psychiatric patients (Butzlaff & Hooley, 1998; Chambliss & Steketee, 1999; Hooley, et al., 1986; Hooley & Teasdale, 1989, Kwon, et al., 2006). Criticism has been identified as the most powerful component of Expressed Emotion in causing patients’ relationship distress and predicting relapse (Hooley & Teasdale, 1989). A fundamental difference between CIT and other therapies is that the primary focus of CIT is to teach patients how to deal with highly critical negative interactions. While there have been a variety of interventions used to address relationship distress and communication skills in inpatients settings, none of these has utilized CIT directly with a

patient population. The aim of the study was to develop and pilot-test with inpatient psychiatric participants the effectiveness of an ICIT intervention, compared to treatment as usual (TAU). Research shows that patients who return home to live with relatives rated high in expressed emotion relapse at significantly higher rates than patients who return home to live with relatives with lower rates of expressed emotion (Hooley & Teasdale, 1989). The chief aim of this study was to expand current research by examining whether a brief, intensive CIT intervention, which is designed to target and reduce relationship conflict, would offer hospitalized patients important skills that would improve their ability to handle negative, highly critical interactions within a relationship and thus decrease their vulnerability to emotion dysregulation and relapse post-hospitalization.

Research Question

This study sought to answer the following research question: Will patients on an acute inpatient psychiatric unit receiving an ICIT intervention show greater improvement in relationship satisfaction and emotion dysregulation, decreased rehospitalization rates, and decreased destructive thought processes at the end of a six week period after discharge when compared to the TAU group?

Limitations and Assumptions of the Study

This study was limited to the patients admitted to an inpatient psychiatric unit in central Virginia who met the research criteria and consented to participation, and who were hospitalized during the weekends that the research took place. It was assumed that

patients would be truthful in identifying a distressed relationship on which they were motivated to work. The patients were asked not to discuss treatment with other patients.

Other variables that may have influenced the course of treatment include unit atmosphere, staff attitudes and beliefs regarding the research study, mixture of patients on the unit, family and staff involvement, the consistency of the intervention throughout the treatment groups, and the discharge environment to which each patient returned. While patients were required to meet the inclusion and exclusion criteria, the personality and temperaments of the patients might have impacted group dynamics. Patients also had a variety of cognitive levels. There were some patients who continued to work with a therapist after discharge, while others did not. Patients in both groups also participated in a group where they were introduced to CIT that is conducted as part of the regular weekly Cognitive Therapy group on the unit. Due to the nature of inpatient units, patients' medications were often being adjusted, which may have impacted the patients' ability to concentrate at times. Also, having worked on the inpatient unit, there were two patients who participated in the study with whom the researcher was previously acquainted.

Terms and Definitions

Cognitive Behavioral Therapy—Cognitive Behavioral Therapy seeks to help the patient overcome problems by identifying and changing dysfunctional thinking, behavior and emotional responses. The goals of therapy include helping patients develop skills for identifying distorted thoughts, modifying beliefs and changing behavior patterns.

Cognitive Interpersonal Therapy—Cognitive Interpersonal Therapy seeks to help patients by focusing on personal motivation and acceptance of personal responsibility in

relationships. The patient is taught a skill set that emphasizes the patient's ability to respond appropriately when responding to criticism.

Expressed Emotion—Expressed Emotion is the measure of the amount of emotion (primarily hostility, criticism and emotional over-involvement) displayed by a family. A high level of EE in the home can worsen the prognosis in patients with psychiatric illness.

Interpersonal Therapy—Interpersonal Therapy is a time-limited therapy that focuses on the patients' interpersonal context and interpersonal skills. The focus of IPT is on interpersonal process rather than intrapsychic processes. The goal of IPT is to impact and change the patients' interpersonal behavior by fostering adaptation to current interpersonal roles and situations.

Relationship Dysregulation— Relationship Dysregulation is a condition in a relationship that is predominately characterized by unresolved conflict that causes the partners emotional despair.

Emotion Dysregulation—Emotion dysregulation refers to an emotional response that is poorly modulated. It can be demonstrated by labile emotions or difficulty in dealing with anger or other strong emotions. It can lead to behavioral problems and often causes problems in the patient's personal relationships.

Motivation—Motivation is the activation of goal-oriented behavior. The patient will need to be motivated to change to impact relationships positively by applying skills that effect change.

Mentalization—Mentalization is the active process and ability to describe the mental state of oneself as well as others.

Destructive Thought Processes—Destructive Thought Processes are negative thoughts that can include self-critical thoughts, self-abusive thoughts, and suicidal ideation.

Summary

The impact of relationship conflict on the clinical course of a psychiatric patient can have long term deleterious effects (Butzlaff & Hooley, 1998; Chambliss & Steketee, 1999; Hooley, et al., 1986; Hooley & Teasdale, 1989, Kwon, et al., 2006). Research has shown that the inability to handle conflict, specifically the inability to deal with criticism, is one of the greatest indicators of relapse potential (Hooley & Teasdale, 1989). This study addressed an important but under researched area of short term intensive inpatient interventions that focuses on relationship conflict, primarily targeting the patient's ability to handle criticism. To the knowledge of this researcher, until this study, Cognitive Interpersonal Therapy had yet to be evaluated with a clinical population in an acute care setting.

Cognitive Interpersonal therapy is very different from CBT or IPT in that it specifically targets this important area of relationship conflict. Chapter two will include an overview of Expressed Emotion and the role that it plays in psychiatric illness. Cognitive Behavioral Therapy, IPT, and CIT will be discussed, as will the approach used by these therapies when addressing relationship conflict. Lastly, research addressing relationship conflict in a variety of psychiatric illnesses will be examined, making evident the need for short-term intensive inpatient interventions targeting relationship conflict.

CHAPTER TWO: REVIEW OF THE LITERATURE

The following chapter describes the relationship between psychiatric illness and relationship conflict. Expressed Emotion and its impact on families of psychiatric patients are reviewed, as is the impact of EE on the patient's clinical course. The theories of Cognitive Behavioral Therapy, Interpersonal Therapy, and Cognitive Interpersonal Therapy are examined, as well as the specific approaches of each of these therapies when directed at relationship distress. Empirically supported relationship interventions are discussed and, lastly, inpatient research that specifically targets relationships and communication is reviewed.

Psychiatric Illness and Relationships

Interpersonal relationships play a fundamental role throughout one's life. Because people are social beings, human interactions are required to meet their needs, attain their goals and fulfill their potential. Humanity's essence is displayed in the patterns of public and private interactions (Kiesler, 1996). While relationship conflict can be a common occurrence for many, there is a growing body of research that shows relationship difficulties frequently co-exist in persons with existing psychiatric illness (Borkovec, et al., 2002; Burge, et al., 1995; Gross, 1998; Halford & Bouma, 1997; Sydner & Whisman, 2003).

While examining the association between 12-month prevalence of common Axis I disorders and marital dissatisfaction, Whisman (1999) discovered that spouses with any mood, anxiety or substance disorder reported significantly greater relationship conflict and marital dissatisfaction than spouses without these disorders. Greater marital

dissatisfaction was associated with seven of twelve specific disorders for women. The largest associations for women were obtained in Post-Traumatic Stress Disorder (PTSD), dysthymia and major depression. For men, marital dissatisfaction was greater in 3 of 13 specific disorders; these were dysthymia, major depression, and alcohol dependence (Whisman, 1999).

In a representative sample from the United States, Whisman and Uebelacker (2003) found that maritally distressed persons were three times more likely to have a mood disorder, two and a half times more likely to have an anxiety disorder, and two times more likely to have a substance use disorder than individuals who were maritally satisfied. Goering, Lin, Campbell, Boyle, and Offord (1996) observed in a sample of over 4,000 married persons that people with affective disorder, anxiety disorder, substance abuse, or mixed (i.e., more than one) disorder were more likely to report having troubled relationships than those without a disorder.

Not only does relationship conflict co-exist with many psychiatric disorders, it has also been shown to have a major impact on the clinical course of many diagnoses. Relationship conflict has also been shown to impact relapse rates in schizophrenia (Leff & Vaughn, 1981; Vaughn & Leff, 1976; Vaughn, Synder, Jones, Freeman & Falloon, 1984), depression (Hooley & Teasdale, 1989), anxiety disorders (Durham, Allan & Hackett, 1997; Milton & Hafner, 1979), and alcohol-use disorders (Maisto & O'Farrell, 1988), and has also been associated with a poorer prognosis in treatments for depression (Kung, 1996; Rounsaville, Weissman, Prusoff, & Hercet-Baron, 1979) and anxiety disorders (Bland & Hallam, 1981; Monteiro, Marks, & Ramm, 1985).

While research has not conclusively determined the etiological association between psychiatric disorders and relationship conflict, studies provide increasing evidence that relationship disturbances are associated with the course of many psychiatric disorders (Segrin, 2001; Whisman, 1999). Whatever the primary causes, it is understood that psychiatric illness and relationship conflict create a vicious cycle that mutually and constantly affect each other (Goldfarb, Gilles, Boyer & Preville, 2007). After several decades of examining the interaction between psychiatric illness and family environment, research has isolated a specific family environment that is a highly reliable psychosocial predictor of relapse, a family with high expressed emotion (EE).

Expressed Emotion and its Impact on Psychiatric Illness

The study of the family environment became of particular interest to George Brown and his colleagues in London in the 1950s. Vaughn (1989) states that Brown and his colleagues were observing many long term schizophrenic patients who were being discharged into the community. There were concerns because many of these patients who had dramatic improvement and progress in the hospital did not do well after discharge, even when compliant with their prescribed medication regime.

To examine this phenomenon, Brown, et al. (1958) conducted a study that involved the discharge of 229 male schizophrenic patients who had been inpatients for two years or more. This research showed that there was a significant link between relapse and the type of living environment to which the patient returned. Patients returning to live at home with parents or spouses were significantly more likely to relapse than other patients. To examine some of the competing explanations Brown, Monk, Carstairs, and

Wing (1962) developed some direct measures for family environment. The researchers examined the amount and types of emotions exhibited by 128 discharged male patients and key female relatives at home. Of the patients returning to families that were judged to have “high emotional involvement,” three-quarters relapsed, compared to less than one-third of the remaining patients. The focus then became to design an instrument of measure (Brown & Rutter, 1966; Rutter & Brown, 1966).

This study led to the development of the standardized, semi-structured Camberwell Family Interview (CFI). During an interview of a member of the patient’s family, the interviewer measures a variety of feelings and emotions expressed by the family member. The CFI was utilized by Brown, Birley and Wing (1972). The researchers were able to determine aspects of family life associated with post-discharge relapse. The most important indicators of relapse included the relative’s critical comments, hostility and emotional over-involvement. Expressed Emotion (EE) is a measurement that reflects the extent to which relatives of psychiatric patients express critical, hostile, or emotionally over-involved attitudes toward their family members. The findings were then replicated by Vaughn and Leff (1976) and Vaughn, et al. (1984). According to Vaughn (1989) in each of these replication studies, the measure of a “relative’s EE at the time of admission proved to be the best single predictor of symptomatic relapse, more powerful than any clinical feature of the patient’s illness” (p. 15).

The last several decades have continued to establish EE as a highly reliable psychosocial indicator of symptom fluctuation, psychiatric relapse and treatment outcome (Butzlaff & Hooley, 1998; Hooley & Parker, 2006; Hooley & Teasdale, 1989). When

persons with psychiatric illness live in a family environment that is characterized by critical, hostile, or emotionally over-involved family members, they are at a significantly elevated risk for relapse compared to persons who do not live in such a family environment. When measured during a time of crisis (i.e., during a hospitalization or a period of exacerbation of symptoms), these characteristics are a reliable predictor of relapse in psychiatric patients (Hooley, 2004). Expressed Emotion was initially studied and found to be a factor for relapse in families of patients with schizophrenia (Leff & Vaughn, 1981; Leff & Vaughn, 1985; Lopez, et al., 2004; Vaughn & Leff, 1976; Vaughn, et al., 1984). Butzlaff and Hooley (1998) conducted a meta-analysis of 27 studies examining the relationship between EE and relapse in schizophrenia. Across the studies, the expected 9 to 12 month relapse rate for patients who were in high EE families was 65% and for patients in low EE families, 35%. Out of the 27 studies examined, 24 showed a positive association between EE and relapse, with higher levels of EE being associated with greater rates of relapse.

While the initial studies focused on EE in patients with schizophrenia, EE has been shown to influence many other psychiatric illnesses. Expressed Emotion has also been found to be indicative of relapse for depression (Butzlaff & Hooley, 1998; Gilhooly & Whittick, 1989; Hooley, 1986; Hooley, et al., 1986; Hooley & Teasdale, 1989; Miklowitz, Goldstein, Nuechterlein, Snyder & Mintz, 1988; Priebe, Wildgrube, & Muller-Oerlinghausen, 1989; Vaughn & Leff, 1976), anxiety disorders (Chambless, Bryan, Aiken, Steketee, & Hooley, 2001), substance abuse (O'Farrell, Hooley, Fals-Stewart, & Cutter, 1998), bipolar disorder (Miklowitz, Goldstein, Nuechterlein, Snyder &

Doane, 1986; Miklowitz, et al., 1988; Simoneau, Miklowitz, & Saleem, 1998) and eating disorders (Butzlaff & Hooley, 1998).

The majority of research surrounding relationship distress has focused on one target disorder without considering comorbid disorders. Unfortunately, most patients do not present with only one diagnosis. According to the National Comorbidity Study, 60% of the respondents with at least one lifetime disorder had two or more disorders (Kessler, et al., 1994). However, even in studies that included comorbid conditions, EE continues to be a strong predictor of relapse. Pourmand, Kavanagh and Vaughan (2005) found that in comorbid conditions of schizophrenia and substance abuse disorder, high EE was the strongest predictor of relapse. Hooley (1989) states that when clinical characteristics, such as illness severity and chronicity, are statistically controlled, the association between EE and patient relapse has remained significant.

The measurement of EE reveals attitudes, behaviors, and general coping styles that act as stressors that influence the outcome of many disorders (Vaughn, 1989). The concept of EE is supported by the predominant view of the etiology of mental disorders, the diathesis-stress model (Corcoran et al., 2003). This model states that environmental stress interacts with a genetic predisposition to produce illness and impact its course (Post, 1992). The diathesis-stress model also explains the bidirectional influence of mental health and relationship distress. The patient's relative may be temperamentally predisposed to high EE attitudes and the onset of the patient's symptoms may be sufficient to activate high EE responses (Hooley & Gotlib, 2000). The criticism, hostility and over-involvement expressed by EE families can exacerbate illness and influence the trajectory of an individual's mental health (Whisman & Uebelacker, 2003).

While EE is a measurement of the patient's family member, it is understood that EE is more accurately a measure of the patient-relative relationship. Hooley and Gotlib (2000) conceptualize EE within an interactional framework, with negative characteristics from the patient generating critical attitudes in relatives. Interactions in high EE families are associated with reciprocal negativity within the relationship (Cook, Kenny, & Goldstein, 1991; Hahlweg et al., 1989; Hooley, 1990; Simoneau, et al., 1998). These negative patterns of interaction transcend diagnosis. In high EE families, a negative statement or nonverbal cue made by one partner is much more likely to generate another negative behavior from the second partner. This results in a sequence of negative verbal escalation (Hooley, 1990). In contrast, low EE families are able to handle negative behaviors in a manner that deescalates this negative interaction (Hahlweg, et al., 1989).

Although the predictive validity of EE is no longer in question, many aspects of the EE concept and its mechanism in relapse are not well understood (Barrowclough & Hooley, 2003). Vaughn (1989) proposed that it is possible that EE is associated with relapse only because of its association with another variable that is the causal agent. However, other factors have been examined by researchers and none have predicted relapse independently of EE (Franks, Shields, Campbell, McDaniel, Harp & Botelho, 1992; Hooley, Rosen, & Richters, 1995; Leff & Vaughn, 1985).

Expressed Emotion and medication compliance.

Expressed emotion appears to play a role in relapse even when patients are compliant with their medication regime. In fact, it was the observation that schizophrenic patients who had been experiencing dramatic improvements on medications when

hospitalized did not sustain these improvements upon discharge despite maintenance on regular medications that was the catalyst for EE research (Vaughn, 1989). A longitudinal study of patients with a recent diagnosis of schizophrenia found that high EE predicted relapse, even when medication was standardized and ensured through depot administration (Nuechterlein, et al., 1986).

Lithium is an effective medication for bipolar disorder. However, Miklowitz, et al. (1988) found that 15 out of 16 patients with bipolar disorder who were medication compliant but were from families with high expressed emotion (EE) or negative affective style (AS) experienced relapse.

Gitlin, Swendsen, Heller and Hammen (1995) evaluated relapse in eighty-two patients diagnosed with bipolar disorder who were closely monitored for maintenance pharmacotherapy. While EE was not specifically examined, the researchers used a variety of symptom ratings and psychosocial scales. Despite the consistent pharmacology intervention, research indicated a five year risk of relapse into mania or depression at 73%. Poor psychosocial functioning predicted shorter time to relapse, even after control for the number of prior episodes. The researchers concluded that many bipolar patients have poor outcomes while receiving aggressive pharmacological maintenance treatment.

In order to assess the impact of EE on patients who had been medication compliant, Priebe, et al. (1989) examined EE in families of 21 patients with bipolar disorder or schizoaffective psychosis who had been taking lithium for at least three years and were asymptomatic at the time the research was conducted. The researchers examined EE status and the course of illness. Results showed that patients from the high EE families had a higher risk of relapse. While limitations of this study include the small

number of subjects and the conduction of the CFI interviews at a time when patients were symptom free, it does support the hypothesis that patients from high EE families are vulnerable to relapse even when they are medication compliant. These studies reinforce that while encouraging medication compliance is very important, for patients whose relationships are characterized by conflict, medication compliance alone is not sufficient to prevent relapse.

Cognitive Behavioral Therapy and Interpersonal Therapy are empirically validated treatments. The following will give the reader a general overview of each of these therapies' theoretical background and approach to relationship conflict. Cognitive Interpersonal Therapy and its approach to relationship conflict will be also reviewed.

Overview of Theories

Cognitive Therapy and Cognitive Behavioral Therapy

Cognitive Therapy (CT) was introduced by Aaron Beck in the early 1960s. It was developed as a structured, short-term psychotherapy for depression (Beck, 1995; James & Gilliland, 2003). Beck became aware of a pervasive negative bias that permeated the cognitions of depressed persons. He identified this cognitive structure as a negative cognitive triad that consisted of a negative view of oneself, one's world, and one's future. Beck developed Cognitive Therapy to change these maladaptive thought patterns (Beck, Rush, Shaw, & Emery, 1979). Many clinicians and researchers have contributed to theory of CT, and it has been successfully adapted to a variety of psychiatric diagnoses (Beck, 1995; Glass & Arnkoff 1992a).

The primary goal of CT is to assist patients in solving their problems by identifying dysfunctional thinking. The theoretical premise of CT is the cognitive model that “people’s emotions and behaviors are influenced by their perception of events” (Beck, 1995, p.14). Therefore, emotional disturbances are not caused by one’s situation, but by what one believes about his situation (James & Gilliland, 2003). Beliefs about oneself, others and the world begin to develop before one can articulate or understand them. While these cognitive distortions often cause an ongoing negative internal dialogue, Goldfried (2003) notes that there are times when the patient is not responding to his internal dialogues, but rather to his implicit meaning structures that are associated with events, people and situations. While patients may not be able to identify their internal dialogue, they react “emotionally, cognitively, and behaviorally ‘as if’ they were saying certain things to themselves” (p. 55).

Cognitive Therapy identifies these most central beliefs as core beliefs or schemas. These core beliefs play an important role in the way people process information and interact with others. They are generalizations about oneself, based on past experience that “organize and guide the processing of the self-related information contained in an individual’s social experience” (Markus, 1977, p. 63). Core beliefs tend to be global, rigid and overgeneralized. People often act upon these core beliefs as if they are absolute truths. Furthermore, they tend to focus selectively on data that confirms their core beliefs and ignore data that would challenge those beliefs. The objective of the Cognitive therapist is to assist the patient to identify, reality test, and correct his dysfunctional thinking (Beck, 1995; Dobson, Barks-Dermott, B., & Dozois, 2000; Leahy, 2003).

Based on the newly emerging contributions of cognitive research and clinical need, behavioral therapists recognized the importance of the development of cognitive methods in behavioral therapy. This recognition evolved into what is now known as Cognitive Behavioral Therapy (CBT) (Dobson & Block, 1988; Glass & Arnkoff 1992b; Goldfried, 2003). While there is much emphasis on cognitive factors, the Cognitive Behavioral therapist and patient work together to identify the relationship between thoughts, feelings, and behavior (Leichsenring, Hiller, Weissberg & Leibing, 2006). The focus in CBT is the here and now. Therapy goals are formulated based upon the patient's diagnosis and identified goals. The goal of CBT is to "directly target symptoms, reduce distress, re-evaluate thinking and promote helpful behavioral responses" (Leichsenring, et al., 2006, p. 234). A key component of the CBT orientation is that therapeutic change involves the development of new behaviors (Goldfried, 2003). A number of behavioral interventions are utilized to facilitate new experiences for the patient. Therapists use these corrective experiences to assist patients in restructuring their self-schemas.

In CBT a patient's progress is determined by his ability to identify and correct his dysfunctional cognitions. These corrected cognitions are processed as new corrective experiences. Another aim of CBT is to encourage patients to alleviate their distress by identifying and using their own resources. The therapist encourages the patient to apply between sessions what he has learned in session. The patient begins to experience self-efficacy as he learns that he can make needed changes to improve his life (Leichsenring, et al., 2006). Leichsenring, et al. (2006) assert that CBT is not about trying to prove the patient wrong, but about moving toward a skillful collaboration in which patients come to

discover for themselves that there are realistic positive alternatives to their dysfunctional cognitions and behaviors.

Dobson and Block (1988) and Kendall and Bemis (1983) (as cited in Glass & Arnkoff, 1992) found that while there are varying forms of Cognitive Behavioral therapy, there are features and propositions that are common to all of them:

a) collaborative relationship between patient and therapist, (b) the assumption that emotional disorders and behaviors are at least in part a function of disturbances in cognitive process, (c) a focus on changing cognitions in order to produce desired changes in affect and behavior, and (d) a generally time-limited and educative treatment focusing on specific target problems. (p. 660)

Extensive research demonstrates that CBT is an empirically sound and effective treatment in psychotherapy that has been applied to an increasing array of clinical disorders (Beck, 1995; Beck, 2005; Chambless, et al, 1996, Chambless, et al, 1998; Cutler, Goldyne, Markowitz, Devlin, & Glick, 2004; Dobson & Craig, 1996).

Cognitive Behavioral approach to relationship problems.

When a couple is experiencing distress in their relationship, the Cognitive Behavioral therapist will assess the behavioral, cognitive and affective components of the relationship, and how these three factors interact. While the three factors may not have an equal contribution to the relationship dysfunction, it is important to address all three of them in therapy (Baucom & Epstein, 1990).

The cognitive component in couple therapy has its roots in the cognitive model of individual psychotherapy (Baucom & Epstein, 1990; Dattilio, 2002). A significant assertion of CBT is that relationship dysfunction is a result of inappropriate information processing. The patient's cognitive appraisals of relationship events are said to be invalid

or based upon unreasonable standards. Individuals often fail to evaluate the appropriateness and truthfulness of their cognitions. Many dysfunctional beliefs are often not articulated but exist as vague concepts of how a relationship should be (Beck, 1988). The underlying premise of CBT is that behavioral changes alone are not sufficient to correct dysfunctional relationships; therapy must address the couple's thinking as well as maladaptive behavior patterns (Dattilio, 2002).

When applying CBT to relationship problems, there are several principles that are incorporated into therapy. These are: examining and modifying unrealistic expectations in the relationship, exploring and correcting faulty attributions, and teaching patients techniques to help improve communication. A primary objective of the CBT approach to relationship dysfunction is helping patients identify their beliefs and expectations and then evaluating the validity and reasonableness of them (Baucom & Epstein, 1990; Beck, 1988; Epstein, 1986).

Behavioral modification is also an important focus of CBT. Cognitive Behavioral Treatment incorporates behavior interventions based on the social learning model that proposes that an individual's behavior both influences and is influenced by his or her environment (Baucom & Epstein, 1990). This premise provides the foundation for the behavioral intervention in CBT. Patients are often unaware of the impact of their behaviors on their partners. The therapist will devote time to identifying and modifying behaviors and skills that prevent couples from having a successful relationship. The behaviors targeted in CBT are: "(a) excesses of displeasing acts and deficits in pleasing acts exchanged by members of a couple, (b) general communication skills, (c) problem-solving skills, and (d) behavior change skills" (Baucom & Epstein, 1990, p. 17).

The CBT approach also focuses on emotion as a major component of functional and dysfunctional relationships. Emotions that are experienced by the patient influence his cognitions and behaviors. So in addition to helping couples identify cognitions and behaviors that influence emotions, cognitive behavioral therapists seek to identify emotional states that can influence couples' cognitions and actions toward each other (Baucom & Epstein, 1990). Baucom and Epstein (1990) have identified four interrelated aspects of affect in intimate relationships that should be identified when working with couples with relationship dysregulation. These include

(a) the overall degrees of positive and negative emotions that an individual experiences toward his or her partner and their marriage, (b) the degree of difficulty an individual has in recognizing his or her emotions and their causes, (c) the degree to which each spouse overtly expresses emotions of which he or she is aware, and (d) the presence of emotional reactions that interfere with adaptive functioning between partners. (p. 92)

When working with couples using CBT it is important to determine the specific nature of the emotions experienced by each spouse. The cognitive theory presupposition is that there can be different factors associated with different emotions. For instance, persons diagnosed with anxiety or mood disorders often experience an assortment of negative and distorted cognitions. Understanding the nature of the emotion allows the therapist to design interventions that are appropriate and patient specific (Baucom & Epstein, 1990).

In conclusion, the CBT approach to understanding patients' relationship problems includes examining how the couple thinks, experiences emotions, and behaves. Clinical evaluation takes place by interacting with the couple and assessing the domains of behavior, cognition, and affect, and how these domains interact.

Interpersonal Theory

The origins of Interpersonal Therapy (IPT) are the contributions of Harry Stack Sullivan (1953). Sullivan, in contrast to the individualistic theoretical orientation of his time, stated that human behavior can only be understood in relation to its historical and interpersonal contexts (Kiesler, 1996). Sullivan deviated from the psychoanalytic understanding of psychopathology, instead adopting the relational structure model. This model states that it is one's relationships with others that provide the infrastructure of one's mental life. Sullivan saw relationships as the motivating force behind human behavior (Greenberg & Mitchell, 1983). Weissman, et al. (2000) state that

Sullivan, who linked clinical psychiatry to anthropology, sociology, and social psychology, viewed psychiatry as the scientific study of people and the processes that go on among them, rather than the exclusive study of the mind or of society. Sullivan popularized the term “interpersonal” as a balance to the then-dominant intrapsychic approach. (p. 7)

It is the pattern of transactions between the patient and his significant other that is the primary clinical focus in IPT (Kiesler, 1996; Weissman, et al., 2000). Interpersonal Therapy was originally developed for patients diagnosed with depression, although it has been adapted for other disorders as well (Weissman, et al., 2007). Interpersonal Therapy views depression as having three components: (a) symptom function, (b) social and interpersonal relations, and (c) personality and character problems. The aim of intervention is primarily in the first two of these processes (Weissman, et al., 2000). These processes are addressed while keeping the emphasis on current disputes, frustrations, anxieties, and wishes as defined in the interpersonal context.

Interventions of IPT are often described as “supportive.” Weissman, et al. (2000) believe that this is often a pejorative term used to describe therapies that are not insight-

oriented. These authors state that “supportive” psychotherapies help patients adjust to their interpersonal relationships by building on existing defenses, and often aim to help patients accommodate to existing reality rather than try to help them change it. However, the goal of IPT is to help patients change, rather than simply to understand and accept their current life situation. The overall treatment goals are identified as “encouraging the mastery of the patient’s current social roles and adaptation to interpersonal situation” (Weissman, et al., 2000, p.9).

Interpersonal Therapy was developed based on empirical research on the psychosocial aspects of depression. It is understood that specific situations, because of their impact on relationship attachments, can be triggers for depression and relationship problems. The key interpersonal problem areas identified by research are: complicated bereavement, marital disputes, life changes encompassed by interpersonal role transitions, and interpersonal deficits. Interpersonal Therapy is used with patients who develop symptoms in association with these situations (Weissman, et al., 2000; Weissman, et al., 2007).

Interpersonal approach to relationship problems.

Interpersonal Therapy aimed at relationship problems is an extension of the individually based interpersonal therapy (Klerman, Weissman, Rounsaville, & Chevron, 1984). This approach is aimed at helping persons renegotiate their interpersonal context. Like individual IPT, the treatment addresses four major interpersonal problem areas, namely, grief, interpersonal role disputes, role transitions, and interpersonal deficits. The focus in relationships is often on interpersonal deficits. A couple’s functioning is assessed

in areas of communication, intimacy, boundary management, leadership, and attainment of socially appropriate goals (Kung, 2000).

Kiesler (1996) states that the interpersonal approach endorses a circular rather than linear causality. With this bidirectional causality, the patient's behavior or conflict is not viewed as being driven "solely by situational factors or by intrapsychic motivations" (p. 3). It is the relationship that is framed as a two-person group in which each member exerts mutual influence. A vital Interpersonal Therapy concept is that any emotional dysregulation taking place in an individual requires an examination of context. The individual is embedded in an environment that influences and is influenced by him (Hammen, 1999). The goal of the therapist is to diagnose the gravity of the dispute and to help the patient reach a solution. The therapist works to accomplish this by helping the patient identify the disagreement, choose a plan of action, and modify communication or expectations so that the difference of opinion is resolved (Weissman, et al., 2007). Interventions involve encouraging spouses to modify maladaptive communication patterns and to reassess or renegotiate their expectations of marital roles. The therapist also encourages intimacy between partners in an attempt to increase mutual marital support (Kung, 2000).

The therapist will assess the stage of the disagreement to determine the interventions for the patient. The stages are renegotiation, impasse and dissolution. If the patient is willing to renegotiate, the therapist will concentrate on teaching him new communication skills. The new skills to be taught will be determined based upon the communication deficit the patient exhibits. If the patient has difficulty voicing his needs and concerns, the therapist will validate the patient's feelings and help him to put those

feelings into a statement and tone of voice appropriate to communicate them. While IPT usually takes place with an individual, it is often useful for the partner to enter treatment as well. If the patient is at an impasse, the therapist may attempt to bring other issues of conflict out into the open in order to develop better ways of dealing with conflict. Lastly, if the patient would like to dissolve the relationship, the focus then turns to assisting the patient with sadness or guilt associated with the loss of the relationship (Weissman, et al., 2007).

Interpersonal Therapy addresses the way the patient feels, thinks, and acts in problematic interpersonal relationships. Unlike CBT, cognitions and behaviors are not the central focus. Cognitions and behaviors may be addressed, but only as they pertain to significant persons in the patient's life. The IPT therapist may draw attention to a distorted thought, for instance, to bring attention to a discrepancy in what the patient is saying and doing, but the cognitions are not the primary clinical focus. The primary goal in IPT is to change the relationship pattern rather than cognitions (Weissman, et al., 2007).

Cognitive Interpersonal Therapy

Dr. David Burns (1990) developed and introduced Cognitive Interpersonal Therapy (CIT) in his book, *The Feeling Good Handbook*. Burns created this therapy based upon twenty-five years of clinical experience and personal research. Cognitive Interpersonal Therapy presents a new way of addressing relationship conflict. Burns, who has a cognitive theory background, spent his career working with patients with a variety of diagnoses. Working with patients who were angry, critical, or unreasonable often

presented a challenge that he was determined to overcome. Burns observed that regardless of diagnosis, most of his patients presented with relationship conflict (Burns, nd, audio recording; Burns 1990; Burns, 2008). The ongoing challenge of relationship conflict prompted Burns to dissect and examine his interactions with his patients and their responses to him. During this process he developed CIT. While developing CIT, Burns began to examine how interpersonal conflict was addressed by various theories. Burns (2008) states that there are basically two theories regarding interpersonal conflict: the deficit theory and the motivational theory.

The Deficit Theory.

The deficit theory states that people do not get along because they are lacking the skills that are required to solve their interpersonal problems. Most current therapies used for relationship dysregulation are based on deficit theories. Burns states that deficit theories include the CBT, gender theories and IPT. For example, the CBT model of interpersonal conflict states that conflict results from negative cognitions and if people are taught to change their cognitions and the way they view the conflict, then they can resolve interpersonal conflict. The behavioral component of CBT states that a person's interpersonal conflict will be resolved when he is taught new behaviors that promote close relationships. Gender difference models address the difference in the way genders relate. The therapeutic goal is to teach the patient to relate to the opposite gender appropriately. Interpersonal Therapy's goal is to teach persons new relationship skills that will change their negative relationship patterns. These theories and perspectives all share the idea that people are inherently positive and loving, and that they want loving

relationships. If the barrier (cognitive, behavior, gender issues, or interpersonal skill deficit) is removed, intimacy will result. Burns states that these models are rich in the description of interpersonal phenomena; however, controlled clinical outcomes based in the deficit theories of conflict are not as effective as they need to be (Burns, nd, audio recording; Burns 1990; Burns, 2008). Research has shown that when therapists apply CBT techniques to interpersonal problems, they are not effective (Castonguay, et. al., 2004). The lack of efficacy of these deficit theories led Burns to a radically altered view of relationship conflict.

The Motivational Theory.

The motivational theory states that people do not get along because there is a lack of motivation to get close to the others. After examining the relationships of many patients, Burns began to examine what he calls “the dark side of human nature,” exploring the motivations underlying relationships (Burns, 2008, p. 16). Burns began to question the assumption that people are inherently good, with positive motivations and a desire for good relationships. Based on his observation and work with patients he became confident that it is often negative, destructive motives that play a major role in relationship conflict. This different view of human motivation states that there is part of human nature that prefers conflict and hostility. Burns describes 12 motives that compete with the desire for intimacy. These motives include power and control, revenge, justice and fairness, narcissism, pride and shame, scapegoating, truth, blame, self-pity, anger and bitterness, competition, and hidden agendas. Burns (2008) believes that

you can provide people in troubled relationships with all the interpersonal skills in the world, but it won't do them a bit of

good if they aren't strongly motivated to develop greater intimacy or get close to the person they're at odds with. In most cases hostility and conflict probably do not result so much from skill deficits, but rather from overpowering motivational factors. The skill deficit theories sound great on paper, but they just don't cut it in the real world. (p.36)

Motivation is the determining factor of whether intimacy is achieved. The most important determinant for the efficacy of CIT is what the patient wants more, the rewards of the battle or the rewards of a close loving relationship (Burns, 2008). This progression of thought led Burns to develop the approach he calls CIT.

Foundations of Cognitive Interpersonal Therapy

Burns (2008) developed CIT based upon three concepts:

1. We all provoke and maintain the exact relationship problems that we complain about. However, we don't seem to realize that we're doing this, so we feel like victims and tell ourselves that the problem is the other person's fault.
2. We deny our own role in the conflict because self-examination is so shocking and painful, and because we are secretly rewarded by the problem we are complaining about. We want to do our dirty work in the dark so we can maintain a façade of innocence.
3. We all have far more power than we think to transform troubled relationships—if we're willing to stop blaming the other person and focus instead on changing ourselves. The healing can happen far more quickly than you might think. In fact, you can often reverse years of bitterness and mistrust almost instantly—but you'll have to be willing to work hard and experience some pain along the way if you want to experience this kind of miracle. (p.36)

Cognitive Interpersonal approach to relationship problems.

This author divides Cognitive Interpersonal Therapy into two sets of interventions. The first and most important set addresses the patient's motivation, and is the "Will Set." The second set is the application of important communication techniques,

which Burns describes as “The Five Secrets of Effective Communication” (2008, p. 58), and are included in the “Skill Set.”

The will set.

The initial step in the CIT approach is to determine the patient’s motivation to change his relationship. The concept of relationship intimacy is discussed with the patient. Intimacy is described to the patient as being determined by his willingness to endure the negative emotions that arise in his relationship. The patient is presented with three options that need to be addressed when dealing with a troubled relationship. One can maintain the status quo, end the relationship or make the relationship better. This decision is up to the patient. The only stipulation in making the relationship better is that the person must be committed to focus on changing himself, not his partner (Burns, 2008). The next step will help the patient examine the personal cost of change and will determine if the patient is truly motivated to do the work required to have a more intimate relationship.

The next step in the “Will Set” is the most important and the most challenging. This step involves examining the price of having an intimate, close relationship. Burns (2008) conducted research with more than 1,200 individuals to identify attitudes that lead to happy and unhappy marriages. Participants were asked a variety of questions about their relationships, and they completed the Relationship Satisfaction Scale and an intimacy inventory that assessed a variety of attitudes and beliefs about personal relationships and self-esteem.

Beliefs about relationships included four areas: submissiveness (pleasing others, conflict phobia, perceived narcissism, self-blame); demandingness (entitlement, justice/fairness, truth, other-blame); dependency (love addiction, fear of rejection, approval addiction, mind reading); and detachment (achievement addiction, perfectionism, perceived perfectionism, disclosure phobia). Each self-defeating belief was represented by several statements.

Using a Likert scale, participants were able to indicate how strongly they agreed with each statement. This allowed the researcher to develop a unique profile of beliefs for each person in the study. Burns states that the demographic variables such as gender, socioeconomic status, education or religious affiliation had little or no impact on how happy or depressed the participants were, or how satisfying or conflicted their relationships were. The presence or number of children or the length of the relationship did not impact the outcome either. Burns (2008) found that “by far the most important mind-set was other-blame” (p. 58).

Research participants who blamed their partners for problems in their relationship were found to be “angry, frustrated, unhappy, and intensely dissatisfied with their relationships” (p. 58). This is the reason that the price of intimacy is described as giving up blame, or giving up the right to punish the other person. The therapist helps the patient to understand and evaluate how his contribution to the relationship conflict has “worked” for him in the past. This step requires focused self-examination, humility and honesty. Unlike CBT, the therapist’s goal is not to change the patient’s cognitions about his partner or himself, but to help him become aware of his role in the relationship dysfunction; all while modeling empathic communication with the patient. The therapist

will assist the patient in completing a blame cost-benefit analysis (CBA) (p. 53). The patient, assisted by the therapist, will list all of the advantages of blame on one side of the CBA and the disadvantages on the other side. Using a 100 point scale, the patient gives a “weight” to each side. Based upon this weight analysis, the patient then determines which of these, the advantages or disadvantages, are more important to him.

This examination is an important tool for assessing motivation (Burns, 2008). If the patient decides that he is not willing to make the changes required to improve his relationship, which according to Burns is statistically the more common choice, the therapist will then assist the patient with another symptom or issue, but will not focus on the patient’s relationship. If the patient is willing to give up blame and focus exclusively on changing himself, the therapist will next begin to teach the patient a set of communication skills.

The skill set.

After motivation has been addressed and confirmed, the patient will then receive instruction on specific components of good communication and bad communication, which includes Burns’ five secrets of effective communication. The five secrets include a variety of listening and self-expression skills. Listening skills include: The Disarming Technique (DT), Thought and Feeling Empathy (TE) (FE) and Inquiry (IN). Self-expression skills include: “I Feel” Statements (IF) and Stroking (ST). These skills are organized in the manner in which they will be taught.

The patient is reminded that while he is examining the dynamics involved in why he and his partner are having conflict, the focus will be exclusively on his communication

errors, not his partner's. Instruction begins by introducing the acronym used for the good communication skill set: EAR, which stands for empathy, assertiveness, and respect. Bad communication is described as the opposite of these three skills, not listening, not expressing one's feelings and not conveying any care or respect (Burns, 2008).

Empathy.

The first and most important communication skill addressed is the ability to convey empathy. Burns divides empathy into thought empathy and feeling empathy, stating that empathy is only considered accurate when it is acknowledged (verbally spoken) and confirmed by the partner (i.e., "Yes, that is exactly what I'm thinking and feeling"). Burns states that empathy is a spiritual theme. It is related to the concepts of compassion and acceptance. It requires that the patient temporarily put all of his feelings on hold in order to comprehend the thoughts, feelings and suffering of another person. Kindness, humility, consideration and love, along with a strong desire to truly understand the other person's point of view, are required on the part of the patient. This is an important part of the mentalization process. Learning to surrender one's own agenda in order to focus on the other person's thoughts, feelings and values, while accepting and respecting instead of judging or blaming, is a process that requires self-discipline, determination and practice. CIT is supported by findings of Jacobson and Christensen (1996). These researchers identified several key factors that maintain marital distress and dysfunction, one of which is the notion that partners' non-acceptance of and efforts to change their partner's behavior often incites couple distress, especially when coercion to change is employed as a strategy. These authors state that the partners' non-acceptance

of each other's differences may directly undermine the efficacy of the change-based couple interventions used in behavioral marital therapies. Like Burns, these authors support the importance of acceptance in relationships. Jacobson and Christensen (1996) define acceptance as the act of ceasing efforts to change partner behavior and using problems and differences to engender increased intimacy.

Inquiry is another skill that is often helpful when one is uncertain of an emotion or thought being expressed by a partner. Burns states that the biggest mistake most people make is by pushing one's own agenda without really listening. Inquiry is a skill that is simple to master and most useful in helping one develop an accurate understanding of others' thoughts and feelings. Inquiry is simply using gentle, probing questions to learn more about what the other person is thinking and feeling, such as: "How do you see the situation?" or, "It sounds like you are feeling lonely and upset, am I right?" (Burns, 2008, p. 129). Inquiry allows a person to give others an opportunity to affirm or deny their thoughts about what they are thinking and feeling, as well as letting them see that one has a genuine interest in their perspective.

In his consideration of empathy, Burns discusses what he describes as the most powerful communication technique of all, the Disarming Technique. It is based on what is described as the "Law of Opposites" (p. 100). Burns describes the paradox that happens when someone attempts to defend himself from criticism. Burns (2008) writes,

when you try to defend yourself from a criticism that seems totally irrational or unfair, you'll instantly prove that the criticism is completely valid. This is a paradox. In contrast, if you genuinely agree with the criticism that seems totally untrue or unfair, you'll instantly prove that the criticism is wrong, and the other person will suddenly see you in an entirely different light. This is also a paradox. (p. 100)

Learning this skill is challenging; pride and fear often need to be examined and addressed when looking for the truth in a partner's criticism. Human nature tends to respond, "I shouldn't have to agree with him because there isn't any truth in what he's saying. I'm right and he's wrong" (p. 105). Burns warns that if one heeds this internal voice and gives in to the desire to defend oneself, one will always stay in conflict. The mindset one has when attempting the disarming technique is very important. Burns (2008) describes the thought process needed to appropriately hear criticism and effectively use the disarming technique skillfully:

I always try to remind myself that when someone is criticizing me, he's trying to tell me something important, and that, on some level, is *always* right. My job is to listen carefully so I can hear the valid part of what he's trying to say, rather than dwelling on the part that seems distorted or unfair. If you do this skillfully, you can work miracles in your interactions with other people. However, you have to see that the criticism really is true and acknowledge that truth in a friendly way, conveying humility and self-respect. (p. 106)

Assertiveness.

The second characteristic of good communication is assertiveness, and is described as the patient's opportunity to address his concerns. The difference between assertiveness and aggressiveness is discussed with the patient. The format taught to the patient for addressing his concerns includes "I feel" statements (p. 72). This can be challenging for many patients because often they will hide their negative feelings or act them out, rather than verbalize them. A feeling chart, consisting of a list of emotions, is provided to assist the patient in identifying his own emotions. The importance of employing these feeling words to keep the focus on emotions is emphasized.

Respect.

Respect is the third characteristic of good communication and addresses the tone and attitude with which the entire conversation should take place. The goal in the conversation is to treat the other person with kindness, caring and respect, without judging him or his motives, even when feeling frustrated and annoyed (p.72). When working on specific relationship problems, patients are encouraged not to attribute their difficulties to evil intentions or global negative characteristics of their partners, but to evaluate the situation while keeping in mind and validating the partner's good intentions. This increases the patient's acceptance of his partner and helps to maintain a positive atmosphere conducive to increasing intimacy.

Stroking is another skill that allows one to convey respect. Stroking is a skill that requires "that you express positive regard for the other person, no matter how upset you feel" (p. 140). Burns based the concept of stroking on the work of the twentieth century theologian Martin Buber, who described two types of human relationships, "I-It" and "I-Thou" (p. 140). In an "I-It" relationship, the other person is viewed as an object to be manipulated; in an "I-Thou" relationship, one chooses to treat the other with dignity and respect, conveying a desire to develop a closer and more intimate relationship. The goal is to be honest and real, not insincere or phony. Burns states that stroking is more of a philosophy than a technique; it is a spirit and an attitude that one brings to the interaction and conveys value to the other person. Examples of using stroking appropriately include giving the other person a genuine compliment or letting the other person know that he is respected or admired, and that his friendship is valued even though the two parties are both feeling angry or disagreeing with each other at the moment. Another important part

of stroking is not judging the other person's motives, but framing them in a more positive light (Burns, 2008).

The Relationship Journal (Situational Analysis).

Cognitive Interpersonal Therapy employs a relationship journal to allow the patient to review a very specific relationship conflict. This relationship journal requires a situational analysis (SA). While Burns does not describe the relationship journal as a situational analysis, it does meet the requirements for this as described by McCullough (2000). The situational analysis requires that the patient step back and view the interpersonal event as an "observer." Burns' (2008) journal steps are:

- Step one: Write down exactly what the other person said to you.
- Step two: Write down exactly what you said next.
- Step three: Evaluate your communication; did you use good or bad communication techniques?
- Step four: Consequences, did your response make the problem better or worse? Why?
- Step five: Revised response. Revise what you wrote down in step 2, using the five secrets of effective communication. (p. 68)

This process is an important target area for psychiatric patients. McCullough (2000, 2003) describes the "primitive thought structure" of chronically ill psychiatric patients. McCullough (2003) compared this primitive thought structure to Piaget's construct of preoperational thinking. The comparison to preoperational thinking was made based on the following statement by Piaget (1981), "Preoperational thought remains bound to perceptual experience" (p. 55). This description is applicable to many patients who have chronic psychiatric illness and who are unable to step back and view social-interpersonal events as an "observer." The ability to disengage from the moment and analyze an interpersonal situation requires the use of formal operations (McCullough,

2003). McCullough states that using a situational analysis challenges the patients' preoperational thinking. The situational analysis is designed to: "a) demonstrate to the patient that his or her behavior has consequences; b) overthrow preoperational functioning and; c) expose the maladaptive behavior of the patient in the session so that it can be modified" (p. 253).

Steps one and two of the relationship journal's situation analysis require that the patient identify a time-specific interpersonal negative relationship event, usually one that involves the patient being hurt or criticized. It is required that the interpersonal situation involve a relationship that is important to the patient and that he is committed to improving. Identifying a specific relationship event can also be very challenging for psychiatric patients, in that they tend to think in a global manner (McCullough, 2000). This targets and increases the patient's ability to move from preoperational thinking to formal operational thinking. Another important benefit of working with specific relational situations is that cognitive-emotive rigidity is quite common, and the situational analysis "becomes a microcosm of the universe of problems that the individual has" (McCullough, p. 254). Because of the patient's interpersonal rigidity, the situational analysis has a "rich generalization and transfer of learning potential—the learning available in one SA exercise easily generalizes to numerous other interpersonal events" (p. 254).

Steps three and four require the patient to dissect his response to his partner and determine if the communication techniques he used were good or bad communication. The primary goal of the situational analysis is to target the patient's ability to mentalize

and to increase this ability by assisting the patient in making connections with causal and logical thinking where his communication skills are concerned (Burns, 2008).

Again, the most important component in CIT is the patient's willingness to acknowledge his contribution to the relationship problem. When completing the relationship journal, the impact of the patient's behavior on the other person will become clear. Acknowledging and accepting responsibility for one's contribution can be painful and humiliating. The therapist will need to utilize the very concepts that he or she is teaching, empathy and respect. The concept that makes CIT unique in dealing with interpersonal conflict is that when one accepts the fact that he cannot change his partner and focuses on changing himself, his partner will change (Burns, 2008). Burns (1990, 2008) states that because of the circular system of causality, when one changes, the other will also change at the exact moment. This is a paradox. Burns states that "we change other people every time we interact with them" (p. 82)—even while unaware of it. The goal of CIT is to make the patient aware of his contribution to the relationship conflict, help the patient foster humility and teach the required skills to resolve and repair relationship conflict. One can see how the emphasis for intervention is unique for CBT, IPT and CIT. Research utilizing relationship focused interventions for these theories in outpatient and inpatient populations will now be reviewed.

Relationship and Communication Focused Interventions

With the growing body of empirical findings regarding the impact of relationships on the course of psychiatric illnesses, many researchers developed a variety of targeted interventions for relationship dysfunction. However, due to the complexity of patients'

illnesses and relationship distress, these interventions have demonstrated different degrees of efficacy. Finding effective interventions for psychiatric patients experiencing relationship distress is a challenging process. In national surveys, therapists indicate that clients who have relationship distress and emotional or behavioral disorders present the most difficult problems they encounter in clinical practice (Whisman, et al., 1997).

It is understood that relationship distress contributes to the development or maintenance of individual psychopathology. Because of this understanding, research has been conducted that targets relationship dysfunction in order to impact an individual's psychopathology. The majority of research using interventions specifically targeting relationship dysfunction to impact psychiatric diagnoses takes place in an outpatient setting. The following is a review of research that targets relationship distress and its impact on a variety of psychiatric diagnosis in an outpatient setting.

Empirically Supported Relationship Interventions

Depression

Baucom, Shoham, Mueser, Daiuto and Stickle (1998) examined a variety of relationship focused interventions targeting individual psychiatric disorders. These studies used the criteria put forth in Chambless and Hollon (1998) to determine efficacy, effectiveness, and clinical significance. Because relationship focused interventions can take a variety of forms, the researchers divided the interventions reviewed into three categories: partner-assisted or family-assisted interventions (PFAIs), disorder-specific couple or family intervention, and general couples or family therapy.

PFAIs are typically developed from the CBT framework in which the patient has specific assignments outside of the therapy sessions. The partner or family is used as a surrogate therapist or coach, encouraging the client with assignments outside of the treatment session. PFAIs do not focus on the couple's relationship, but on the clients' diagnosis. In disorder specific interventions the focus is on the couple or family relationship and how it directly influences the client's diagnosis and/or treatment. The last type of intervention, general couples or family therapy, employs common types of therapies aimed at the treatment of marital or relationship distress (i.e., Behavioral Marital Therapy, Cognitive Behavioral Therapy, Emotion-Focused Therapy, etc.). These therapies were utilized with the intent of assisting in the treatment of an individual's disorder. The researchers limited their review to published investigations that utilized adequate sample size, and they considered treatments separately unless they follow the same manual or clearly articulated treatment protocol.

Based on their inclusion criteria, Baucom et al. (1998) reported three well-controlled studies that had been conducted with the explicit purpose of treating depression by targeting relationship distress. Two of these studies examined the efficacy of Behavioral Marital Therapy (BMT). These studies were conducted by Jacobson, Dobson, Fruzzetti, Schmaling, and Salusky (1991) and O'Leary and Beach (1990). The third study examined Co-joint Interpersonal Therapy conducted by Foley, Rounsaville, Weissman, Scholomskas and Chevron (1989). The primary purpose for the studies was to examine the interventions' impact on depression; however, the impact on relationship functioning was also assessed.

The wives of the couples in the BMT studies were clinically depressed (Jacobson, et al., 1991; O’Leary & Beach, 1990). O’Leary and Beach (1990) included 36 maritally distressed couples in which the wife met the *Diagnostic and Statistical Manual of Mental Disorders* (third edition; DSM-III; American Psychiatric Association, 1980) for depression or dysthymia. The researchers compared BMT, Individual Cognitive Therapy (CT) for the wife and a waiting list condition. The BMT and individual CT treatments met weekly and lasted for 15-16 weeks. BMT and CT were more efficacious than the waiting list condition, but there were no significant differences between them on the patient’s depression. The wives receiving the BMT showed clinically significant reduction in marital discord; however the patients receiving individual CT did not have a significant reduction in marital discord. The researchers conducted a follow-up study (Beach & O’Leary, 1992) and found that BMT and CT were equivalent in altering depression at one year. While the findings support BMT for reduction in depression and marital distress, CT, while beneficial for depression, did not significantly impact relationship conflict. Interestingly, at a later analysis of these same couples, O’Leary, Riso, and Beach (1990) and Beach and O’Leary (1992) found that the women who reported that their depression preceded their marital issues did better with CT than those who reported that their marital issues preceded their depression. The theory offered is that those whose depression preceded marital conflict viewed their relationship more positively, and their cognitive distortions were less pronounced; while those whose conflict preceded the depression viewed the relationship more negatively and did not respond to CT. This finding supports the conclusion that standard CT is not very effective for relationship distress.

Jacobson et al. (1991) conducted a study of 60 couples in which the wives were diagnosed with depression. While some of the subjects were experiencing marital distress, there were some participants who were not maritally distressed. The couples were assigned to treatments of Behavioral Marital Therapy (BMT), Cognitive Therapy (CT), or a treatment combining Behavioral Marital Therapy and Cognitive Therapy (CO). Each of these treatments lasted 20 sessions. Cognitive Therapy was found to be more effective at alleviating depression than BMT for couples who were not experiencing relationship distress. The combined treatment was not more effective than either of the separate treatments, regardless of level of distress. However, for couples who were maritally distressed, the treatments were found to be comparable, which is different from the results found in the previously mentioned study by O'Leary and Beach (1990). Jacobson et al. (1991) surmise that this difference in outcome has to do with the subjects recruited for these studies. They state that O'Leary and Beach (1990) recruited subjects who were experiencing marital distress and depression, while the subjects in their study were not excluded or selected based on marital distress. They state that even those in their subsample of maritally distressed were seeking help for depression, not for marital distress. Jacobson et al. (1991) state, "The samples may have differed: subjects viewing their problems as marital (the O'Leary and Beach study) versus most participants who view depression as their primary problem" (p. 555). This difference in population suggests that those for whom relationship distress does not play a vital role, BMT and CT are effective forms of therapy targeting depression.

Foley, et al. (1989) compared individual Interpersonal Therapy (IPT) with a conjoint marital form of IPT (IPT-CM) in a pilot study of 18 couples, with nine in each

treatment group. IPT assessed five major areas of the couple's dynamics: communication, intimacy, boundary management, leadership, and attainment of socially appropriate goals. Treatment focused on the dysfunctional behaviors of these areas. Treatment measures included depression, improving social functioning and marital adjustment. Both treatments showed significant decreases from pre-test to post-test on depression; however, there were no differences between the treatment groups with regard to depression. This study would indicate that the couple IPT is as effective as individual IPT for the alleviation of depression symptoms. The couples receiving the IPT-CM were significantly more satisfied with their relationship and showed greater affectional expression than couples in which the patients received the individual IPT. The patients in the individual IPT showed no mean change in marital adjustment and also showed a trend toward decreased affectional expression. However, these results should be interpreted with caution since the study was done with a small sample and without a control group.

Teichman, Bar-El, Shor, Sirota and Elizur (1995) examined the efficacy of Cognitive Marital Therapy (CMT), individual Cognitive Therapy (CT) and no therapy on depression. Treatments lasted for 13 weeks. CMT is an integrative treatment modality and is based on Teichman and Teichman's (1990) reciprocal model of depression. This method expands cognitive therapy from a personal approach to an interpersonal approach. The primary assumption of this model is that the interpersonal context of the depressed person is affected by his/her depression and affects it in return. However, unlike traditional IPT which focuses on general interpersonal themes, this model focuses on the interpersonal context of depression. Its focus is on the couple's relationship and the dysfunctional reciprocities that characterize couples in which one of the spouses

suffer from depression. The dysfunctional reciprocities have been identified as overprotection, hostility and ambivalence. CMT is aimed at helping couples identify their underlying reciprocities in which they are involved, and to elucidate the consequences of these reciprocities. Teichman, et al. (1995) state that

the primary aim is to increase the insight of the spouses regarding their respective part in maintaining the depression, and then to motivate the search for alternative reciprocal patterns. The implication is that change in the depressed patient is insufficient; it must be accompanied by changes in significant others and reflected in the reciprocities in which the patient is involved. (p. 136)

This study found that while both individual CT and couple CMT reduced depression in the patients, CMT reduced depression to the recovery level in more patients than in CT, and both were more effective than the no treatment group. Although the CMT produced effective changes sooner, at the 6-month follow-up the differences between both treatments were no longer evident. Since marital adjustment was not measured, the impact of the treatments on marital functioning is not known (Teichman, et al., 1995).

In 2008 Barbato and D'Avanzo performed a meta-analysis of eight outpatient controlled clinical trials involving 567 subjects that examined couple therapies targeting depression. These studies included Interpersonal Therapy (Foley et al., 1989), Behavioral Marital Therapy (Beach & O'Leary, 1992, Emanuels-Zuurveen & Emmelkamp, 1996, 1997; Jacobson et al., 1991), Cognitive Marital Therapy (Teichman et al., 1995), Systemic Couple Therapy (Leff et al., 2000), and Emotion Focused Couple Therapy (Dessaulles, Jonson & Denton, 2003). The authors state that the main result of the meta-analysis is that there is no evidence of difference between couple therapy and individual psychotherapy in the treatment of depression. However, relationship distress was significantly reduced in the couple therapy groups. The authors also state that couples

therapy for depression is better than no therapy, but the evidence on efficacy of couple therapy as a treatment for depression is inconclusive. The subjects included mainly middle-aged adults with mild to moderate depression, leading the researchers to state that their findings do not support couple therapy as an approach to major depression.

Anxiety Disorders

The review of empirically validated treatments (Baucom et al., 1998) included studies on two anxiety disorders, obsessive compulsive disorder (OCD) and agoraphobia. Two studies on OCD compared outpatient treatments of exposure in vivo and response prevention, implemented either with or without the client's partner (Emmelkamp, de Haan, & Hoodguin, 1990; Emmelkamp & de Lange, 1983). The first of these two studies, conducted by Emmelkamp and de Lange (1983), had 6 patients per treatment condition. This study demonstrated that the partner-assisted group had better results on post-test subjective and therapist-rated measures of anxiety. In the second study, Emmelkamp, de Hann and Hoodguin (1990) included 25 patients per group and found no significant differences between the partner-assisted and non-assisted treatment groups. The treatments were found to be equally effective regardless of the couples' marital distress. Based on these studies, a partner-assisted exposure intervention for OCD is at least as beneficial as exposure procedures without the partner.

Partner-assisted interventions for agoraphobia were also reviewed. Three studies utilizing two different types of interventions were examined. The interventions differ in the extent to which relationship issues thought to impede treatment gains were addressed.

The two different approaches utilizing partners included: (a) partner-assisted interventions and (b) disorder-specific couple interventions.

The first type of partner-assisted intervention involves graded exposure practice conducted in the patient's home environment. The patient's partner is actively involved in helping to plan and carry out homework assignments. Partners were to reinforce all practice attempts by the patient with attention and praise. This type of partner-assisted intervention does not focus on cognitive techniques or relationship; it is thought to be effective by providing the client with a safe and supportive environment that will lead to increased exposure experiences and decreased avoidance behaviors. The partner-assisted intervention for agoraphobia has been compared with non-assisted exposure therapy (Cobb, Mathews, Childs-Clarke, & Blowers, 1984; Emmelkamp et al., 1992), group exposure therapy (Hand, Angenendt, Fishcher, & Wilke, 1986), and friend-assisted exposure (Oatley & Hodgson, 1987). The results of these studies indicate that the partner-assisted intervention was equivalent to, but not superior to, the comparison treatment.

However, Jannoun, Munby, Catalan and Gelder (1980) compared a partner-assisted exposure intervention to a partner-assisted problem solving intervention. Partner-assisted exposure therapy proved to be more effective for agoraphobia than the partner-assisted problem solving intervention. While the inclusion of a partner in the treatment of patients with agoraphobia is not more effective than other exposure formats, it appears to be at least equal with other formats, and is superior to a partner-assisted problem solving intervention.

Partner-assisted exposure therapy also includes partner assisted cognitive-behavioral treatment. Barlow and Waddell (1985) viewed the couple's relationship as an

important environmental component that may play a role in reinforcing agoraphobic symptomatology. As in other partner-assisted interventions, the partner is taught to utilize graduated exposure, act as coach, reinforce progress, and praise the patient. However, in this intervention the partners are trained to use cognitive skills to help patients manage panic and prevent cognitive avoidance. The goal of this intervention also includes working on the couple's communication skill and relationship distress as it interferes with the client's progress. Barlow, O'Brien, and Last (1984) compared this partner-assisted cognitive intervention with a similar intervention that did not include the partner or relationship issues. The two groups did not differ significantly on the clinician ratings and subjective measures at post-test. However, the patients in the partner-assisted group had significantly less work interference immediately after treatment.

The last partner-assisted intervention reviewed included the basic interventions: graduated exposure, coaching, reinforcement, and praise, as well as the addition of communication skills training. The communication training included constructive speaking, empathetic listening, and conflict resolution. Communication skills were focused on relationship issues that could interfere with treatment, but not on broader relationship difficulties. Arnow, Taylor, Agras, and Telch (1985) compared couples receiving partner-assisted exposure therapy along with eight sessions of communication training to couples receiving the same exposure therapy along with eight sessions of couple relaxation training. Couples receiving the communication intervention had significantly more positive and fewer negative communication behaviors, scored lower on subjective anxiety scales, and participated in more unaccompanied excursions than the exposure plus relaxation group.

These empirically supported relationship therapies have proven to be effective in the treatment of psychiatric disorders but have been less effective when targeting relationship dysfunction. An important characteristic of these studies is that they were long term studies that took place on an outpatient setting. The focus will now turn to inpatient shorter term interventions.

Inpatient Relationship and Communication Interventions

Empirical research specifically targeting relationship dysfunction during hospitalization on the psychiatric inpatient unit is limited, and studies utilizing short-term interventions are almost nonexistent. This author included for review any inpatient studies that utilized an intervention that addressed a component of communication or relationship skills. While a few studies included families in the intervention, most included the patient only.

There have been several inpatient studies that utilized Dialectical Behavior Therapy (DBT), which is a form of cognitive-behavioral therapy. DBT is designed to be used specifically with patients with Borderline Personality Disorder (BPD). Dialectical Behavior Therapy is a multifaceted intervention that includes a “major focus on problem solving, informed by behavioral principles and techniques, with an attitude of acceptance embodied in validation, empathy, and a radical acceptance of things as they are in the moment” (Swenson, Sanderson, Dulit, & Linehan, 2001, p. 310). It utilizes a psychoeducation format and focuses on skill acquisition in four areas: mindfulness, regulation of emotion, interpersonal effectiveness and distress tolerance. Two studies

(Barley, et al, 1993; Bohus, et al., 2000) took place in inpatient facilities conducted over several months.

Barley, et al. (1993) describe research of an inpatient unit that adapted DBT as a unit wide approach to patient care. The psychiatric Personality Disorders Treatment Program (PDTP) is a 16 bed self-contained unit whose population is composed of patients who have not succeeded in previous inpatient and outpatient treatment programs. An overview of the DBT program includes DBT orientation and target priorities for patients on admission, individual therapy, group skills training, self-monitoring with diary cards, unit-wide incorporation of contingency management strategies, an emphasis on validation, acceptance and behavior chain analysis. The researchers examined parasuicide rates on the PDTP unit and on a general adult psychiatry unit that maintained a consistent, non DBT treatment and program for a comparable period (43 months). The parasuicide rates were compared for three time intervals: the 19 months prior to DBT's introduction, the 10 months during which DBT was being introduced, and the 14 months while DBT was in full operation. Parasuicide rates were significantly lower during the time DBT was in full operation. The rates did not change throughout the entire 43 months on the more traditional general psychiatric unit.

Bohus et al. (2000) hypothesized that DBT could be accelerated and improved by developing DBT therapy for the inpatient setting. The treatment consists of a three-month inpatient treatment prior to long-term outpatient therapy. This pilot study compared 24 female patients on admission to the hospital, and at one month after discharge with respect to psychopathology and frequency of self-injuries. The research

showed significant improvements in ratings of depression, dissociation, anxiety, and global stress, as well as a highly significant decrease in the number of parasuicidal acts.

Springer, et al. (1996) conducted research to examine whether DBT could be successfully modified for a shorter-term inpatient setting. The research compared outcomes between patients assigned to a Creative Coping (CC) group that incorporated DBT skills versus a Wellness and Lifestyle Discussion (W & L) group, which functioned as a control group. Patients who met criteria for personality disorder were randomly assigned to either the CC group (16 subjects) or Wellness and Lifestyle discussion control group (15 subjects) by a paired randomization procedure. Both groups met for 10 sessions that lasted for 45 minutes each day. The average number of sessions attended by both groups was six, with an average stay of 12.3 days. Based on previous studies the researchers anticipated an improvement of all subjects on measures of depression, hopelessness and suicidal ideation. However, contrary to what the researchers anticipated, there were no significant differences between groups on other areas that the researchers theorized they would see. The researchers proposed that the CC group would show greater improvement in areas reinforced by DBT, which were anger, locus of control, increased knowledge of coping skills and acting out on the unit than the W & L group. These predictions were not supported. The CC group actually had more acting out (parasuicidal acts) on the inpatient unit than the W & L group. One theory for the increase of acting out by the researchers is that suicidal ideation is a major topic of conversation in the CC groups. It may have been that CC group may have heightened the issue of parasuicidality for some patients through its explicit focus. Due to the number of

variables being examined and the small sample size the results are to be interpreted with caution.

Social skills education is another intervention that incorporates communication skills that has been utilized for psychiatric inpatients. Foxx, et al. (1985) used a commercially available social skills training game that features the use of response specific feedback, self-monitoring, individualized reinforcers and individualized performance criteria. The intervention targeted verbal behaviors in six communication components: compliments, social interaction, politeness, criticism, social confrontation, and questions/answers. Six in-patients with chronic schizophrenia were matched on their pre-assessment scores and then randomly assigned to one of two groups. All patients had been institutionalized for at least one year prior to the study. The researchers noted that the pre-assessments of the subjects revealed that the social deficits were similar to those of mentally retarded individuals who were involved in their previous research. The social skills game included education on how to initiate interactions (e.g. give compliments or criticism), as well as respond to interactions by others (e.g. to respond to criticism). The game took place once a day for 45-60 minutes. The two groups played four to eight baseline assessment games and both groups played 12 training games. The research showed that the intervention was successful in increasing the participants' social skills (as measure by scores in the game) and a generalization test that showed that all of the participants displayed more appropriate social behavior in the psychiatric setting outside of the research situation. The researchers state that while the increase in social skills training may have a positive impact, the impact of these skills to the successful adaptation of these psychiatric patients outside of the treatment setting is not known.

However, this research does show that short interventions on severely challenged psychiatric patients can improve social skills.

Monti, et al. (1979) compared three groups, social skills group training, social skills training through bibliotherapy alone, and a Treatment as Usual (TAU) control group. The patients assigned to the skills training group participated in 10 hourly sessions conducted by a therapist. The sessions were based on a 10 chapter treatment manual and written homework assignments accompanying each chapter. The bibliotherapy group received the same chapter content plus the assignments in 10 daily installments. The control group participated in the normal hospital routine for the two week period. There were 10 participants in each group; the diagnoses were described as seven psychotics and 23 neurotics. The skills taught included topics such as giving and receiving compliments and criticism, and starting conversations. The group that received skills training had an increase on assertiveness scores from pre-test to post-test, as measured on the Rathus Assertiveness Schedule. The control group was slightly better, and the bibliotherapy group appeared worse. The Clinical Outcome Criteria Scale used ten months after the treatment suggested that the social skills group was significantly “more healthy” (p. 191) as compared to the other two groups. The overall results should be interpreted cautiously due to the limited number of subjects, but it does appear that the social skills group treatment was effective for the clinical population tested. However, these results indicate that bibliotherapy without therapist facilitation is not effective in teaching social skills to psychiatric patients.

Frisch, et. al. (1982) designed two treatment programs to enhance interpersonal competencies. The researchers review several models that have been offered that address

interpersonal functioning impairments that plague many psychiatric patients. The models include the skills deficit model (McFall, 1976), the anxiety inhibition model (Wolpe, 1973) and the cognitive inhibition model (Schwartz & Gottman, 1976). The skills deficit model proposes that the interpersonal impairments are from a lack of social skills within the patients' behavior abilities. The anxiety inhibition model asserts that patients possess the social skills but are inhibited by anxiety that has become conditioned to interpersonal settings. The cognitive inhibition model suggests that maladaptive and self-defeating cognitions rather than anxiety are responsible for patients' lack of social skills.

The researchers attempted to examine the impact of these theories by evaluating a combined treatment program with hospitalized patients that examined a treatment that included social skills training and stress management training compared to social skills training alone. The social skills training for both groups included modeling, coaching, covert and overt rehearsal, corrective feedback, social reinforcement, and homework assignments. These techniques were used to teach verbal and nonverbal skills associated with each of five social response classes: initiating and maintaining a conversation; making and refusing requests; giving and receiving criticism; giving and receiving compliments; and interpreting the nonverbal cues of others. The stress management training component within the combined treatment intervention included applied relaxation training, self-control desensitization and cognitive restructuring. These procedures were designed to teach patients ways to reduce anxiety and replace irrational cognitions with positive, adaptive self-statements in a variety of social situations. A minimum treatment control group consisted of the ongoing therapy regimen administered in the day hospital psychiatric ward. Twenty four hospitalized day patients were

randomly assigned to social skills training alone ($n=12$), social skills in conjunction with stress management training ($n=12$) or a minimal treatment control group ($n=10$). The behavioral measures of social skill showed that both groups scored significantly higher than the minimal treatment control group. The overall analyses revealed no differences between the social skills training condition and the combined training condition, and neither group differed from the control group on self-report measures of social anxiety and social self-esteem.

It is interesting to note that the researchers state that some of the subjects in the stress management group stated that the cognitive restructuring portions of the stress management were especially difficult to understand and apply in actual social encounters and they instead tended to focus upon the more concrete social and relaxations skills rather than cognitive restructuring. The researchers state that four common irrational beliefs were discussed along with their irrational bases, their negative social consequences and their rational alternatives. The four common irrational beliefs included perfectionism and failure, approval from others, catastrophic thinking and the prevailing importance of past events in determining one's future. This finding would support the findings that traditional cognitive behavioral interventions are not effective in addressing interpersonal relationship issues (Burns, 2008; Castonguay, et al. 2004).

The effectiveness of a life skills group with a male psychiatric population was examined by Powell, Illovisky, O'Leary and Gazda (1988). Fifty-nine male patients at the Veterans Administration Medical Center in Augusta, Georgia were randomly assigned to two groups: life skills training group ($n=31$) and treatment as usual group ($n=28$). The diagnosis for the patients included major affective disorder, schizophrenia, Post-

Traumatic Stress Disorder, substance abuse and adjustment disorder. The life skills group received two weeks of vocational development training and three weeks of communication skills training. The training sessions were one and a half hours a day, four days a week. The patients in the control group received treatment as usual, which included physical therapy, work detail, traditional group therapy, recreational therapy and occupational therapy. The group that received skills training had higher scores on measures of interpersonal communication skills and vocational development skills than did the patients in the control group. At one year the participants responded to a follow-up self-report questionnaire. Results of the self-report showed that the life skills group had fewer rehospitalizations than the control group (50% versus 57%), were less likely to receive mental health treatment after discharge (65% versus 80%), reported greater improvements in communication and relationship with others (65% versus 50%), and were twice as likely to be employed (40% versus 20%). While the researchers did not include for review the content of the life skills classes so the reader is unsure of the specific communication skills addressed, the research does provide evidence that important life skills can be taught to patients in a psychiatric hospital in a relatively short period of time utilizing didactic and simulation techniques.

Only two studies could be found that had interventions that completely focused on relationship skills. Relationship Enhancement (RE) therapy, developed by Bernard Guerney (1977), has been used as a treatment focused on interpersonal relationships in acute inpatient settings. RE involves directly training patients in attitudes and skills that foster respect, honesty and understanding in relationships. Waldo and Harmon (1999) state that RE can be applied to

small groups and is appropriate for patients and staff because it teaches specific behaviors and skills, can be conducted in a limited amount of time, can be offered to persons with highly varied levels of cognitive functioning, does not assume underlying pathology within the participants, and can be offered to large or small groups of person who are or are not familiar with each other. (p.29)

The continual interpersonal interactions between patients, as well as between patients and staff, have the potential for furthering or impeding therapy goals. The researchers state that it is imperative that patients and staff be equipped with relationship skills that will at least serve to protect against the inherent emotional and interpersonal stress that is in the hospital setting. Waldo and Harman (1999) used RE in their pilot research study that included 20 participants from three separate inpatient psychiatric units; patient diagnoses included schizophrenia, mood disorders, serious personality disorders, or a combination of these disorders. The three units included an acute treatment unit that provided short term treatment ($n=7$), an extended treatment unit for the chronically mentally ill ($n=8$), and a forensic unit which served patients who were mentally ill and had committed serious crimes ($n=5$). The groups were voluntary and lasted for 50 minutes. Patients attended an average of three sessions each. Groups for the staff members were offered in a series of three two hour meetings. Twenty-two staff members attended. The research collected qualitative data on the participants and staff's responses/feelings about the group. The groups were well received by patients and staff and both found learning RE behaviors and skills to be enjoyable and beneficial to their communication; however, the impact, if any, on personal relationships and diagnosis was not examined.

Lomis and Baker (1985) studied the usefulness of a seven and one half hour micro-training intervention aimed at developing therapeutic empathic communication

skills of peer counselors in a group of violent forensic inpatients with personality disorders. The goals of the interventions were to “a) increase peer counseling skills and b) to influence cognitive perspective taking so that automatic, self-centered reactions of offenders would become more other-centered, or empathic” (p. 91). Patients who volunteered to participate were randomly assigned to a skills group ($n=8$) where they were trained in the cognitive correlate of empathy and counseling skills or an attention group ($n=8$) in which counseling films were viewed. Both groups participated in a one day workshop composed of three sessions, each two and one half hours long. The three sessions for the skills group included: considering another’s position, open invitation to talk, and reflection of feeling. The three sessions for the attention group featured films demonstrating: behavioral counseling, client-centered counseling, and rational-emotive therapy. Multiple modes of measurement including written, observer ratings and oral ratings were used to assess knowledge acquisition, counseling effectiveness, and generalization to personality and behavior functioning. The skills group showed significantly greater improvement in written knowledge of empathy and greater use of counseling skills. However, the effects of the empathy training did not impact personality measures or behavior on the ward. The results of this study indicate that a short term intervention can have some positive results in a forensic population where empathy development has not proceeded normally.

To date there have been no studies that have examined the efficacy of CIT directly with any patient population, inpatient or outpatient. However, in 2004, Castonguay, et al., taught CIT, which was referred to as Integrative Cognitive Therapy (ICT), to therapists to use CIT with their patients. Research had shown that while CT

was effective in the treatment of depression for many persons, there were still a number of patients that failed to respond to treatment (Elkin, Gibbons, Shea, & Shaw, 1996; Elkin, et al., 1989; Robins & Hayes, 1993). This led researchers to propose that the efficacy of CT could be improved.

Castonguay, et al. (1996) found that while the quality of the therapeutic alliance was positively related to client change, therapist focus on intrapersonal issues such as the causal relationship between the client's thoughts and his or her emotions (a crucial aspect of cognitive techniques) correlated negatively with outcome. After conducting qualitative analysis to discover the reason for this finding, it was revealed that the cognitive therapists in the study attempted to resolve alliance ruptures by increasing their adherence to cognitive technique, such as trying to persuade the client of the validity of the cognitive rationale or by identifying negative therapeutic reactions as evidence of the client's distorted thoughts that need to be challenged. These interventions worsened the alliance and thus potentially interfered with the client's improvement. The researchers proposed that CT efficacy may be improved by the adoption of more appropriate strategies aimed at repairing alliance problems. The study compared Integrative Cognitive Therapy to a waiting-list condition (WL). The study had 11 participants in the ICT group and 10 in the WL group.

The intervention required therapists to conduct CT according to the guidelines of Beck et al.'s (1979) treatment manual, unless problems in therapeutic alliance emerged during treatment. The therapists were to use Burns' empathy scale (Burns, 1989, 1995) to identify therapeutic rupture. After they identified the rupture they were no longer to use CT interventions, but to address the rupture by strategies that were identified by Burns

and Auerbach (1996) and Safran and Segal (1990). These are the strategies that are also utilized in CIT, including:

- (a) invitation for the client to explore the potential rupture,
- (b) empathic response to the client's emotional reaction toward the therapist and/or therapy,
- (c) disarming (exploration and validation of at least some aspects of the client's perception of the therapist's contribution to the alliance rupture). (p. 10)

Once the therapeutic rupture had been addressed, the therapist was to resume the use of CT. Results showed that the patients of the therapists in the ICT group experienced significantly greater therapeutic gains in all three outcome measures (Beck Depression Inventory, Hamilton Depression Rating Scale and Global Assessment of Functioning Scale) than the WL group. Because of the positive treatment outcomes of CIT principles when taught to therapists to use with patients, it is hypothesized that CIT principles and skills would also be effective when taught to a patient population to use with personal "relationship ruptures" with their loved ones.

There has been inpatient short-term intervention studies that have been effective at providing preliminary support for therapies that have not been communication or relationship focused. Bach and Hayes (2002) examined the impact of a brief version of Acceptance and Commitment Therapy (ACT) with psychiatric inpatients. The researchers were interested in the impact of ACT on the rehospitalization rates of these patients. The participants were experiencing auditory hallucinations or delusions at the time of their admission and were not limited to a specific diagnosis. Forty patients were randomly assigned to receive treatment as usual (TAU), and forty patients received TAU plus ACT. The ACT group received four 45-50 min individual ACT sessions. The four sessions were spaced over 9 to 11 days. Four months after discharge, rehospitalization rates were

determined. The researchers found that 20% of the ACT participants had to be rehospitalized, while 40% of the of the TAU group were rehospitalized. This readmission rate was especially interesting in light of the fact that more of the ACT patients reported symptoms, but reported lower believability of symptoms as compared to the TAU group.

In 2006, Gaudiano and Herbert replicated this study. Forty hospitalized psychiatric inpatients participated, with 19 patients in the ACT group and 21 in the TAU group. The average length of stay on the unit was 10.7 days, and the ACT group received an average of three individual ACT sessions. At the four month follow-up the researchers found that 45% of the participants in the TAU were rehospitalized compared to only 28% of those in the ACT group. This meant that the TAU group had 1.62 times greater likelihood of rehospitalization, although this difference was not statistically significant. While the magnitude of between-group differences in overall symptom severity was in the medium effect size range, mean improvement on most measures clearly favored the ACT group. The researchers' purpose was to develop a feasible intervention that could be implemented in the short-term treatment of patients with psychotic symptoms. Again, the results of these inpatient studies support the further investigation of short-term interventions with the acute care hospitalized psychiatric inpatient.

Further support for short term interventions comes from Brooks, Guernsey and Mazza (2001) utilizing Relationship Enhancement Therapy, a 12 week relationship focused intervention. These researchers stated that participants expressed frustration that it took four weeks of education before they could address conflicts. These researchers suggested that one marathon session would make an interesting research project and

could immediately get the participants addressing conflict. These authors state that this would not be feasible with the current state of managed care as insurance companies would not pay for eight concurrent hours that would be required for a marathon session. However, the present research project was able to approximate the researchers' suggestion by conducting six hours of patient instruction over two days at no additional charge to the participants.

Conclusion

Cognitive Behavioral Therapy, Interpersonal Therapy and Cognitive Interpersonal Therapy have unique views and interventions in dealing with relationship conflict. Each of these therapies has been effective in addressing psychiatric illness, but has had less success with relationship conflict. The goal of this current research is to determine whether CIT could be a useful intervention for psychiatric patients experiencing relationship conflict.

This author proposes that CIT can be an effective intervention for several reasons. First, CIT can be utilized in group settings and is easily adaptable to an inpatient setting. Next, this therapy directly targets an area in relationship communication that research has identified as an important trigger for relapse, criticism. Additionally, CIT helps patients identify affective cognitive processes and teaches important communication skills. Lastly, CIT can also be offered to persons with varied levels of cognitive functioning and does not assume a specific underlying psychiatric diagnosis; therefore it can be utilized by a diverse psychiatric population.

Research shows that patients who return home to live with relatives rated high in expressed emotion relapse at significantly higher rates than patients who return home to live with relatives with lower rates of expressed emotion (Hooley & Teasdale, 1989). The purpose of this current study is to determine whether a short-term intensive CIT intervention, that is specifically designed to target and reduce relationship conflict, can impact patients' relationship satisfaction, emotion dysregulation, destructive thought processes, and rates of rehospitalization. To this researcher's knowledge, no other published studies to date have examined CIT and its impact on patients in an acute clinical inpatient setting. This study will begin to address what Gaudiano and Herbert (2006) state is a "dearth of research investigating feasible and effective psychotherapeutic approaches exclusively for inpatients" (p.417). The following chapter includes an overview of the methodology used for research, the measurement tools, and a description of statistical analysis that was utilized.

CHAPTER THREE: METHODS

Overview

The following is an overview of methodology. The research design is discussed, as are the criteria used for recruiting patients to participate. Measurements that were utilized are reviewed and validity and reliability are discussed. The schedule and content of the treatment protocol, Intensive Cognitive Interpersonal Therapy, is described. Lastly, the statistical method of analysis of data is addressed.

Research Design

The design of this study was a pseudo-experimental prospective, non-blinded pilot trial with the aim of providing preliminary evidence for a brief intervention for psychiatric inpatients. Patients in the ICIT group participated in the regular inpatient treatment groups plus a six hour intervention group that took place over two days. Their results were compared to those of a treatment as usual (TAU) group. ICIT's impact on relationship satisfaction, emotion regulation, destructive thought processes and rehospitalization was examined. The follow-up period began after patients were discharged from the hospital. At six weeks after discharge, patients were contacted to make a follow-up appointment. All follow-up calls and appointments were conducted by the primary investigator.

Selection of Participants

Participants were recruited from an acute care psychiatric inpatient unit at a hospital in the Eastern United States. The inclusion criteria were: (1) participants were

currently hospitalized with a psychiatric diagnosis and would be in the hospital on Saturday and Sunday; (2) participants were willing to complete the participation in CIT or treatment as usual group; (3) participants agreed to be contacted for a follow-up appointment after discharge; (4) participants acknowledged that relationship conflict impacts their psychiatric illness; (5) participants were patients of the psychiatrists and psychologists at a local psychiatric care facility. The exclusion criteria were: (1) inability to participate in psychotherapy/research due to acute medical condition or florid psychosis; (2) a diagnosis of organic brain syndrome or mental retardation; (3) current participation in the dual diagnosis program. The patients meeting the criteria were referred to the study by the physicians on the psychiatric unit. For the physician referral form see Appendix A. All patients meeting the inclusion criteria who were referred were invited to participate. Initially the primary investigator had a goal of 25 patients in each group, but with the progression of the study the goal number of patients was reduced to 20 in each group. Participants were told that the aim of the study was to learn more about the challenges they faced, to examine the impact of this program, and identify possible ways to improve their treatment.

Procedures

This study was reviewed by the university Institutional Review Board and the hospital Institutional Review Board. This study was designed to compare treatment as usual (TAU) to an Intensive Cognitive Interpersonal Therapy (ICIT) intervention on an inpatient adult psychiatric hospital unit. To increase the validity of the study it was decided that the groups would not be concurrent, but that one group (TAU or ICIT)

would take place on weekends until it had reached 20 participants, then the second group would take place and continue until it had reached 20 participants. It was further decided that due to logistics of the inpatient daily schedule, the research groups would take place on weekends. Participants in the research would still be able to attend the physician ordered regular weekend TAU groups.

The toss of a coin by the manager of the psychiatric unit determined that the ICIT intervention group would be the first group to enroll patients. Patients were referred for participation in the study by the physicians on the acute psychiatric floor where the study was conducted. The researcher went to the adult inpatient psychiatric unit every Friday to get the physician referrals. The patients were then interviewed by the primary investigator on Friday evenings. Friday evening was chosen for the interview to assure that participation in the study did not conflict with other therapeutic groups and because the inclusion criteria required patients to be in the hospital for the next two days (Saturday and Sunday).

Approximately three months into enrolling patients in the CIT group there were ten patients enrolled and only two patients had completed the follow-up. This attrition rate of post-treatment follow-up concerned the researcher. With the approval of the dissertation committee chairman, a modification of the study was presented to the IRB to include an option for participants to have a follow-up appointment by telephone if they were unable to come in for the follow-up appointment. The measures included in the phone follow-up were the Burns Relationship Satisfaction Scale (BRSS), the Brief Mood Survey, (BMS) and the Perceived Criticism Scale (PCS). Therefore, the post-treatment statistical analyses for the two groups were limited to the Burns Relationship Satisfaction

Scale (BRSS) and the Brief Mood Survey (BMS), which includes a Depression Scale, Anxiety Scale, and Anger Scale. The BMS Suicidal Urges scale was not included in the phone follow-up due to an inadequate ability to assure patient safety, so it is not included in the statistical analysis. Participants who had completed the CIT group who had not responded to the follow-up meeting were called and given the option to complete the phone questionnaires. All follow-up meetings (phone and in person) were conducted by the researcher. Participant recruitment and research is described below:

- 1) The toss of a coin determined that the ICIT group would be the first group to enroll patients.
- 2) Patients were admitted to acute psychiatric inpatient hospital (average stay is 5-7 days).
- 3) Physicians completed the referral form for patients who met the criteria to be included in the study. The primary investigator went to the hospital unit on Friday evening to meet with each patient that the physicians referred to determine if he or she would like to participate in the study. Participants were told that the aim of the study was to learn more about the challenges they faced, to examine the impact of this program, and identify possible ways to improve their treatment.
- 4) If the patient did not want to participate in the group, he continued with regular inpatient TAU without any follow-up from the primary investigator.
- 5) Consent was obtained from patients who agreed to participate. After signing the consent patients then completed the pre-treatment measures. The ICIT groups took place on the two days that followed, Saturday and Sunday. Patients participated in six hours of ICIT group conducted by the primary investigator (sessions were staggered throughout

both days so as not to interfere with regular groups). When the patients were discharged, the researcher contacted them to make an appointment for 6 weeks after their discharge to complete post-treatment measures. If patients were unable to come in for their appointment, they were offered the option of completing a phone follow-up that included the Brief Mood Scale, Burns Relationship Satisfaction Scale and the Perceived Criticism Scale.

6) The researcher returned to the hospital unit every Friday to repeat the processes above. This process continued weekly until there were 20 patients enrolled in the ICIT group.

7) After the enrollment of 20 patients in the ICIT group the researcher started enrolling patients in the TAU group. For continuity, the researcher continued to go on Fridays to meet with the patients referred by the physicians.

8) If the patient did not wish to participate in the TAU group, he continued with the normal TAU without any follow-up from the primary investigator.

9) From patients who agreed to participate in the TAU group, consent was obtained and then the pre-treatment measures were completed. The TAU group received no additional interventions beyond the usual treatment received when admitted to the psychiatric floor. Treatment as usual includes medications and daily visits from the patient's physician.

Below is a brief description of the groups that physicians may include in the patients' treatment. Each group lasts from 30 to 45 minutes.

Community Group: This group is the first group in the mornings. It is designed to allow new patients to be introduced to the schedule for the day, as well as to the guidelines for the floor. Patients are also encouraged to let the staff know if they are having any issues or problems on the floor (for example, if their room is too cold or hot, etc.) Patients are

asked how they are feeling and also asked to set a practical goal on which they focus for the next 24 hours. This group is led by a psychiatric nurse or mental health counselor.

Life Skills Group: This group is led by a therapist and addresses a variety of topics. The topics address practical issues that assist patients in many different areas of life. Included are topics such as how to make decisions, relationship issues, dealing with symptoms of psychiatric diagnosis, etc.

Psychotherapy Group: This group is a psychodynamic group that deals with topics related to relationship issues. Patients are asked to “set an agenda,” which means the patients are asked to choose one relationship on which they would like to focus while in that group. The patients are given the opportunity to share their relationship issues with the group, and other group members are asked to share their insights and thoughts. One primary goal of this group is to expose patients to insights from others who have had similar experiences. This group is led by a social worker or master’s level counseling intern.

Grief and Loss Group: Psychiatric patients are often dealing with issues of grief and loss. This group addresses the stages of grief and the issues experienced by those who are experiencing loss. While this group does address grief and loss in the context of losing a loved one, it also address a variety of types of losses that psychiatric patients suffer such as loss of job, loss of friends, loss of hope, etc. This group is led by a therapist.

Cognitive Therapy Group: Cognitive Therapy is an empirically validated treatment that addresses how the patient’s thoughts impact his or her emotions and behaviors. Patients are introduced to Cognitive Therapy concepts and how they apply to everyday events that

each patient experiences. Two days a week, patients are taught Cognitive Interpersonal therapy concepts and how they impact relationships.

AA Group: Alcoholics Anonymous is a 12 step program designed to help patients stay sober and help other alcoholics achieve sobriety.

Issue Work Time: While issue work time is not a formal group, there is a time in the schedule set aside for patients to deal independently with specific personal issues they are facing. During issue work time patients can use resources provided for them from their groups or from their physicians and nurses.

Relaxation Group: This group teaches patients how to use relaxation techniques to deal with emotions such as anxiety.

Optional Groups:

Spirituality Group: This group is facilitated by the chaplain. Patients are encouraged to ask questions and discuss issues related to spirituality.

Task Group: This group is facilitated by a therapist and offers a therapeutic creative outlet for patients in a relaxed group atmosphere. Patients sit around a large table and work on a craft of their choice. It is designed to promote health and wellness by allowing patients to engage in the creative process and enjoy a time a recreation. Patients also have individual sessions and family sessions made available to them. Some patients may also be assigned a social worker.

Pet Therapy: This group utilizes trained animals and handlers to achieve specific physical, social, cognitive, and emotional goals with patients.

When the patients were discharged, the researcher contacted them to make an appointment for 6 weeks after their discharge to complete post-treatment measures. If patients were unable to come in for their appointments, they were offered the option of completing a phone follow-up that included the Brief Mood Scale, Burns Relationship Satisfaction Scale and the Perceived Criticism Scale.

Treatment

Cognitive Interpersonal Therapy Group

Patients who met the inclusion criteria and agreed to participate in the research were assigned to either ICIT group or TAU; this was determined by which arm of the research was taking place when the patient was enrolled into the study. Patients in the ICIT group completed the pre-treatment measures described below. The group content was derived from David Burns' book, *Feeling Good Together*. The ICIT group consisted of six hours of group over two days. The groups were scheduled in between regularly scheduled groups. The outline of the group content is as follows:

Day One:

Module One: 1) Introduction of participants and facilitator; 2) Introduction to CIT and identification of focal relationship; review of group rules (confidentiality with peers); 3) Description and Discussion of Will Set and Skill Set; 4) Discussion of Blame and Blame Cost/Benefit Analysis; Description of Situation Analysis

Module Two: 1) Practicing/Modeling of Skills with several scenarios; Empathy: Thought Empathy and Feeling Empathy; 2) Disarming Technique

Module Three): 1) Practicing/Modeling of Skills with several scenarios; Assertiveness, Respect, Stroking and Inquiry

Day Two:

Module Four: 1) Review the Skills; 2) Have patients identify a personal relationship upon which they want to focus and utilize situational analysis for personal scenario; 3) Practice and Role Play using personal scenarios

Module Five: 1) Practice and Role Play using personal scenarios; 2) Have patients identify situations they have encountered during their hospital admission

Module Six: 1) Practice and Role Play using a variety of emotional interpersonal scenarios; 2) Have patients identify scenarios that they will encounter after discharge and role play using EAR skills. See Appendix B for full treatment protocol.

Patients in the TAU completed the pretreatment measures and then participated in the regular treatment of the unit during the weekend. Regular treatment consists of psychopharmacology, psychotherapy (group and individual) and case management. Patients also participated in milieu therapy. The groups that were available for TAU patients included community, health promotion, psychotherapy, life skills, task, cognitive behavioral and spirituality, and were described above. Patients were seen by their psychiatrists, and group and family sessions on the unit were conducted by psychologists, social workers, nurses, mental health counselors and psychology interns.

Measures

Biographical Information, Patient History and Follow-up Information

Patients completed a biographical information questionnaire that included descriptive information such as gender, age, and race/ethnicity. The patient history section included current diagnosis and information regarding medications and treatments. See Appendix C and D.

Relationship Satisfaction

Burns Relationship Satisfaction Scale (BRSS).

The BRSS is a seven-item self-report inventory that assesses satisfaction in various areas of the relationship and characterizes the degree of relationship satisfaction, including communication and openness, conflict resolution, degree of caring and affection, intimacy and closeness, satisfaction with roles in relationship, and overall relationship satisfaction (Burns, 1997). Respondents indicate their degree of satisfaction in each of these areas on a Likert-type scale from 0 (very dissatisfied) to 6 (very satisfied). Total scores are the sum of items and range from 0–42, with higher scores reflecting greater satisfaction. Internal consistency for the scale is high (coefficient alpha = .94) and is strongly correlated with other measures of relationship satisfaction, including the Locke-Wallace MAT ($r = .80$) and both the Dyadic Adjustment Scale ($r = -.89$) and

Norton's Quality of Marriage Index ($r = .91$). Total scores range from 0 (lack of intimacy, extreme conflict) to 42 (highest level of satisfaction) (Burns, 1997). See Appendix E.

Family Emotional Involvement and Criticism Scale.

The Family Emotional Involvement and Criticism Scale (FEICS) was developed to assess, from the recipient's perspective, the two major variables of Expressed Emotion which are Perceived Criticism (PC) and Emotional Involvement (EI). The questionnaire is a 14 item self-report measure that includes questions rated from "almost always" to "almost never" on a 5-point Likert-type scale. The items are equally distributed among the two subscales, Perceived Criticism (PC) and Emotional Involvement (EI), both of which have stable item structure and reliability. Scores for each subscale are determined separately. The first study examining the validity of the scale found the internal consistency of Cronbach's alpha at 0.82 for PC and 0.74 for EI (Shields, Franks, Harp & McDaniel, 1992). Shields et al. (1994) completed a replication of the reliability and validations study for the FEICS and found the internal consistency to compare with previous results (0.82 for PC and 0.76 for EI). See Appendix F.

Perceived Criticism Scale.

Hooley and Teasdale (1989) found that alternative assessment variables of the patient-relative relationship are as effective at predicting relapse in psychiatric patients at least as well as the more expensive standard measure of EE, the Caldwell Family Interview. Hooley and Teasdale (1989) state

criticism is without question the most important element of the expressed emotion index. Indeed, the majority of high-expressed emotion

relatives are classified as such because they make critical rather than hostile or emotionally over-involved comments about patients. Given the importance of criticism to the EE construct and the empirical evidence suggesting that, during face-to-face interactions, patients are indeed targets of relatives' criticism, it is perhaps surprising that no study to date has sought to obtain data directly from patients themselves concerning their perceptions of criticism from family members. (p. 230)

The Perceived Criticism Scale was designed to assess the level of criticism the patient experiences. The Perceived Criticism Scale (PCS) consists of a single question: "How critical do you consider your relative to be of you?" It is administered as a 10-point Likert scale and anchored with the values "not at all critical" and "very critical indeed." Predictive as well as concurrent validity of PCS is high and has been consistent in a variety of samples. In addition, Hooley and Teasdale asked patients how critical they thought they were of their relatives using the same scale. A subsequent addition expanded the questions to include ratings of upset ("When [your relative] criticizes you, how upset do you get?" or "When you criticize [your relative] how upset does he or she get?")

Hooley and Teasdale (1989) assessed PC in a sample of depressed patients and their spouses. Patients' PC scores were correlated .51 with spouses' overall EE ratings (high or low) as assessed with the CFI, although the correlation with spouses' criticism assessed with the CFI was a more modest .27. Nonetheless, patients' perceptions of their partner's criticism level (assessed during the index hospitalization) was highly predictive ($r = .64$) of patient relapse over the course of a nine-month follow-up. Patients who relapsed rated their spouses as significantly more critical than did patients who remained well. It was observed that none of the patients who gave their spouses a PC score less than two relapsed during the follow-up period. In contrast, all of the patients who assigned their spouses a PC rating of six or higher relapsed. It is unlikely

that illness severity explains the relation between patients' PC ratings and subsequent relapse, because depressed patients' PC scores were not related to their Beck Depression Inventory scores or to clinical symptomatology. Both patient and spouse PC ratings also showed good test-retest reliability from initial assessment to three months later ($r=.75$ for patients; $r=.60$ for spouses; Hooley & Teasdale, 1989). See Appendix G.

Emotion Regulation

The Brief Mood Survey (BMS).

The Brief Mood Survey (BMS; Burns 1995) is a self-report instrument that assesses an individual's level of various emotions related to current life experiences. Patients are asked to rate 22 statements regarding emotions they may have felt during the preceding week on a 0 (not at all) to 4 (substantially) Likert-type scale. The instrument is divided into three subscales measuring emotions associated with Depression, Anxiety, Anger. The Depression subscale is comprised of five items (e.g., "feeling worthless or inadequate"), the Anxiety subscale has 5 items (e.g., "worry about things"), and the Anger subscale has five items (e.g., "resentful"). Initial studies indicate moderately high internal consistency estimates for each of the subscales (Burns, 1997). Cronbach's alpha statistics for internal reliability on each of the four subscales are: Depression (.94), Anxiety (.91), and Anger (.94). See Appendix H.

Difficulties in Emotion Regulation Scale (DERS).

The Difficulties in Emotion Regulation Scale (DERS) (Gratz & Roemer, 2004) is a brief 36 item, self-report questionnaire designed to assess multiple aspects of emotion dysregulation. The DERS is based on an integrative model of emotion regulation measuring one's ability to modulate emotional arousal, degree of emotional awareness, understanding and acceptance of emotional arousal, and capacity to function in daily life despite one's emotional state (Gratz & Roemer, 2004). Patients are asked to rate 36 statements using a five point Likert-type scale. Each item is rated on "how often the following statements apply to you" with a response format ranging from 1 (almost never) to 5 (almost always). The measure yields a total score as well as scores on six scales derived through factor analysis: 1) Non-acceptance of emotional responses (Non-acceptance, 6 items, e.g., "When I'm upset, I become angry with myself for feeling that way"); 2) Difficulties engaging in goal directed behavior (Goals, 5 items, e.g., "When I'm upset, I have difficulty concentrating"); 3) Impulse control difficulties (Impulse, 6 items, e.g., "When I am upset, I have difficulty controlling my behaviors"); 4) Lack of emotional awareness (Awareness, six items, e.g., "When I'm upset, I acknowledge my emotions"); 5) Limited access to emotional regulation strategies (Strategies, eight items, e.g., "When I'm upset I believe that there is nothing I can do to make myself feel better"); 6) Lack of emotional clarity (Clarity, five items, e.g., "I have difficulty making sense out of my feelings"). Results showed a high internal consistency with Cronbach's $\alpha=.93$. All of the DERS subscales (computed from the six factors obtained in the factor analysis) also had adequate internal consistency, with Cronbach's $\alpha > .80$ for each subscale (Gratz & Roemer, 2004). See Appendix I.

Symptom Checklist 90-Revised.

The Symptom Checklist 90-Revised (SCL- 90-R) (Derogatis, Lipman, & Convi, 1973) is a brief multidimensional self-report inventory that screens for nine symptoms of psychopathology (somatization, obsessive compulsive, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism) and provides three global distress indicators (global severity index, positive symptom distress index, and positive symptom total). The SCL-90-R provides an overview of symptom severity and intensity. The SCL-90-R is an established instrument and has over 1,000 independent studies supporting its reliability and validity. The internal consistency coefficient rating ranged from 0.90 for Depression and 0.77 for Psychoticism. Test-retest reliability has been reported at 0.80 to 0.90 with a time interval of one week.

Destructive Thought Processes

The Firestone Assessment of Self-Destructive Thoughts (FAST).

The Firestone Assessment of Self-Destructive Thoughts (FAST) (Firestone & Firestone, 1996) is a self-report questionnaire consisting of 84 items. The FAST is designed to capture different symptoms that are characteristic of suicidal individuals including hopelessness, depression, anxiety, and suicide ideation. In addition to providing a means of assessing these characteristics, the FAST is a measure of a broad range of self-destructive behavior patterns. The self-destructive thoughts identified include Self-Depreciation (eight items), Self-Denial (eight items), Cynical Attitudes (eight items), Isolation (eight items), Self-Contempt (six items), Addictions (eight items), Hopelessness

(six items), Giving Up (eight items), Self-Harm (eight items), Suicide Plans (eight items) and Suicide Injunctions (eight items). Each item is designed to assess the current frequency of a self-destructive thought and is rated using a five-point Likert scale ranging from 0 (Never) to 4 (Most of the Time). The FAST has been administered to adult patients in psychiatric hospital settings and a variety of outpatient treatment settings as well as nonclinical college students (Firestone & Firestone, 1996). The internal reliability of the FAST has been established using Cronbach's alpha coefficients. The internal consistency coefficients for the 11 level scores ranged from .76 to .91. Internal reliability for the four composite subscales and the total scale ranged from .84 to .97. The FAST has high test-retest reliability with correlations ranging from .63 to .94. The test-retest reliability of the total score ranges from .88 to .94 in psychiatric inpatients, psychotherapy outpatients and nonclinical college student samples (Firestone & Firestone, 1998).

Convergent and discriminant validity of the FAST levels, composite scores and total score has been found using the Suicide Probability Scale, the Beck Depression Inventory, the Beck Hopelessness Scale and the Beck Scale for Suicide Ideation (Firestone & Firestone, 1998). The Suicide Intent Composite subscale was empirically derived by summing items that were found to have the most significant discriminatory power for distinguishing patients with and without suicide ideation. The Suicide Intent Composite subscale was highly correlated with the Suicide Ideation subscale of the Suicide Probability Scale ($r=.85$) and the Beck Scale for Suicide Ideation ($r=.81$).

Relapse Data

Criteria for clinical psychiatric relapse is defined as: (a) rehospitalization, (b) the exacerbation of psychiatric symptoms based on explicit statement of relapse in the patients psychiatric medical records or (c) an increase or change in medication required because of exacerbation of psychiatric symptoms. Data on relapse was collected by the researcher at the post-treatment appointment and from each patient's medical records.

Global Assessment of Functioning Scores (GAF)

The Global Assessment of Functioning (GAF) score is used for reporting a patient's overall level of functioning (APA, 2000). The score is useful in tracking a patient's progress over time. The score is determined by the patient's psychological, social and occupational functioning at the time of the assessment. The GAF score is a numeric scale rated from 0 to 100. The rating of 0 indicates "inadequate information." The highest ratings (91-100) indicate superior functioning while the lowest ratings (1-10), indicate very poor functioning. This scale is useful for clinicians as they determine treatment, measure its impact and predict outcomes. The patient's primary psychiatrist or psychologist, who will be blinded to the treatment group in which the patient participates, will be responsible for the GAF scores. The scores will be assessed beginning of treatment and at the six week follow-up.

Reaction to Treatment Questionnaire (RTQ)

The patient's expectancy of and motivation for treatment plays an important role in the outcomes experienced. When a patient believes in a treatment and he expects to be

able to utilize it, this belief impacts his engagement in the therapeutic process. The patient's belief in a treatment would facilitate active participation, while patients with negative expectancies would take a more passive role in the therapeutic process (Delsignore & Schnyder, 2007). In this study patients' belief in the credibility of treatment and expectancies of outcomes was measured by the Reaction to Treatment Questionnaire (RTQ) (Holt & Heimberg, 1990). While the measure was originally designed for use with patients with social phobias, Holt and Heimberg (1990) encourage the modification of questions to apply to other treatments. Each item in the measure is rated on a 1 to 10 scale (higher is more logical, more confident, or more successful). The first section of this measure includes four items developed by Borkovec and Nau (1972) to assess the patient's belief in the credibility of treatment. The second section has been modified to apply to relationship conflict scenarios and patients rate their confidence that the treatment in question would be beneficial for their relationship conflict. Confidence in treatment efficacy is rated on a scale from 1 ("not at all confident") to 10 ("very confident"). The third section assesses how the patient rates the severity of the relationship conflict at the present and expectations of the severity at the end of treatment, one year after treatment, and five years after treatment. Severity of conflict for each time period is rated on a scale of 1 ("not at all severe") to 10 ("very severe"). The four ratings are analyzed separately as outcome expectancies for increasing time periods. The RTQ has shown high internal consistency and has predictive validity regarding treatment outcome (Safren, Heimberg & Juster, 1997). See Appendix J.

Methods of Analysis

One way ANOVAs were used for statistical analysis. The ANOVA was utilized to assess the “statistical significance of the relationship between categorical independent variable and a continuous dependent variable” (Vogt, 1993, p. 9). The one-way analysis of variance was used because it compares the means of a variable for populations (the scores on the scales) that result from a classification by one other variable (receiving the CIT treatment or not). ANOVA compares “the variance (variability in scores) between the different groups (believed to be due to the independent variable) with the variability within each of the groups (believed to be due to chance)” (Pallant, 2010, p. 249).

Summary

For psychiatric patients, relationship conflict can cause increased emotion dysregulation and decreased satisfaction in relationships, and can set the stage for relapse and increase the potential for suicidal ideation. Knowing the importance of relationship conflict, it is the responsibility of those providing care to find the most effective intervention for this population. This study sought to determine whether ICIT, an intervention that targets the patient’s ability to deal with criticism, could ultimately help patients have healthier, happier relationships that would have a direct result on their clinical course.

CHAPTER FOUR: FINDINGS

The purpose of this study was to examine whether a brief, intensive Cognitive Interpersonal Therapy (ICIT) intervention would reduce relationship conflict; improve patients' ability to handle negative, critical interactions within their close relationships; decrease their vulnerability to emotion dysregulation; increase relationship satisfaction; decrease destructive thought processes; and reduce rates of rehospitalization. The study used a pseudo-experimental, pre-test post-test control group design and took place in an acute care adult psychiatric inpatient unit.

There were several questions this study initially sought to answer. These questions were: Is there a difference between the ICIT intervention group and the Treatment as Usual (TAU) group in relationship satisfaction as measured by the Burns Relationship Satisfaction Scale (BRSS), Family Emotional Involvement and Criticism Scale (FEICS), and the Perceived Criticism Scale? Is there a difference between the CIT intervention group and the TAU group in emotion regulation as measured by the Brief Mood Survey (BMS), the Difficulties in Emotion Regulation Scale (DERS), and the Symptom Checklist 90-Revised (SCL-90-R)? Is there a difference between the ICIT intervention group and the TAU group in destructive thought processes as measured by the Firestone Assessment of Self-Destructive Thoughts (FAST)? Lastly, is there a difference between the ICIT intervention group and the TAU group in the number of patients being readmitted to the hospital during the six weeks after discharge from the hospital?

Results

Before the study began it was determined by the toss of a coin that the ICIT intervention group would be the first group to enroll participants. Patients were referred for participation in the study by the physicians on the acute psychiatric unit where the study was conducted. The researcher went to the adult inpatient psychiatric unit every Friday to get the physician referrals. The patients were then interviewed by the primary investigator on Friday evenings. Friday evening was chosen for the interview to assure that participation in the study did not conflict with other therapeutic groups and because the inclusion criteria required patients to be in the hospital for the next two days (Saturday and Sunday).

After consenting to participate in the study, the patient would complete the pre-treatment assessments. The researcher returned every weekend to enroll patients and conduct the interviews. All recruitment interviews were administered by the researcher. The ICIT treatment groups took place every weekend for six hours, three hours on Saturday and three hours on Sunday. The groups were scheduled at times when there were no other regularly scheduled treatment groups. There were two occasions while the treatment groups were being conducted that a pet therapy group was conducted. Patients attending the ICIT group at that time were given the opportunity to participate in the pet therapy group if they wished; all patients declined. All treatment groups were conducted by the researcher and followed the treatment manual written by the researcher for this study.

Every week eligible, referred patients who agreed to participate would be consecutively admitted to the ICIT intervention group. This procedure was followed

every weekend until the goal number of 20 participants had been met. Approximately five weeks after being discharged, each participant was contacted by the researcher to schedule a face-to-face follow up appointment for the patient to complete the post-treatment assessments. These meetings took place at an outpatient psychiatric center located on the grounds of the hospital where the treatment was given.

The ICIT intervention group meetings took place every weekend, and it took a total of four months to reach the enrollment goal. During the four month period 39 patients were referred by physicians as eligible to participate in the ICIT intervention group (14 males and 25 females). At the end of four months there were 20 patients enrolled in the ICIT group (8 males and 12 females). Of these 20 patients, four females did not complete the ICIT groups because they were discharged from the hospital before the group started on Saturday morning, and one female dropped out of treatment. Of the 15 that did complete the ICIT group, 11 completed treatment follow-up (6 males and 5 females). The average age range of the ICIT group participants was 40-49 years old.

The ICIT group was primarily Caucasian, with one patient of Latino ethnicity. Nine of the patients had been previously admitted to a psychiatric hospital, with three of the nine having been admitted within the last six months. Seven of the ICIT patients were employed full time (64%), two were on disability (18%), one was unemployed (9%), and one was a homemaker (9%). One of the ICIT participants had a master's degree (9%), four had bachelor's degrees (36%), four identified as having "some college" (36%), and two had high school diplomas (18%). Forty-five percent of this group were married, one was separated (9%), one was divorced (9%), two were living with their partners (18%), and two were single (18%). There was a significant degree of within group variability

regarding the primary diagnosis. The primary diagnoses for the 11 patients completing the ICIT group included Major Depression ($n = 5$), Bipolar Disorder ($n = 3$), Episodic Mood Disorder ($n = 1$), Schizoaffective Disorder ($n = 1$) and Schizophrenia ($n=1$). After the enrollment of 20 patients in the ICIT group, enrollment in the TAU group began. Figure 1 is a diagram depicting participant flow throughout the ICIT portion of the study.

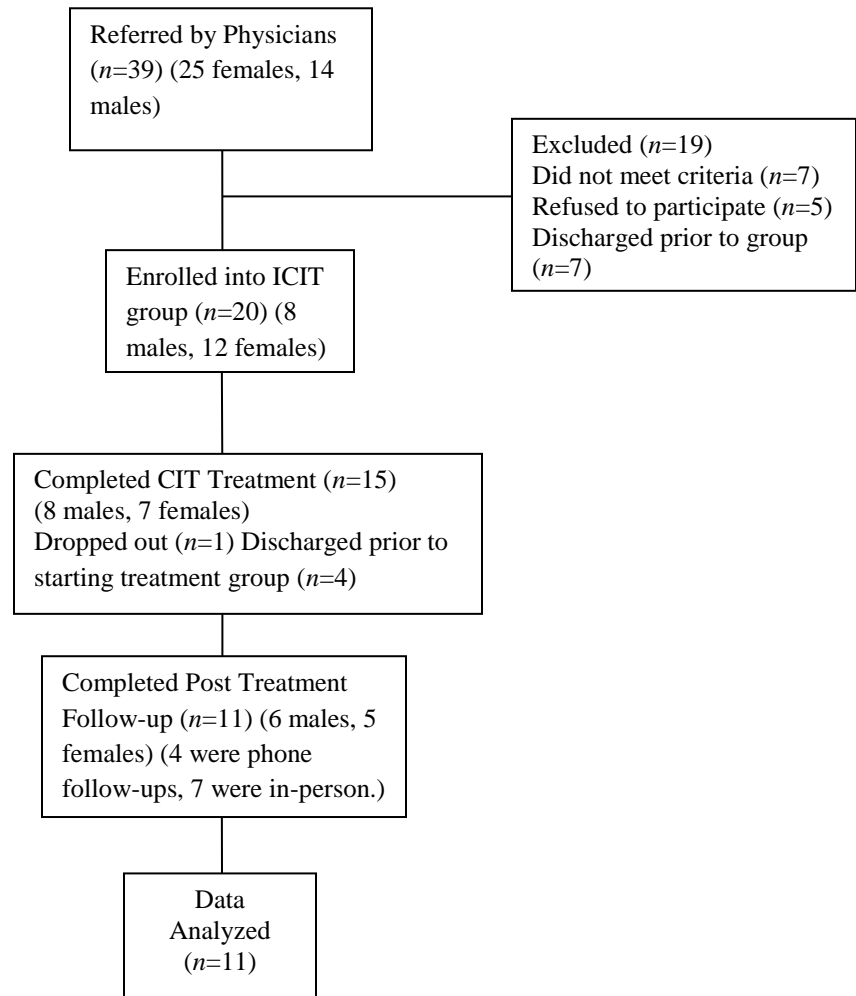


Figure 1. Participant flow diagram for the ICIT portion of the study.

The TAU group took place over nine months. The same method of enrollment was followed. For consistency the researcher went to the adult psychiatric inpatient unit on

Friday evenings to interview referred prospective patients, obtain consent, and complete pre-treatment assessments on those who agreed to participate. Patients then attended the regular treatment groups on Saturday and Sunday. There were 34 patients referred by physicians as eligible to participate in the TAU group (8 males and 26 females). At the end of nine months there were 20 patients enrolled in the TAU group (5 males and 15 females). Of these 20 patients, one female did not complete all of the assessments. Out of the 19 TAU patients who completed all of the pre-treatment assessments, 10 patients completed treatment follow-up (4 males and 6 females).

The average age range of the TAU group was 30-39 years old. The ethnicity of the TAU group was 100% Caucasian. All of the patients had been previously admitted to a psychiatric hospital, with two of them having been admitted within the last six months. One of the TAU patients was employed full time (10%), four were employed part-time (40%), three were on disability (30%), and two were unemployed (20%). Three of the TAU patients had bachelor's degrees (30%), four identified as having "some college" (40%), and three had high school diplomas (30%). Sixty percent of this group were married, one was separated (10%), one was divorced (10%), and two patients were single (20%). The primary diagnoses for the 10 patients completing the TAU group included Major Depression ($n = 4$), Bipolar Disorder ($n = 4$), Schizoaffective Disorder ($n = 1$) and Anxiety Disorder ($n = 1$). Figure 2 depicts participant flow throughout the TAU portion of the study. Complete diagnoses of patients in the TAU and ICIT group are listed below in Table 1.

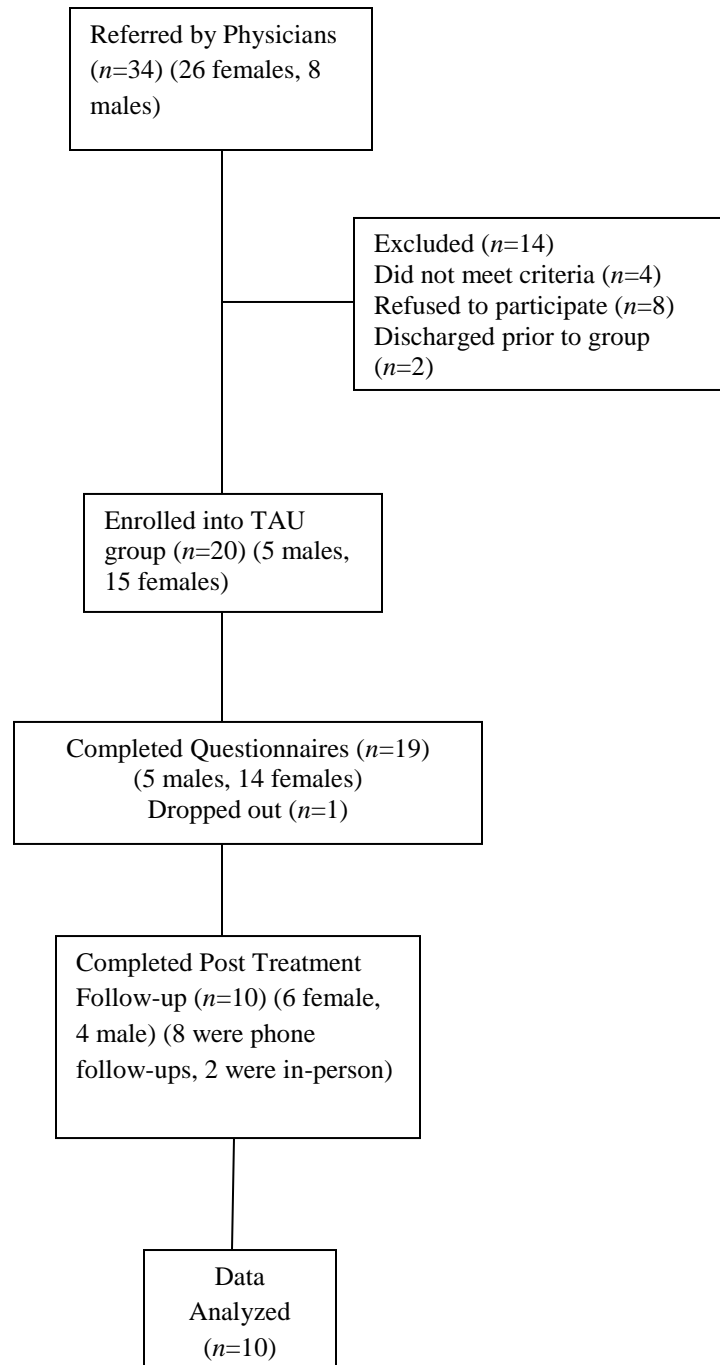


Figure 2. Participant flow diagram for the TAU portion of the study.

Patient	Sex	Complete Diagnoses
CIT1	M	Major Depression, Generalized Anxiety Disorder; Psychosis unspecified
CIT2	M	Major Depression, Cannabis Abuse, Psychosis unspecified
CIT3	F	Major Depression, Gender Identity Disorder, Panic Disorder with Agoraphobia, Attention Deficit Disorder, Cluster B Personality Traits
CIT5	M	Bipolar Disorder, depressed
CIT8	M	Major Depression with suicide attempt
CIT9	F	Major Depression, Anxiety Disorder, Delusional Disorder
CIT13	F	Bipolar Disorder, Anxiety Disorder, Borderline Traits
CIT15	M	Schizophrenia
CIT16	F	Bipolar, mixed episode
CIT18	M	Episodic Mood Disorder, Panic Disorder without Agoraphobia
CIT19	F	Schizoaffective Disorder, depressed, Anxiety Disorder
TAU1	F	Bipolar Disorder
TAU2	F	Major Depression, Post Traumatic Stress Disorder, Anxiety Disorder
TAU3	F	Bipolar Disorder
TAU5	M	Schizoaffective Disorder, Impulse Control Disorder, Antisocial Personality Disorder, Psychosis NOS; Borderline Traits
TAU7	F	Adjustment Disorder; Bipolar Disorder
TAU10	M	Major Depression
TAU12	M	Bipolar Disorder, depressed
TAU16	F	Anxiety Disorder
TAU19	F	Major Depression
TAU20	F	Major Depression

Table 1. Complete diagnosis of patients in Intensive Cognitive Interpersonal group and Treatment as Usual group. Patients in the ICIT group are identified with the patient identifier CIT and the Treatment as Usual group, with patient identifier as TAU.

Approximately three months into enrolling patients in the ICIT group there were ten patients enrolled and only two patients had completed the follow-up. This attrition rate of post-treatment follow-up concerned the researcher. With the approval of the dissertation chairman, a modification of the study was presented to the IRB to include an option for participants to have a phone follow-up appointment if they were unable to come in for the follow-up appointment. The measures included in the phone follow-up were the Burns Relationship Satisfaction Scale (BRSS), the Brief Mood Survey (BMS), and the Perceived Criticism Scale (PCS). Therefore, the post-treatment statistical analyses for the two groups were limited to Burns Relationship Satisfaction Scale (BRSS) and the Brief Mood Survey (BMS), which includes a Depression Scale, Anxiety Scale, and Anger Scale. The BMS Suicidal Urges scale was not included in the phone follow-up due to an inadequate ability to assure patient safety, so it is not included in the statistical analysis.

Participants who had completed the ICIT group but had not responded to the follow-up meeting were called and given the option to complete the phone questionnaires. Due to the inclusion of the phone follow-ups and a health crisis for a family member of the researcher, the average time for follow-up for the ICIT group was 12 weeks. The average time for follow-up in the TAU group was 7 weeks.

Initially ANCOVAs were run using the pre-test scores as covariates for each of these scales. It was determined that the pre-test scores were not related to the post-test scores. At that point, to determine if there were differences between the ICIT group and the TAU group on the BRSS and BMS (which includes subscales of depression, anxiety and anger) a one-way analysis of variance (ANOVA) was used with each of these scales.

Analysis of Variance is a statistical test that is used to evaluate mean differences between two or more populations. The one-way analysis of variance was used because it compares the means of a variable (the scores on the scales of each group) that result from a classification by one other variable (receiving the ICIT treatment or not). ANOVA compares “the variance (variability in scores) between the different groups (believed to be due to the independent variable) with the variability within each of the groups (believed to be due to chance)” (Pallant, 2010, p. 249). ANOVA is the preferred statistical test over multiple t-tests, which would significantly increase the risk of a type-I error (Devore & Farnum, 2005). A Bonferroni adjustment was used, with the resulting $p = .0125$ used to determine statistical significance. Preliminary analyses were conducted to examine the comparability of groups. No significant differences were found between groups. Normality and homogeneity of variance assumptions were assessed by examining the Kolmogorov-Smirnov test for normality, histograms, Levene’s Test of Equality of Error Variances, and the skewness and kurtosis for each dependent variable.

Research question one.

Is there a difference between the ICIT intervention group and the TAU group on relationship satisfaction as measured by the Burns Relationship Satisfaction Scale (BRSS)? A between-groups analysis of variance (ANOVA) was conducted to explore the difference in variance of group means in relationship satisfaction, as measured by the Burns Relationship Satisfaction Scale (BRSS) between the ICIT group and the TAU group. The mean scores and standard deviations for the ICIT treatment group were $M = 33.10$, $SD = 5.02$, 95% CI [25.05, 41.09], and for the TAU group were $M = 27.50$, $SD =$

15.82, 95% CI [19.51, 35.50]. There was no statistically significant difference at the $p < .05$ level, $F(1, 19) = 1.06$, $p = .317$, $\eta_p^2 = .059$, Cohen's $d = .5$. The partial eta-squared indicates a medium effect size. Pre- and Post-test means and standard deviations for BRSS scores between the ICIT group and TAU group are listed in Table 1.

Research question two.

Is there a difference between the ICIT intervention group and the TAU group on Burns Brief Mood Survey, Depression Scale? A between-groups analysis of variance (ANOVA) was conducted to explore the difference in variance of group means in depression, as measured by the Burns Brief Mood Survey (BMS) Depression Scale between the ICIT group and the TAU group. The mean scores and standard deviations for the ICIT treatment group were $M = 4.73$, $SD = 4.22$, 95% CI [1.34, 7.99], and for the TAU group were $M = 7.3$, $SD = 6.04$, 95% CI [3.89, 10.85]. There was no statistically significant difference at the $p < .05$ level, $F(1, 20) = 1.39$, $p = .254$, $\eta_p^2 = .072$, Cohen's $d = .5$. The partial eta-squared indicates medium effect size. Pre- and Post-test means and standard deviations for BMS Depression scores between the ICIT group and TAU group are listed in Table 1.

Research question three.

Is there a difference between the ICIT intervention group and the TAU group on Burns Brief Mood Survey, Anger Scale? A between-groups analysis of variance (ANOVA) was conducted to explore the difference in variance of group means in depression, as measured by the Burns Brief Mood Survey (BMS) Anger Scale between

the ICIT group and the TAU group. The mean scores and standard deviations for the ICIT treatment group were $M = 4.82$, $SD = 3.97$, 95% CI [1.76, 8.18], and for the TAU group were $M = 7.5$, $SD = 6.35$, 95% CI [3.96, 10.70]. There was no statistically significant difference at the $p < .05$ level, $F(1, 20) = 1.13$, $p = .302$, $\eta_p^2 = .059$, Cohen's $d = .5$. The partial eta-squared indicates medium effect size. Pre- and Post-test means and standard deviations for BMS Anger scores between the ICIT group and TAU group are listed in Table 1.

Research question four.

Is there a difference between the ICIT intervention group and the TAU group on Burns Brief Mood Survey, Anxiety Scale? A between-groups analysis of variance (ANOVA) was conducted to explore the difference in variance of group means in depression, as measured by the Burns Brief Mood Survey (BMS) Anxiety Scale between the ICIT group and the TAU group. The mean scores and standard deviations for the ICIT treatment group were $M = 6.64$, $SD = 4.37$, 95% CI [3.34, 8.76], and for the TAU group were $M = 9.5$, $SD = 4.72$, 95% CI [7.30, 13.00]. There was a statistically significant difference at the $p < .05$ level, $F(1, 20) = 4.56$, $p = .047$, $\eta_p^2 = .202$, Cohen's $d = 1.0$. The partial eta-squared indicates a large effect size. Pre- and Post-test means and standard deviations for BMS Anxiety scores between the ICIT group and TAU group are listed in Table 2.

Assessments at Pre and Post Test						
	ICIT Group			TAU Group		
Assessments	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
BRSS						
Pretest	11	19.2	10.83	10	18.6	12.14
Posttest	11	33.1	5.02	10	27.5	15.82
Depression						
Pretest	11	13.8	5.94	10	13.4	6.25
Posttest	11	4.73	4.22	10	7.3	6.04
Anger						
Pretest	11	9.8	3.45	10	11.7	6.16
Posttest	11	4.82	3.97	10	7.5	6.35
Anxiety						
Pretest	11	16.5	5.38	10	13.4	5.97
Posttest	11	6.64	4.37	10	9.5	4.72

Table 2. ICIT= Intensive Cognitive Interpersonal Therapy; TAU= Treatment as usual; BRSS= Burns Relationship Satisfaction Scale; BMS= Brief Mood Scale

Listed below are the changes observed from pre to post-test in clinical levels. The BMS clinical levels scores for Depression, Anxiety and Anger are noted in Table 3. Table 4 represents the changes in clinical level by both of the groups on all of the BMS scales.

Score	Burns BMS: Depression, Anxiety and Anger Scale
0-1	Few or no symptoms, best possible score
2-4	Borderline Symptoms
5-8	Mild Symptoms
9-12	Moderate Symptoms
13-16	Severe Symptoms
17-20	Extreme Symptoms

Table 3. Levels of Change in the Burns Brief Mood Survey Scale

BMS DEPRESSION SCALE	ICIT Group	TAU Group
5 Levels	<i>n</i> = 3	<i>n</i> = 0
4 Levels	<i>n</i> = 1	<i>n</i> = 1
3 Levels	<i>n</i> = 2	<i>n</i> = 2
2 Levels	<i>n</i> = 3	<i>n</i> = 2
1 Level	<i>n</i> = 0	<i>n</i> = 2
No Change	<i>n</i> = 1	<i>n</i> = 1
Negative Level Change	<i>n</i> = 1	<i>n</i> = 2
Total with positive change	<i>n</i> = 10	<i>n</i> = 7
Total with no change or decrease in level	<i>n</i> = 2	<i>n</i> = 3
BMS ANGER SCALE		
5 Levels	<i>n</i> = 0	<i>n</i> = 0
4 Levels	<i>n</i> = 1	<i>n</i> = 1
3 Levels	<i>n</i> = 3	<i>n</i> = 0
2 Levels	<i>n</i> = 3	<i>n</i> = 2
1 Level	<i>n</i> = 2	<i>n</i> = 4
No Change	<i>n</i> = 0	<i>n</i> = 2
Negative Change	<i>n</i> = 2	<i>n</i> = 1
Total with positive change	<i>n</i> = 9	<i>n</i> = 7
Total with no change or decrease in level	<i>n</i> = 2	<i>n</i> = 3
BMS ANXIETY SCALE		
5 Levels	<i>n</i> = 1	<i>n</i> = 0
4 Levels	<i>n</i> = 1	<i>n</i> = 0
3 Levels	<i>n</i> = 3	<i>n</i> = 0
2 Levels	<i>n</i> = 3	<i>n</i> = 4
1 Level	<i>n</i> = 2	<i>n</i> = 4
No Change	<i>n</i> = 0	<i>n</i> = 0

Negative Change	<i>n</i> = 1	<i>n</i> = 2
Total with positive change	<i>n</i> = 10	<i>n</i> = 8
Total with no change or decrease in level	<i>n</i> = 1	<i>n</i> = 2

Table 4. BMS= Brief Mood Scale; ICIT = Intensive Cognitive Interpersonal Therapy; TAU= Treatment as Usual; Changes in levels indicate improvement in clinical status. The negative change indicates a decrease in clinical status.

In the ICIT group 81 % of the patients showed improvement in their depression symptoms. Five patients (45%) moved from varying levels of depression to “few or no symptoms” category, the best possible score. Four patients (36%) improved from extreme or severe category to mild. One patient (9%) showed no change in symptoms and one patient’s anxiety increased one level from borderline to moderate (9%). In the TAU group, 80% of the patients showed improvement in depression symptoms. Two patients (20%) moved from varying degrees of the depressed category to “few or no symptoms” two patients (20%) moved to borderline symptoms, four patients (40%) while still in the depressed category, decreased 1 to 2 levels in depression, and two patients (20%) became more depressed.

Seventy-two percent of the ICIT group showed improvement on the Anger scale. Two patients (18%) moved from moderately angry to “few or no symptoms.” Four patients (36%) moved from varying levels of depression to borderline symptoms. Four other patients (36%) decreased one level in symptoms but still remained in the depressed category. Two patients (18%) became angrier. In the TAU group 70% of the patients showed improvement. Two patient’s (20%) moved from mild or borderline to “few or no symptoms.” Three patients (30%) moved to borderline symptoms. And while still in the

depressed category, two patient's (20%) moved one level. No improvement was seen in two (20%) of the patients and one patient (10%) became more angry.

Lastly, on the Anxiety scale, 100% of the patients in the ICIT group showed improvement. One patient (9%) moved from extreme symptoms to “few or no symptoms.” Four patients (36%) moved from severe or extreme anxiety to borderline symptoms. While still having some symptoms of anxiety, all of the others (54%) showed improvement in their anxiety, moving from one to three levels. Eighty percent of the patients in the TAU group showed improvement in anxiety. However, no patients reached the “few or no symptom” category. Two (20%) moved from mild to borderline symptoms. While still having some of the symptoms six (60%) moved one to two levels in their symptoms, and two (20%) became more anxious.

Table 5 includes the scores for the levels of relationship satisfaction as described by the BRSS questionnaire. Table 6 indicates the patients' changes in levels of relationship.

BRSS Levels of Satisfaction	
0 - 10	Extremely Dissatisfied
11 - 20	Very Dissatisfied
21 - 25	Moderately Dissatisfied
26 -30	Somewhat Dissatisfied
31 - 35	Somewhat Satisfied
36 -40	Moderately to Very Satisfied
41 - 42	Extremely Satisfied

Table 5. BRSS = Burns Relationship Satisfaction Scale

BRSS	ICIT Group	TAU Group
6 Levels	<i>n</i> = 0	<i>n</i> = 1
5 Levels	<i>n</i> = 0	<i>n</i> = 0
4 Levels	<i>n</i> = 4	<i>n</i> = 3
3 Levels	<i>n</i> = 3	<i>n</i> = 0
2 Levels	<i>n</i> = 2	<i>n</i> = 0
1 Level	<i>n</i> = 0	<i>n</i> = 2
No Change	<i>n</i> = 1	<i>n</i> = 2
Negative Level Change	<i>n</i> = 1	<i>n</i> = 2
Total with positive change	<i>n</i> = 8	<i>n</i> = 6
Total with no change or decrease in level	<i>n</i> = 2	<i>n</i> = 4

Table 6. BRSS = Burns Relationship Satisfaction Scale; ICIT = Intensive Cognitive Interpersonal Therapy; TAU= Treatment as Usual; Changes in levels indicate improvement in clinical status. The negative change indicates a decrease in clinical status.

In the ICIT group, 81% indicated that their relationship had improved. Nine patients progressed from varying degrees of dissatisfied (extremely, very, or somewhat) to somewhat satisfied, 81% of the group. Two patient's (18%) improved but remained in the dissatisfied category, moving from very dissatisfied to somewhat dissatisfied, and moderately dissatisfied to somewhat dissatisfied. One patient (9%) remained the same, moderate to very satisfied, on the pre and post-test.

In the TAU group five patients (50%) indicated that their relationship had improved from varying degrees of dissatisfaction (extremely, very, or somewhat) to varying degrees of satisfaction (extremely, very, or somewhat). Two patients started in the satisfied range, one showing no change (10%) and the other improving one level in satisfaction (10%). One patient (10%) with a pre-test of extremely dissatisfied showed no

change in his post-test score. Lastly, two patients (20%) with pre-tests in the dissatisfied range showed decreases in their satisfaction score, becoming more dissatisfied.

Rehospitalization

This study also examined the rehospitalization rate of the patients who completed the follow-ups. The patients' hospital records were reviewed (with each patient's consent) at six weeks after discharge from the hospital. There were no readmissions in either the ICIT group or the TAU group at the six week follow-up.

CHAPTER FIVE: SUMMARY FINDINGS, DISCUSSION, AND RECOMMENDATIONS

The goal of this research was to determine whether patients in an inpatient psychiatric hospital participating in an intensive CIT group would show improvement in relationship satisfaction, emotion regulation, and rehospitalization rates. The results of the statistical analysis showed that there were no significant statistical differences between these groups on relationship satisfaction, depression, or anger scales. However, there was a moderate effect size noted for each of these scales. The results did indicate a significant difference for the anxiety scale, and it was found to have had a large effect size.

Discussion

There were no significant differences between groups based on the results of the ANOVA except on the Brief Mood Scale (BMS) Anxiety subscale, where there was a statistical difference. While there was no significance found for the other scales, the effect size of each of the scales range from medium to large. Fritz, Morris and Richler (2012) state that effect sizes “provide a description of the size of observed effects that is independent of the possibly misleading influences of the sample size” (p. 2). Research that is not statistically significant does not prove the null hypothesis; it can often be due to other determinants. Jacobson and Truax (1991) state that statistical significance tests are limited in two ways. First, they provide no information about the variability of response to treatment within a sample, and they have little to do with the clinical

significance of the treatment. The efficacy of a psychotherapeutic treatment is determined by “the benefits derived from it, its potency, its impact on clients, or its ability to make a difference in peoples’ lives. Conventional statistical comparisons between groups tell us very little about the efficacy of psychotherapy” (Jacobson & Truax, 1991, p. 12).

Kraemer et al. (2003) also discuss the limitations of statistical significance and the importance of effect size. They observe, “Because the presence or absence of statistical significance does not give information about the size or importance of the outcome, it is critical to know the effect size” (p. 1524).

For the BMS Anxiety Scale the partial eta-squared result of .202 indicates a large effect size. On the Associated Values Scale by Fritz, et al. (2012, p. 8) the associated equivalent of the .202 eta-squared is a Cohen’s *d* of 1.0, with an associated equivalent Probability of Superiority (PS) score of 76. The PS score, also called the “common language effect size indicator,” was developed by McGraw and Wong (1992, p. 361). Its purpose was to introduce simplicity into understanding effect size and to provide novel information that may assist researchers to “assess the real-world importance of research findings” (p. 365). The PS score converts an effect into a probability. Fritz, et al. (2012) describe it as follows, “the Probability Score gives the percentage of occasions when a randomly sampled member of the distribution with a higher mean will have a higher score than a randomly sampled member from the other distribution. (p. 14)

The PS score for the Anxiety Scale is 76. This finding for the Anxiety Scale indicates that Cognitive Interpersonal Therapy appears to directly impact patients’ anxiety levels as measured by the Burns Brief Mood Scale.

While the results of analysis did not indicate a statistical significance between the groups on the BRSS, Depression or Anger scales, there were positive changes noted on relationship satisfaction and the clinical levels assessed by the questionnaires. The majority of patients in both groups showed evidence of a reduction in symptoms based on the Depression and Anger scale of the BMS, and there were more patients in the ICIT groups that showed improvement in clinical levels than those in the TAU group. Also, more patients in the CIT group increased in Relationship Satisfaction as measured by the BRSS. This was evidenced by the effect size noted for each of these scales. The BRSS, Depression, and Anger scales had partial eta squared scores of .059, .072, and .059, respectively. According to Pallant (2010) the partial eta squared effect size indicates the “proportion of variance of the dependent variable that is explained by the independent variable” (p. 210). The corresponding Cohen’s *d* for each is .5, which is indicative of a moderate effect size and a PS score of 64 for each. This effect size lends credibility to the clinical significance of ICIT as a treatment. Clinical significance is based on standards provided by clinicians, patients and/or researchers, and there is still little consensus about the exact criteria for these efficacy standards (Kraemer et al., 2003). Many agree that clinical significance would include “a lower percentage of treated clients than comparisons with negative outcomes or at risk, elimination of the problem, or normative levels of functioning (meeting or exceeding the cut-score) at the end of treatment” (Kraemer et al., 2003, p. 1526). Jacobson and Truax (1991) suggest that one way of operationalizing clinical significance is that “the level of functioning subsequent to therapy places that client closer to the mean of the functional population than it does to

the mean of the dysfunctional population” (p. 13). Kazdin (1999) states that clinical significance refers to the practical or applied value of the effect of the intervention, “that is, whether the intervention makes a real (e.g., genuine, palpable, practical, noticeable) difference in everyday life to the clients or to others with whom the clients interact” (p. 332).

The outcomes on the measures used in this study indicate that the scores of the patients in the ICIT group fall more in the normative range, and those in the group who did not reach the normative range still improved their scores across more clinical levels (indicating a decrease in symptoms.) While a client’s behavior may not have changed enough to fall within a normative range, the change may be important and clinically significant. The same is true for the BRSS, indicating a greater overall increase in relationship satisfaction in the ICIT group. Kazdin (1999) observes,

After all, from the standpoint of symptoms, one can be a little better or a lot better (e.g., fewer or less severe symptoms) without being all better or just like most people (e.g., no symptoms, normative range of symptoms, or recovered). If one is a little better or a lot better, that is important to identify for research and clinical purposes. (p. 333)

Because of the lack of statistical significance, the researcher is unable to reject the null hypothesis; however, the effect sizes are moderate and indicate that further research is needed to explore the benefits of CIT for inpatients.

The Anxiety subscale of the BMS did reach statistical significance. Burns (2006) offers one possible explanation for the impact on patients’ anxiety levels. Burns suggests that for many people anxiety is a result of being too “nice.” Anxious people are often characterized by self-defeating beliefs regarding relationship conflict. These beliefs include: the need to please others at the expense of one’s own needs, the feeling that one

is not allowed to be angry, and the desire to avoid all conflict because of the overwhelming need to get along with everyone all of the time. These beliefs induce anxiety because patients are often afraid to admit feelings of anger or hurt. Burns argues that this interpersonal anger is at the heart of anxiety. When patients learn how to better deal with relationship conflict utilizing Cognitive Interpersonal Therapy, it allows them to set appropriate boundaries and become more assertive, directly impacting their anxiety levels.

While there is much research that validates the association between depression and anxiety (Gotlib & Cane, 1989), there are also those who argue that there are specific cognitive and affective differences between the two emotions (Beck, et al., 1979). It could be theorized that having the additional preparation for relationship stress may have influenced their anxiety responses in comparison to the TAU group. Potentially, learning the information and skills may have helped decrease patients' anxiety level even if they were not motivated to use them.

The study as originally designed had several strengths, including the use of standardized tests and pre-test/post-test follow-up design, with a TAU comparison group; however, it also had some limitations. While it may be theoretically possible that there are no significant benefits to an *intensive* CIT group format for inpatients, the effect sizes in this study indicate that the likelihood of finding no statistical difference between groups is due to other limitations, primarily the small number of participants, rather than the efficacy of the treatment.

One of the major limitations of the study was the small sample size. The sample size was very modest for detecting group differences. Two factors might have been

modified by the researcher to increase the follow-up response rate. The researcher could have also mailed the follow-up questionnaires to provide another response option for those who did not want to respond on the phone or in person. The researcher could also have reduced the number of questionnaires participants were asked to complete. Lengthy questionnaires have been identified as a barrier to patient participation in research (Patel, Doku & Tennakon, 2003). On average it took patients approximately one hour to complete the pretest questionnaires. This may have also contributed to the smaller number of patients who completed the follow-up. While large sample studies are the goal for determining the efficacy of a treatment, small sample studies are also needed to provide preliminary information regarding new treatments (Castonguay, et al., 2004).

Along with the small sample size the heterogeneous group was another factor contributing to the low statistical effect. Often studies limit the treatment group to a specific diagnosis, such as anxiety and/or depression. The participants in this study covered virtually the whole diagnostic spectrum. This type of heterogeneity increases within group variability and thus decreases statistical power.

While small sample size played a role in the statistical analysis, another limitation was identified. This limitation, which addresses exposure of the TAU group to the treatment, is often referred to as diffusion or contamination (Craven, Marsh, Debus & Jayasinghe, 2001). Diffusion is “when one group learns information or otherwise inadvertently receives aspects of a treatment intended only for the second group” (Robson, 2011, p. 89). The researcher was aware that patients on the unit are exposed to a brief overview of the same type of treatment as the ICIT intervention. Patients on the inpatient unit receive approximately two hours a week of instruction about the concepts

of CIT and their application. One of the goals of the current research was to determine whether having patients receive *intensive* CIT group training, six hours over two days, would improve outcomes. The information presented to the two groups (ICIT and regular inpatient CIT group) was similar. The participants of the ICIT group received a more intensive, personalized application of CIT, while the patients in the TAU group attending the regular weekly CIT group received the same introductory content each week.

While the degree of application of the content differed, there is still a concern because the amount of exposure to CIT was varied for both groups. How much additional exposure a patient received was determined by how long the patient remained on the unit and how many of the regular CIT groups he or she attended. For some patients in the ICIT arm of the study, attending the regular inpatient CIT group would have reinforced what they were taught in the treatment group. Patients in the TAU group also received varied amounts of exposure to CIT depending on how long they were in the hospital and how many of these regular groups they attended. It is possible that patients in the TAU group who were discharged on Monday after they were admitted to the study (there are no CIT groups that take place on the weekends) would not have had any exposure to CIT, while others who may have remained as patients for several weeks had the opportunity for much more exposure. This exposure to the CIT treatment for both groups may have impacted the results of the study.

Another possible limitation impacting this study is the participants' degree of motivation to change. A key element of Burns' CIT is the motivation required on behalf of the patient to focus not on the faults and limitations of others, but to focus upon oneself. For example, Burns' disarming technique requires the patient to look for the

truth in the criticism given by the partner, to accept the criticism and hostile affect, and to be willing to identify his or her own short-comings and mistakes. Burns states that the motivation to embrace and act on these skills is a key element to success with CIT (Burns, 2008). The efficacy of CIT is determined by what the patient wants more, the rewards of the battle or the rewards of a close, loving relationship (Burns, 2008). Future studies should include a valid measure of the participants' pre-treatment motivation.

The researcher had the opportunity to describe briefly this research to Dr. Burns while attending a conference. He stated that he believed that the major obstacle for using CIT in this type of setting was adequately assessing the patient's motivation to make the changes required to be successful in intimate relationships (D. Burns, personal communication, February, 2009). The researcher did attempt to assess motivation by including the Reaction to Treatment Questionnaire (RTQ), which includes the question, "How confident are you that this treatment will be successful at decreasing your relationship conflict?" The Likert scale is from 1, not confident at all, to 10, very confident. For the CIT group $M = 6.5$, and for the TAU group $M = 6.9$. While this questionnaire may give insight into the patient's belief that CIT would work for him or her, it fails to assess adequately the patient's motivation to change.

Another area that deserved consideration was the amount of contact the patient had with the person he or she identified as the primary relationship of focus. Research has shown that the amount of face-to-face time one spends with a person who is critical of him or her can impact outcomes (Hooley & Gotlib, 2000). It would have been beneficial for the researcher to assess the amount of time the patient spent with the person in the identified relationship.

The type of relationship the participants identified may also have played a role in the outcomes. Hooley, et al. (1986) note the source of the criticism may play an important role in the response of the patient, stating "...criticism from a spouse may simply be more salient and more distressing for a patient" than that received in other relationships (p. 646). While the majority of patients identified the spouse as their target relationship (CIT group $n = 7$), four patients chose other relationships: mother ($n = 1$), brother ($n = 1$), sister $n = 1$) and friend ($n = 1$). In the TAU group target relationships included spouse ($n = 4$), brother ($n = 1$), boyfriend ($n = 1$), friend ($n = 2$), mother ($n = 1$) and blank ($n = 1$). While it can be assumed that the interactions with the spouses were frequent, the patients with the other relationships may not have had as many encounters. This, as well as the type of relationships, could have impacted the responses on the follow-up relationship satisfaction questionnaire. The data obtained was the result of self-report measures. The findings may have been improved by also including the patients' family members' perspectives of relationship satisfaction.

Lastly, while this research utilized the pre-test/post-test, control group design which is known to control for threats to internal validity (Kazdin, 2003), there were several factors that decreased validity for this study. In this design the effect of the intervention is reflected in the amount of change from pre- to post-intervention assessment. When the intervening period between pre- and post-treatment assessment is the same for each group, threats to validity such as "history, maturation, repeated testing, and instrumentation" (Kazdin, 2003) are decreased. However, due to the addition of the phone assessment and the inclusion of participants who had not returned for the in person follow-up, the average post assessment time for the CIT treatment group was 12 weeks

and the average follow-up time for the TAU group was 7 weeks. Including the two different types of assessments (phone and in person) also decreased the validity of the results. However, the longer follow-up period for the CIT group makes for a more conservative estimate of the results and the findings of the study are likely more durable.

Recommendations

Utilizing the limited time healthcare workers have with patients in the inpatient setting is important. The national average length of a psychiatric hospital stay is one week (Centers for Disease Control and Prevention, 2009). Given the projected path for financial reimbursement in the near future, making sure that interventions are effective has become an even higher priority for healthcare.

On March 23, 2010 the Affordable Health Care Act was signed into law. This Health Care Act will continue to change healthcare by implementing comprehensive health insurance reforms for the next several years. Two of the reforms that will impact inpatient hospital care are the Value-Based Purchasing (VBP) program and the “bundling” of reimbursements. The VBP program offers financial incentives to hospitals that improve quality of care. Hospitals will be required to report a variety of outcome measures that meet the criteria set to receive these financial incentives (U.S. Department of Health and Human Services, nd).

As of January 1, 2013, the law establishes a national pilot program that will also impact financial reimbursement. The goal of this pilot program is to encourage hospitals, doctors, and other providers to work together to improve coordination and quality of care. This program implements “bundling” of payments. Currently, hospitals and physicians

bill patients for individual services provided during a hospital stay. The new program will no longer pay for individual services provided, but will “bundle” a payment. Under payment bundling, hospitals, doctors and providers are paid a flat rate for an episode of care (U.S. Department of Health and Human Services, nd). The ability of a hospital to survive economically in the upcoming years will be dependent upon implementing the most effective interventions in the most fiscally conservative manner. The type of intervention implemented in this study could hold promise to be an effective inpatient intervention that does not require lengthy specialist training but can be implemented by mental health nurses or counselors, not requiring a psychiatrist or psychologist. The identification of potential cost effective interventions is important in this time of health care reform and necessitates the continued research of empirically valid inpatient interventions.

The focus of change in CIT is the patient. It is theorized that when the patient changes the way he or she responds to the criticism of a loved one, the loved one will change as well (Burns, 2008). Hooley and Gotlib (2000) note that while utilizing treatments that are targeted at helping patients cope with stressful relationships might afford them some protection in the absence of family interventions, it is important “to recognize that both patients and relatives are involved in a system of mutual influence in which each provides the stress that acts on the intrinsic vulnerabilities of the other” (p. 136). With this in mind, it may be useful for future research to include the loved one of the patient as well.

While CIT has been shown to be an effective treatment for therapists to use with their patients (Burns, 2008), to this researcher’s knowledge it had not previously been

evaluated in the inpatient setting. The purpose of this study was to determine if an *intensive* inpatient treatment group was a feasible intervention that could be helpful in the treatment of relationship problems in psychiatric inpatients. Cognitive Interpersonal Therapy brings the therapeutic focus to an area which has been shown to potentially impact relapse rates (Butzlaff & Hooley, 1998; Chambliss & Steketee, 1999; Hooley & Teasdale, 1989, Hooley, et al., 1986; Kwon, et al., 2006). It is an important area of clinical focus because often patients are unaware of the impact that interpersonal friction can have on their potential relapse (Fava, et al., 1998).

This study was a logical first step to determine if an intensive CIT group could work and whether it deserves further empirical investigations in the future. While statistical significance was reached only on the BMS Anxiety scale, the moderate effect sizes on the other measures indicate that this treatment is beneficial to inpatients. The patient response to the intervention was very positive and the treatment was not associated with any adverse events. Future researchers may want to consider including Dr. David Burns' book, *Feeling Good Together*, as adjunct bibliotherapy to reinforce the content covered in the treatment groups.

The results of this study indicate that utilizing CIT in an intensive six hour group with patients who have relationship problems is feasible and acceptable to patients. Overall, participants in both groups showed a reduction in clinical symptom level and an increase in relationship satisfaction. While these results cannot be attributed to the use of CIT by either group, they do indicate that the ICIT group is at least as effective as the regular treatment for these clinical samples. Based on the results of this study, this researcher believes that the exposure to ICIT is helpful to psychiatric inpatients. The

effect size of each of the measures indicates that ICIT does have meaningful impact of patient outcomes. It is understood that care must be taken when comparing eta-squared effect size estimates across studies with different designs (Fritz, et al., 2012). This researcher is encouraged by the words of Katz (as cited in Castonguay, et al., 2004) stating that research may be acceptable “even though not definitive in its results, because it opens up a new and promising area of research” (p. 17).

Further research addressing the limitations is needed to continue to examine the impact that ICIT can have in the inpatient setting. Future controlled studies using larger, more homogenous groups are recommended. Larger clinical trials of randomized clinically representative subjects would increase generalizability. If this study is to be replicated on the same psychiatric unit, clearer delineation of the exposure to the treatment would be necessary, as would be controlling for this exposure. A replication of this study would not include this confound in a psychiatric inpatient setting that does not utilize CIT in its treatment as usual protocol. This would increase the expected difference between groups, thus making the conditions of the study more sensitive to the treatment and likely leading to stronger effects (Kazdin, 2003). This type of inpatient environment would be preferred for future studies.

Because of the impact of relationship conflict on psychological health “there has now emerged a widespread consensus that the effects of relationships and relationship events are so central to psychopathology and clinical practice that they should be featured more prominently in the diagnostic system” (Beach, Wamboldt, Kaslow, Heyman & Reiss, 2006 as cited in Whisman, Beach & Snyder, 2009, p. 247). Cognitive Interpersonal Therapy provides motivated patients with the tools and insights to improve their problem

relationships. It also provides patients with self-regulating strategies that allow them to develop skills to forge deeper connections and to repair relationships that have been damaged. Fincham, Stanley and Beach (2007) have hypothesized that these self-regulatory skills and the ability to repair relationships are vital components to making transformative changes in relationships. Because the ability to self-regulate negative emotion is essential to a healthy psychological state, the usefulness of adapting ICIT in acute care settings is an important area of study. Future research can help determine its degree of benefit for psychiatric inpatients.

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Appendix A

Physician Referral Form for Patient Participation in Intensive Cognitive Interpersonal Therapy vs Treatment as Usual Research Study

The chief aim of this study is to expand current research by examining whether a brief, intensive CIT intervention, which is designed to target and reduce relationship conflict, will offer hospitalized patients important skills that will improve their ability to handle negative, highly critical interactions within a relationship and thus decrease their vulnerability to emotion dysregulation and relapse post hospitalization. This study seeks to answer the following research question: Will patients on an acute inpatient psychiatric unit receiving an intensive CIT intervention show greater improvement in relationship satisfaction and emotion dysregulation, decreased rehospitalization rates, and decreased destructive thought processes at the end of a six week period after discharge when compared to the Treatment as usual (TAU) group? Patient must meet all of the following criteria:

- ☐ Patient is currently hospitalized with a psychiatric illness and will be in the hospital on Saturday and Sunday of this week.
- ☐ Patient is currently being seen by psychiatrist or psychologist at Piedmont Psychiatric Center.
- ☐ Patient is not experiencing florid psychosis, organic brain disease, mental retardation or any other acute medical condition that would prevent him or her from participating in the research.
- ☐ Patient is not participating in the dual diagnosis program.

Based on the above criteria I am referring (fill in patient's name or place sticker below)

_____ as a potential candidate for participation in the ICIT vs TAU research study. He or she is mentally capable of making decisions and is able to consent to participation. To be included in the research it is understood that the patient will give their personal consent: 1) to participation in the ICIT group or TAU group; 2) to be contacted by the PI after discharge to make for a post-treatment follow-up appointment to take place at PPC; 3) that relationship problems impact his/her psychiatric illness; 4) that his/her physician will be notified of any thoughts of suicidal or homicidal ideation and steps will be taken to keep the patient safe if necessary; 5) that the Primary Investigator

will have access to their medical records limited to the use of data pertinent to this study.

Physician signature _____.

Appendix B

Treatment Protocol

Intensive Cognitive Interpersonal Therapy

Day One:

I. Module One

- A. Brief overview and schedule of CIT therapy
- B. Introduction of participants and facilitator
- C. Review of group rules (confidentiality)

II. Describe and discuss the Will Set

- A. Importance of motivation and acceptance of personal responsibility
- B. Define intimacy
- C. Describe decision tree
- D. Discussion of Blame and Cost/Benefit Analysis

III. Describe and Discuss the Skill Set

A. Introduction of Three Columns Situational Analysis

- 1. What did they say?
- 2. What did you say?
- 3. How did they respond?
- 4. What were you trying to accomplish?
- 5. Did what you say make things better or worse?

a. Motivation scenario:

He/She said: “You don’t want to get well, what’s wrong with you?”

(Before giving patients the response, ask each patient how they would have responded to this person)

You said: "I can't believe you would say that, you know I want to get better!"

He/She said: "Well then let me see some evidence- you act like you don't even care about yourself."

b. Criticism scenario:

He/She said: "Why can't you cope? Why do you always blow things out of proportion?"

(Before giving patients the response, ask each patient how they would have responded to this person)

You said: "Because you don't listen to me unless I make a big deal about something. You never pay me any attention."

He/She said: "I ignore you because I can't stand all the drama!"

B. Define and discuss thought and feeling empathy

1. Ask each patient to identify what they think "He/She" was thinking and feeling.
2. After every patient has identified the thoughts and feelings, the correct answer will be given.

C. Define and discuss assertiveness

1. Ask each patient what they think "They" was thinking and feeling in the scenario.

2. After every patient has identified the thoughts and feelings, the correct answer will be given.

D. Define and discuss respect/stroking/inquiry

1. Ask each patient how they would have used the respect/ stroking/ inquiry skills.
2. After every patient has identified the way they would have used the Respect/stroking/inquiry skills, the facilitator will give an illustration using each of these skills.

IV. Module Two

A. Practicing/ Modeling of Skills with several scenarios: Empathy: Thought Empathy and Feeling Empathy

B. Practice/modeling skills using Disarming Technique

C. Two ways to use the skill set

1. In the heat of the battle you can
 - a. do what you used to do- explode or withdraw
 - b. use this tools skillfully. It is important to see that you can learn to act differently even when emotionally activated.
 - c. recognize that you are emotionally flooded and take a time out, and come back later when you are not as emotionally overwhelmed and use the skill set to address the issue.
2. The repair cycle: When conversations do not go like you would like them to, you can come back and 'repair' by using the skill set.

Often patients with depression or anxiety use avoidance strategies to deal with conflict, but they never come back and address the situation and hold anger inside or they explode and it causes the conflict cycle to continue. This leaves patients feeling hopeless and helpless and increases problems with emotion regulation.

V. Module Three

A. Practicing/ Modeling of Skills with several scenarios; Assertiveness, Respect, Stroking and Inquiry

Day Two

I. Module Four

- A. Review the Skill Set
- B. Have patient identify a personal relationship on which they would like to focus. Who is a person that you want to have a close personal relationship with, but they often make you angry, frustrated or have some other negative effect on you?
- C. Have patients describe a situation using the situational analysis.
- D. Practice and role play using each patient's personal scenarios

II. Module Five

- A. Practice and Role Play using personal scenarios
- B. Have patients identify situations they have encountered during their hospital admission

III. Module Six

A. Practice and Role Play using a variety of emotional interpersonal scenarios

B. How do you plan to use what you have learned? Have patients identify scenarios that they will encounter after discharge and role play using EAR skills.

Appendix C

Biographical Questionnaire

MR# _____

ID# _____

Age: (0) ☐ 18-29 (1) ☐ 30-39 (2) ☐ 40-49 (3) ☐ 50-59 (4) ☐ 60-69 (5) ☐ 70 and older

Diagnosis _____

Please check the appropriate box:

How many times have you been hospitalized for psychiatric illness?

(0) ☐ This is my first admission. (1) ☐ 2 times (2) ☐ 3 times (3) ☐ 4 times (4) ☐ 5 times

(5) ☐ more than 5 times

Have you been hospitalized in the last six months (not including this hospitalization)

☐ Yes or ☐ No

Gender (circle one): (1) Male or (2) Female

Employment status (please check one):

(0) ☐ full-time (1) ☐ part-time (2) ☐ occasional/per diem (3) ☐ disability/ SSI

(4) ☐ no income

Occupation: _____

Student status (if applicable): (0) ☐ full-time (1) ☐ part-time

Student type (if applicable): (0) ☐ undergraduate (1) ☐ graduate

What is the highest level of education you have completed?

(0) ☐ Grammar school (1) ☐ High school or equivalent (2) ☐ Vocational/Technical school

(3) ☐ Some college (4) ☐ Bachelor's degree (5) ☐ Master's degree (6) ☐ Doctoral degree

Relationship Status:

- (0) ☐ single (no current romantic partner)
- (1) ☐ married: how many years _____
- (2) ☐ living with partner (not married): how many years _____
- (3) ☐ not living with current partner
- (4) ☐ divorced
- (5) ☐ widowed

Ethnicity (check all that apply):

- (0) ☐ African American/ Black
- (1) ☐ Caribbean/ Haitian
- (2) ☐ African
- (3) ☐ Asian American
- (4) ☐ White/ European American/ Caucasian
- (5) ☐ Latino/Latina/Hispanic American/Hispanic
- (6) ☐ Native American
- (7) ☐ Multiracial
- (8) ☐ Other: _____

Were you being seen regularly by a mental health care provider before your admission?

☐yes or ☐no

Would you say that relationship problems contributed to your hospital admission?

☐yes or ☐no

Do you have a history of using cutting to deal with your anxiety or emotional pain?

☐yes or ☐no

If yes, how often do you cut?

- (0) ☐ once a month (1) ☐ once a week (2) ☐ once a day (3) ☐ other _____

To be completed by primary investigator:

MR # _____

(0) ☐ Voluntary Admission (1) ☐ Involuntary Admission

Date of hospital admission _____

GAF on admission _____

Date enrolled into CIT study _____ CIT or TAU

Date of Discharge _____

GAF score at discharge _____

Medications at discharge:

Appendix D

Follow-up Questionnaire

Do you have a mental health provider that you see regularly (0) ☐ yes (1) ☐ no

Have you had an appointment with your mental health provider since your hospital discharge?

(0) ☐ yes or (1) ☐ no

Have you kept all of your appointments with your mental health provider since your hospital discharge? (0) ☐ yes or (1) ☐ no or (2) ☐ I have not had an appointment since discharge

If no, what kept you from keeping your appointment?

How would you describe your important relationships since you have been discharged?

(0) ☐ better than before my hospitalization (1) ☐ the same as before hospitalization
(2) ☐ worse than before hospitalization

☐ Have you used cutting to deal with your emotions since you were discharged?
☐ yes or ☐ no

If yes, how many times have you cut since discharge?

(0) ☐ 1 to 3 times (1) ☐ 4 to 6 times (2) ☐ 6 to 9 times (3) ☐ more than 9 times

Have you been readmitted to the hospital due to a psychiatric relapse since your discharge?

(0) ☐ yes or (1) ☐ no

Have you had to go to the emergency room due to an increase in your symptoms (but were not admitted to the hospital) since discharge?

(0) ☐ yes or (1) ☐ no

Have you been taking your medications regularly since discharge?

(0) ☐ always (1) ☐ most of the time (2) ☐ some of the time (3) ☐ no

Have you had to have your medications adjusted due to an increase in psychiatric symptoms since discharge?

☐yes or ☐no

Is your employment status the same as before? ☐yes or ☐no

If no, what has changed?

If you are currently employed, have you had to miss work since you were discharged from the hospital due to your mental illness? ☐ yes or ☐no

If yes, how many days of work have you missed due to your mental illness?

(0) ☐one day (1) ☐two days (2) ☐three days (3) ☐four days (4) ☐more than four days

Have you been taking your medications regularly since discharge?

(0) ☐ always (1) ☐ most of the time (2) ☐ some of the time (3) ☐ none of the time

Do you feel the treatment you received on Mundy 3 was helpful for you?

☐yes or ☐no

Current Medications:

Appendix E

Burns Relationship Satisfaction Survey

Burns, D. 1997. *Therapist's toolkit: Comprehensive assessment and treatment tools for the mental health professional*. (Available from Feeling Good Inc. by contacting toolkit@feelgood.com). Omitted for publication.

Appendix F

Family Emotional Involvement and Criticism Scale

Shields, C., Franks, P., Harp, J., McDaniel, S. (1992). Development of the family emotional involvement and criticism scale (FEICS): A self-report scale to measure expressed emotion. *Journal of Marital and Family Therapy*, 18(4), 395-407. Omitted for publication.

Appendix G

Perceived Criticism Scale

Hooley, J., & Teasdale, J. (1989). Predictors of relapse in unipolar depression: Expressed emotion, marital distress, and perceived criticism. *Journal of Abnormal Psychology*, 98, 229-235. Omitted for publication.

Appendix H

Burns Brief Mood Survey

Burns, D. (1997). *Therapist's toolkit: Comprehensive assessment and treatment tolls for the mental health professional*. (Available from Feeling Good Inc. by contacting toolkit@feelgood.com). Omitted for publication.

Appendix I

Difficulty in Emotion Regulation Scale

Gratz, K. L. & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioral Assessment*, 26(1), 41-54. Omitted for publication.

Appendix J

Reaction to Treatment Questionnaire

Holt, C., & Heimberg, R. (1990). The reaction to treatment questionnaire: Measuring treatment credibility and outcome expectancies. *The Behavior Therapist*, 13, 213-214, 222. Omitted for publication.