

A MEASURE OF PATIENT'S RESPONSE STYLE TO THERAPIST AND THERAPY: THE DEVELOPMENT OF THE PATIENT RESPONSE STYLE SCALE (PRSS)

M. A. Besharat

Department of Psychology, Faculty of Psychology and Education/University of Tehran, Tehran, Iran

Abstract- Self-disclosure, as communication of information about one's affects, behaviors, and cognitions, has been emphasized as one of the central issues of the psychotherapeutic process. Verbal and nonverbal aspects of disclosure are important factors of psychotherapeutic communication, both for therapist and patient. This paper presents an account of the development and reliability of an observational instrument to measure patient's response style to therapist and therapy: the self-disclosure and emotional engagement. One hundred thirty eating disordered patients were interviewed using a semi-structured interview. Videotapes were assessed by two independent raters. Inter-rater reliability was good for both dimensions of the Patient Response Style Scale (PRSS): Self-Disclosure (SD) and Emotional Engagement (EEn).

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INTRODUCTION

Self-disclosure has been the focus of considerable theoretical and empirical inquiry over a period extending forty years (1, 2). Much of the research interest stems from the role of self-disclosure in theories of psychological adjustment, the psychotherapeutic process, and interactional behavior (3, 4). It has been recognized that self-disclosure as an important interpersonal skill has a crucial impact on initiating, developing, maintaining, and terminating therapeutic relationship (5-10).

To measure self-disclosure, however, researchers have typically relied on a number of inventories that remain subject to the fundamental problems common to many instruments based on self-report.

The purpose of the present research program was to construct a reliable observational instrument to examine empirically and objectively both verbal and nonverbal aspects of self-disclosure in a therapeutic interaction. A brief review of the conceptual background of self-disclosure and the basic parameters of the disclosing process will be presented. The current body of theoretical and empirical knowledge that bears on the relationship of self-disclosure with psychotherapy will also be reviewed. Psychotherapist of all persuasions, on the other hand, agree that nonverbal aspects of disclosure, voice quality, facial expression, and body posture are important factors of psychotherapeutic communication, both for the therapist and the patient (11-14). As nonverbal aspects of self-disclosure, emotional engagement which refers to the quality of a patient's nonverbal participation and engagement in therapeutic interaction will be briefly addressed. Finally, provided evidence for the reliability of the Patient Response Style Scale (PRSS) will be presented.

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*** Corresponding Author:**

Mohammad Ali Besharat, Department of Psychology, Faculty of Psychology and Education/University of Tehran, Tehran, Iran
Tel: +98 21 88250062
Fax: +98 21 88250063
E-mail: besharat@chamran.ut.ac.ir

Conceptual Background

Chelune in his review of self-disclosure research has noted that the concept of self-disclosure is derived primarily from existential and phenomenological theory. To disclose means to make known or show. Self-disclosure, therefore, is the process by which we make ourselves known to other persons by verbally disclosing personal information (15).

Self-disclosure has often been postulated to have important consequences for psychological adjustment and interpersonal functioning. Fromm has referred to self-disclosure as a means for describing both phenomenological distance and alienation from self as well as others (16). The concept of self-disclosing behavior plays a central role in Rogers's theory of personality change (17). For Rogers, self-disclosure is a characteristic of the acceptance of self and the means to achieve this end. Jourard has been a leading advocate of the positive aspects of self-disclosure (18). For Jourard, self-disclosure is both a symptom of personality health and a means to achieve "real-self being" and interpersonal effectiveness.

The role of self-disclosure in interpersonal relationships has been examined extensively within the context of social exchange and social penetration theories (19, 20). According to social penetration theory, the development of an interpersonal relationship is a joint outcome of situational determinants, interpersonal reward/cost factors, and personality characteristics (11, 21). Relationships are thought to proceed from nonintimate to intimate areas of exchange via verbal disclosure, activities jointly engaged in, and nonverbal communication (20). Within relationships the amount of information disclosed to a given individual has been found to be highly correlated with the amount of information received from that person (22, 23). This reciprocity or dyadic effect has been interpreted as a result of a social exchange process in which self-disclosure functions as a social reward (24).

The concept of self-disclosure has also received considerable attention with respect to the psychotherapeutic process. "Most clinical and theoretical description of the psychotherapeutic process has focused upon ... self-disclosure ... as one of the central happening" (25). Truax and

Carkhuff (25, 26) have noted that both the client's and the therapist's disclosures play important roles in the successful outcome of therapy. Yalom (27) has suggested that "self-disclosure is prerequisite for the formation of meaningful interpersonal relationships in a dyadic or in a group situation."

Definition and Parameters of Self-Disclosure

As defined by Jourard (18), self-disclosure refers to the process of telling another person about oneself, honestly sharing thoughts and feelings that may be very personal and private. He believed that the physical and psychological health of individuals and the success of relationships requires adequate self-disclosure to strip away restrictive social masks.

Derlega and Grzelak (28) define self-disclosure as including "any information exchange that refers to the self, including personal states, dispositions, events in the past, and plans for the future" (p. 152). self-disclosure is, thus, the communication of information about one's affects, behaviors, and cognitions with the implication that the material disclosed is either secret, intimate, or emotionally charged.

Definitions of self-disclosure usually emphasize either information conveyed to another person or the process of making oneself known to others (29). We might consider, however, the degree to which measures of self-disclosure tap a personality variable. Cozby (20) acknowledged that self-disclosure refers to "both a personality construct and a process which occurs during interaction" (p. 73). Mahon (30) defined self-disclosure as "a personal variable people bring to encounters with others" (p. 334). It seems reasonable to assume that people vary in the degree to which they are open and accessible to others and that measures of self-disclosure reflect, to some degree at least, this individuals difference. Viewing self-disclosure as an individual difference variable in no way negates the importance of situational factors. Situational factors certainly influence the expression of other variables (e.g., extroversion) that are commonly considered trait like individual difference constructs (31).

The concept of self-disclosure is quite complex, since it encompasses both the qualifying of

verbalizations and the assessment of the content and direction of verbalizations. Cozby (20) has proposed that the dimensions of self-disclosure are 1) the breadth or amount of information disclosed, 2) depth or intimacy of this information, and 3) the duration of time spent in disclosure. Two different parameters suggested by Chelune (32) are 1) the affective manner of presentation of the disclosed material and 2) the flexibility of the disclosure pattern. In addition, other authors have focused on the positive-negative self-evaluative aspect of the content of disclosures (33).

Self-Disclosure and Outcome of Therapy

Different models of psychotherapy agree with the notion that patient self-disclosure makes an important contribution to the progress of treatment (5-10). Self-disclosure, especially early in the treatment process, enables the therapist to understand the patient's problems and the social context in which they occur. Nonverbal sources of information, such as behavioral observation, physiological assessment, and the congruence or incongruence among channels of communication, should further enrich the therapist's understanding of the patient's experience. Since many therapies presumably adapt to the needs of the patient, this information base directly affects the formulation of treatment plans, roles, and goals. Patient self-disclosure, thus, is viewed as a major process variable in psychotherapy.

Generally, the research literature describes a positive relationship between self-disclosure and the outcome of therapy (34-39). However, other studies have failed to confirm these relationships (35, 40-44).

In summary, self-disclosure is seen as a process in which patients learn to understand, develop, and express themselves and their potential. Models that do not regard self-disclosure as a curative factor in therapy nevertheless implicate it in the successful outcome of treatment.

Emotional Engagement

Research in the area of communications generally indicates that, when presented with contradictory verbal and nonverbal messages, individuals

generally give greater credibility to the nonverbal aspects of the interaction (45). In fact, nonverbal signals may convey upwards of 75% of the information people receive from others (46). Emotional engagement refers to the quality of a patient's nonverbal participation and engagement in therapeutic interaction. Some people respond more to nonverbal cues than others. Although nonverbal cues are complex, they are all significant pieces of information that should be integrated into the course of therapy.

The inclusion of nonverbal behavior considerably expands the concept of self-disclosure and the range of interpersonal activities to be observed. In presenting a scale of nonverbal self-disclosure of feelings and emotions, Mehrabian (46) argues that this type of disclosure is as important as verbal disclosure. One person may disclose to another through a smile, a touch, withdrawing, or physical assault. Indeed, nonverbal disclosure alone may express a person's feelings or needs sufficiently or it may confirm or contradict verbal self-disclosure.

It is important to consider how self-disclosure and emotional engagement may operate together in patient's response style to therapist and therapy. To measure both self-disclosure and emotional engagement a new instrument, the Patient Response Style Scale was developed.

The Patient Response Style Scale

The fact that most forms of psychotherapy produce positive changes in a substantial proportion of patients has been established in recent years (6, 47, 48). However, the nature of the curative factors is only vaguely understood and provides an ongoing challenge for psychotherapy researchers. Within the last forty years, a number of variables, each at one time or another considered essential, have been shown to account for far less of the outcome variance than previously believed. These include pretherapy patient and therapist factors, as well as technique and type of treatment variables (6, 48, 49).

As communication of information about one's affects, behaviors, and cognitions, self-disclosure has been emphasized as one of the central issues of the psychotherapeutic process. However, to measure the

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concept researchers have typically relied on a number of inventories (18, 50, 51). These scales, however, have had serious problems with predictive validity. For example, in its various forms the classic Jourard Self-Disclosure Questionnaire (JSDQ) has been shown to be positively related (21, 51, 52), not at all related (53, 54), and even negatively related to self-disclosure (55). The more recent Chelune Self-Disclosure Situations Survey (50) fares little better. Though this measure has been shown to be positively related to self-disclosure for men in an interview situation, it was actually negatively related for women in the same situation (50). In addition, a new social psychological disclosure measure, the Self-Disclosure Index (56) shows considerable promise. While these inventories have tended to be widely used, they remain subject to the fundamental problems common to many instruments based on self-report.

Similarly, nonverbal aspects of disclosure are important factors of psychotherapeutic communication, both for therapist and the patient (11-14). An important barrier in investigating nonverbal aspects of disclosure has been the absence of standardized measures of individual accuracy in interpreting and conveying nonverbal cues in various modalities, or channels. Obviously, well-validated measures of decoding and encoding skills would make it much easier to study such issues as individual differences in nonverbal skills and in the use of different type of disclosure. Researchers interested in these kinds of questions have had to make their own measuring instruments. Without such measures, it is hard to learn whether people with well-developed nonverbal skills differ from other people and, if so, in what ways. It would be important to know, for example, whether those who are better at sending or receiving nonverbal cues are more likely to benefit from psychotherapy. Although the methodological problems in studying these nonverbal levels and types of disclosure are difficult, they desperately need to be addressed for the field to develop comprehensive theories of psychotherapeutic change.

An objective of this research was to develop a reliable observational instrument to examine empirically and objectively the patient's response

style to therapist and therapy. The Patient Response Style Scale was developed specifically as part of the fourth Maudsley study of psychological treatments for eating disorders in which three types of outpatient psychological treatment (family therapy, individual focal psychoanalytic psychotherapy and cognitive analytic therapy) for adults suffering from eating disorders were compared with a fourth control treatment (supportive therapy: 57).

In this study, thus, self-disclosure refers to the process by which the patients make themselves known to the therapist by verbally disclosing personal information. As nonverbal aspects of self-disclosure, emotional engagement refers to the quality of patient's nonverbal participation and engagement in therapeutic interaction. Positive changes in tonal aspects and enthusiasm shown in therapist and therapy by the patient when talking about his/her problem is considered as nonverbal disclosure.

The PRSS is an observer-based rating instrument designed to assess both verbal and nonverbal communicative aspects of the patient's attitudes and behaviors that are expected to facilitate or impede progress in psychotherapy. The PRSS describes the patient's style of involvement in the interaction and predicts the ability to participate in a therapeutic interaction.

This instrument is designed to be applied to videotape recordings of a psychotherapy assessment interview. The interview consists of a series of questions, probes and statements about the patient's personal and family life, problem, and treatment. The main topics covered include issues such as the patient's family, social, intimate, and sexual relationships. The PRSS presently is organized in two subscales, Self-Disclosure (SD) and Emotional Engagement (EEn). Each subscale taps specific aspects. "Simple Response", "Elaboration", "Spontaneity", and level of "Self-Personal Information" are considered as self-disclosure variable. Emotional engagement consists of two variables, "Tone of Voice" and "Interest in the Therapist and Therapy". All of these variables are meant to tap what is assumed to be an important general quality of a patient's engagement in psychotherapy.

The Patients Response Style Scale Rating Criteria

A. Self-Disclosure

The following criteria are used for the rating of self-disclosure:

1. Simple Response

Simple response is a short and limited phrase which is usually of three types: a) indicates agreement, acknowledgement, understanding, or approval of what therapist has said; b) indicates disagreement or disapproval with what the therapist has said; or c) responds briefly to a therapist's question with specific information or facts.

2. Elaboration

Responses placed in this category are detailed accounts of events. They present a series of descriptive statements that serve to provide extended and often factual information about seemingly related incidents. The content is a purposeful elaboration of the patient's feelings and thoughts. The elaboration must be clearly related to the initial proposition and must contain inner references that reflect the patient's problems.

3. Self-Personal Information (*Intimacy of Disclosure*)

As a basic parameter of self-disclosure, self-personal information (intimacy of information) refers to the explicit communication to others of some topics which are of such a nature that the individual is not likely to disclose it to everyone who asks for it. Intimate disclosure is a straightforward revelation of feelings and thoughts about an issue of personal importance to someone who is receptive. Based on a clinical/research interview the following topics have been rated as quite intimate and private: a) Family Personal Information including more private information about the patient's family, the nature of family relationships, and feelings about family members; b) Sexual Matters including private information about sexual experiences, the nature of these experiences, and feelings of sexual adequacy.

4. Spontaneity

Spontaneity refers to volunteered information of the type described under "Elaboration" and/or "Self-Personal Information". To be counted it must be associated with spontaneous comments that have some relevance to the patient's problem. The

spontaneous self-disclosure tends to result in a higher rating. Some patients go well beyond what is strictly required to answer a question to disclose information about themselves. Conversely, the failure to disclose information where opportunities to do so exist would tend to lower the rating.

B. Emotional Engagement

The following criteria are used for the rating of emotional engagement:

1. Positive Tone of Voice

Positive changes in tonal aspects and enthusiasm shown in the therapist and therapy by the patient when talking about his/her problem, is perhaps the most important criterion on which the rating of emotional engagement is based.

2. Interest in the Therapist and Therapy

Enthusiasm for and interest in the therapist and therapy are also relevant, provided that they are shown in relation to therapist and therapy as such. Conversely, there may be an absence of the warmth and interest shown either by considerable negative behavior (negative attitude and behavior, dissatisfaction, displeased, criticism, and even hostility) or simply an absence of positive in the form of flatness and coldness, is regarded as lack of emotional engagement and is balanced against any evidence of emotional engagement when making the final overall judgment.

Allocation of Scores on the PRSS

Taking into account the interview as a whole, the following general principles should be used to determine the scores for a particular subscale of the PRSS:

Self-Disclosure- Self-disclosure is measured on a 6-point global scale from 0 to 5 (0= none; 1= little; 2= some; 3= moderate; 4= high; 5= marked).

High (4) or Marked (5) SD- Instances in which there are definite and clear-cut "Elaboration", "Spontaneity", and "Self-Personal Information", are rated high SD (4) or marked SD (5), according to the amount and depth of information and spontaneity disclosed.

Some (2) or Moderate (3) SD- Instances in which there are definite "Elaboration", but none or only limited "Spontaneity" or "Self-Personal Informa-

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tion", are rated some SD (2) or moderate SD (3), according to the amount of information disclosed.

No (0) or Little (1) SD- In the absence of the rest of the self-disclosure criteria, if "Simple Response" is the predominant patient's style of responding during the interview, little SD (1) can be rated. The rating of no SD (0) is reserved for patients who show a complete absence of the characteristics of self-disclosure.

Emotional Engagement- Emotional engagement is measured on a 6-point global scale from 0 to 5 (0= none; 1= little; 2= some; 3= moderate; 4= high; 5= marked).

High (4) or Marked (5) EEn- Instances in which there are definite and clear-cut tonal warmth, concern and enthusiasm about and interest in the therapist and therapy are rated high EEn (4) or marked EEn (5), according to the amount of emotional engagement expressed.

Some (2) or Moderate (3) EEn- Instances in which there are definite emotional involvement and concern about or interest in the therapist and therapy, but any or only limited warmth of tone, are rated some EEn (2) or moderate EEn (3), according to the amount of concern and interest expressed.

No (0) or Little (1) EEn- If there is only a slight amount of emotional engagement qualities like concern about or interest in the therapist and therapy, little EEn (1) can be rated. The rating of no EEn (0) is reserved for patients who show a complete absence of the qualities of emotional engagement as defined of negative attitude and behavior, and dissatisfaction.

MATERIALS AND METHODS

Sample

The patients who participated in this study came from a group of consecutive referrals to the Maudsley Hospital Eating Disorder Clinic who took part in a RCT of outpatient psychotherapy for eating disorders. The PRSS was developed and tested in a subsample of 136 patients. All the patients met DSM-IV (American Psychiatric Association, 1994) criteria for anorexia nervosa: 97 restricting type and 39 binge/purge type. The mean age was 25.9 years (range: 18 years to 42 years; SD= 6.4 years) and the

mean duration of eating problems was 5.9 years (range: 5 years to 20 years; SD= 5.5 years).

Procedure

The patients were first seen in the Eating Disorder Clinic and the diagnosis established. They were then invited to attend for a research interview with a view to being offered one of four treatments in the outpatient treatment trial. If this attendance was accepted, an individual interview was used (undertaken by one of three clinician/researchers uninvolved with the subsequent treatment programs) to explain the study fully and to gain informed consent and for baseline state to be assessed.

At this attendance, and before random allocation to a treatment, the patient was interviewed using a variant of the Morgan-Russell Assessment Schedule (58, 59). For the purpose of assessment of the patient's responding style to therapist and therapy in this study, the schedule was modified with a series of questions, probes and statements about the patient's personal and family life, problem, and treatment. The main topics covered include issues such as the patient's family, social, intimate, and sexual relationships. The interviews were video-recorded and later used for the rating of PRSS by following the PRSS scoring instructions (6). This was conducted by two independent raters.

RESULTS

The descriptive statistics for the PRSS in 136 eating disorder patients are presented in Table 1. Inter-rater reliability was assessed using the Intra-Class Correlation (ICC) (60, 61), which is a ratio of the between-subject variance to the total variance (consisting of between-subject variance and error variance). The ICC increases with between-subject variance and decreases with error variance. Each dimension of the rating scale was analyzed separately.

As agreement on the rating of each dimension increases, the error variance decreases and ICC increases so that the ICC coefficient represents the degree of agreement between raters. As can be seen in Table 1, the ICC coefficient for the two raters was high (0.92-0.94).

Table 1. Distribution of the PRSS reliability for two raters (A & B) in 136 ED patients

PRSS Scales	Rater A	Rater B	r*
	Mean (\pm SD)	Mean (\pm SD)	
Self-disclosure	3.300 (1.208)	3.367 (1.098)	0.92
Emotional engagement	3.100 (1.348)	2.967 (1.450)	0.94

Abbreviations: PRSS, patient response style scale; ED, eating disorder; SD, standard deviation.

* Intra-Class Correlation.

DISCUSSION

The purpose of this study was to evaluate the inter-rater reliability of the PRSS. Overall, the results of this study suggest that the PRSS is a reliable assessment procedure to measure self-disclosure and emotional engagement in the course of a psychotherapy assessment interview.

The analyses of the PRSS results revealed that individual variations in response style to therapist and therapy can be variously manifested in self-disclosure and emotional engagement expressed during therapy sessions.

Although the importance of nonverbal aspects of disclosure have been emphasized, both for the therapist and the patient (11, 12, 14), most studies of self-disclosure have obtained information about the patient's response style to therapist and therapy from verbal disclosure alone. In Besharat's study (6), the PRSS showed exceptional potential for employing both verbal and nonverbal aspects of the patient's disclosure in the course of psychotherapy sessions. The inclusion of nonverbal, as well as verbal behavior, considerably expands the concept of self-disclosure and the range of interpersonal activities to be observed. Continued use of the PRSS in investigations of therapeutic interactions of patients from different clinical population with therapists from different orientations using different styles of intervention will help to establish whether or not PRSS can identify varying styles of patient's response to therapist and therapy across diverse therapeutic context. Ultimately, however, the utility of the PRSS will depend upon future research that will demonstrate how well its components relate to consequences of therapy.

Conflict of interests

The authors declare that they have no competing interests.

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