

Facilitative Interpersonal Skill Task and Rating Method

Timothy Anderson

Candace Patterson

Department of Psychology

Ohio University

Athens, Ohio

Revised October 2013

Facilitative Interpersonal Skills: Task and Stimulus Clips

Timothy Anderson

Construct Definition

Facilitative Interpersonal Skills (FIS) are a core set of skills used by various helpers that are believed to encourage a person in emotional and psychological distress to initiate change toward improved emotional and psychological well-being. These skills are presumed to be common, not only in that they are found across all forms of psychotherapeutic relationship, but also in that they are found across different helping relationships. These include various role relationships such as found in various medical occupations (e.g., doctors, nurses, dieticians), various magical-religious helping roles (e.g., priests, rabbis, shamans), and numerous other helping roles found throughout societies (e.g., resident advisors in college dorms, hair dressers, bartenders).

The healing components of these relationships have been referred to as *common factors*, which were most fully described in Jerome Frank's 1960 classic text, *Persuasion and Healing*. As finally described by Frank & Frank (1993), there are four common factors found in activities such as psychotherapy.

Psychotherapy research has repeatedly found various that indicators of these common factors are the strongest predictors of outcome for clients in psychotherapy. Most notably, the working alliance and empathy have been noted as having the highest and most consistent correlates to psychotherapy outcome (Norcross, 2011). Strikingly, the contribution of these common factors is substantially larger than effects due to specific techniques from therapies (e.g., Wampold, 2007). This is striking because much of contemporary psychotherapy research focuses on identifying effective the most effective technique. The FIS approach is not to minimize the effect of techniques, however, but to elevate their importance by recognizing that techniques are on par with relationship variables and the other common factors. The FIS assumes that techniques are of great importance, but that there are a variety of techniques that helpers can use. In fact, one difficulty that we have found in training FIS coders is that psychotherapy training may have the potential to bias raters into believing that there is a limited boundary around *appropriate and correctly delivered interventions*. The FIS approach encourages raters to discard those assumptions in order to identify interventions that may appear odd or unusual to the trained clinician, but which would meet criteria, for example, for an intervention that is still highly persuasive.

The problem, however, with studying common factors is that the definition of various common factors has not been as amenable to experimental research designs, allowing only correlative glimpses of these powerful, but poorly understood, variables. FIS is an attempt to identify therapist factors with an eye toward controlling this common factor for experimental study. As the reader already may have noted, part of the difficulty is that any single intervention might be expected to have different effects in different roles and settings.

Interpersonal skills are the learned emotional and interpersonal patterns of behavior that allow some people to be more effective at navigating through difficult and complex interpersonal

situations. The goal of examining these interpersonal skills is to advance the understanding of how therapists contribute to important common psychotherapy processes and outcomes.

While the idea that some people are better helpers than others may have intuitive appeal, the scientific and practical problems in researching this are substantial. One such problem involves the assumption that common factors, such as persuasion and empathy, can be identified as a meaningful trait-level variable that can be observed and assessed through a sample of relatively brief therapist interventions. It is unclear if these “thin slices” of therapist behavior can be used to identify effectiveness of therapists. In the literature, most common and effective psychotherapy processes include a consistent set of findings for efficacious relationships, otherwise known as Empirically Supported Relationships (ESRs). Of course, a critical assumption to FIS is that the collection of identified relationship factors (e.g., Norcross, 2002), can be meaningfully translated and identified as therapist-level skills, and that the measurement of these skills can be used to identify effective therapists. Our goal is to attempt to extend these process findings to identify meaningful variations among therapists ability – regardless of their therapeutic approach – in developing and incorporating ESR principles into their therapeutic work.

Also, FIS is based on an assumption that common relational factors, including ESRs, are likely to account for more of the variance in psychotherapy outcomes than are formally defined “techniques” in Empirically Supported Treatments (ESTs). We hope that the identification of common relational factors will ultimately help researchers weigh the relative efficacy of common and specific therapy factors. In other words, we hope to be able to determine whether or not what one person does to help another in distress (specific techniques) is more or less important than how they attempt to help (common relational factors).

The following definition of FIS has been informed by research, process literature, theory, and our own initial studies. A working definition of these skills involves:

- 1) *perceiving, understanding, and sending a wide range of interpersonal messages and*
- 2) *persuading others who have personal problems to apply proposed solutions to their problems and abandon maladaptive patterns.*

Assumptions

Clearly, a critical assumption of the FIS construct is that optimal interpersonal processes can be translated into stable expressions of skills. In other words, we make the assumption that psychotherapeutic relationships that include efficacious common factors (Empathy, the Alliance/Collaboration, Warmth, and Persuasiveness) are also a common set of skills that differentiate therapist’s ability to create a facilitative environment. It is within this facilitative environment, partly the result of the therapist’s crafting of the relational framework, in which positive therapeutic processes take root. We assume that therapists differ widely in this capacity and we hope that identifying these skills within therapists will ultimately be useful for therapist training.

FIS skills are likely to be useful for a wide variety of activities, including not only

therapists, but also ministers, nurses, friends, spouses, or teachers.

Methodological Consideration

The measurement of FIS is based on a “performance analysis” method that is more frequently used in Industrial-Organizational psychology than in clinical psychology. For example, a performance analysis could be used to rate and assess an applicant’s job performance in an artificial, but realistic test that evaluates job skills that are needed on the job. The initial development of FIS was for the practical purpose of selecting therapists in an initial study of therapist skills (Anderson, Crowley, & Klimek, 2001).

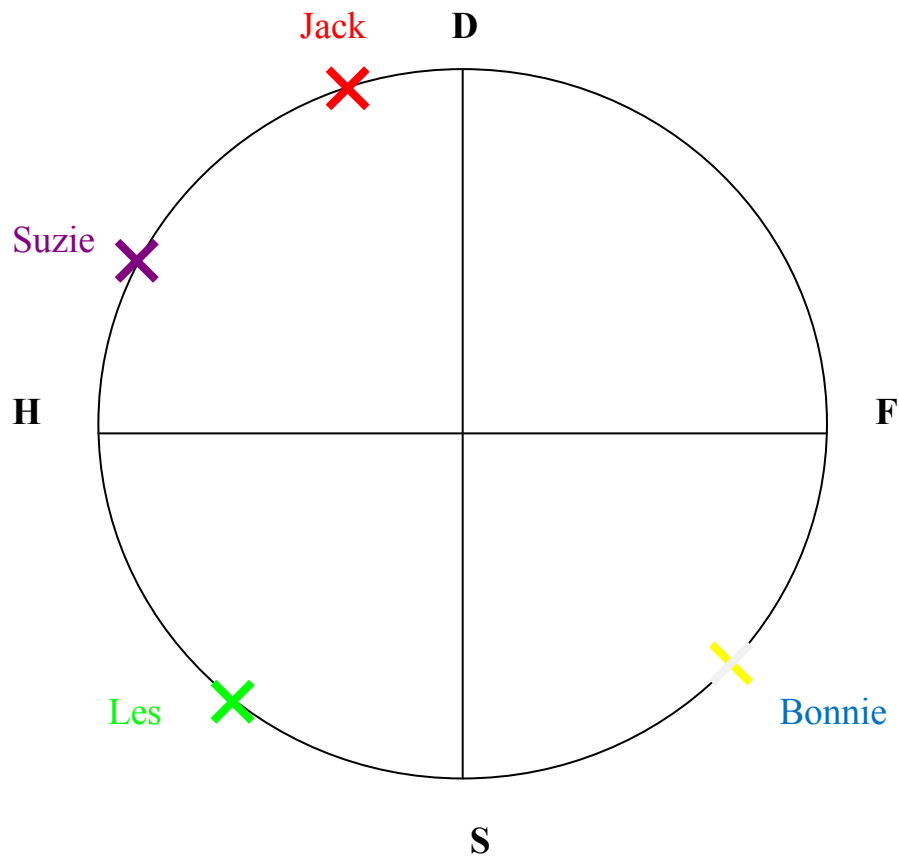
We believed that it was important to develop a method that would not be as obvious as the content items used for the measurement of social skills. While it may be possible to answer items about one’s social ability, it will be more difficult to perform in a socially skillful manner during more complex and challenging situations that sometimes develop while interacting with clients in psychotherapy. Indeed, within any helping relationship, whether it’s a therapist, minister, or shaman, the social roles of helping and receiving help can present certain challenges that are unique to the helping role. The advantage of a performance analysis is that the interventions have a high level of ecological face validity. Having the stimuli that therapists respond to on videotape is also useful because it is a standard, comparable stimuli.

In the FIS performance analysis method, participants are asked to imagine that they are in the middle of an interpersonal exchange. Participants watch several video recorded clips of actual therapy sessions that are performed by actors. At critical points, the video recording stops and participants are asked to respond to the client on the tape as if they were the therapist. These responses are audio recorded and coded by raters using the FIS coding manual.

Versions

The first FIS rating method included 10 items. After the initial studies, these items were condensed into 8 items by removing one items (Focus on Others) and essentially combining the last two items (Responds to the Unique Problems in the Present Situation and Interpersonal Complementarity).

Until recently, responses were from 4 unique client situations / stimuli. Participants gave verbal responses at different points for these 4 different scenarios. The length of the client video clips ranged from just over a minute to approximately 5 minutes long. Subsequently, the clips were edited in the current version so each is more uniform in length. Each video clip was selected by examining 80 cases of psychotherapy offered in the Vanderbilt II psychotherapy project. We selected segments which we considered the most challenging for a therapist to respond. We also wished to select clients who presented from a variety of interpersonal stances. However, we found that actual assessments from raters of the clips were far along the hostile dimension of interpersonal behavior. When we collected a sample of ratings from undergraduates who rated their interpersonal perceptions of these targets, we found only one of the clips was seen along the friendly dimension of the interpersonal circumplex:



For this reason, 3 additional video stimuli clips were developed in which were more clearly friendly, but which we also believed would provide difficult situations for the average therapist or helper to respond. Each scenario continued to involve situations in which the client was speaking directly about some aspect of their relationship with the therapist.

Administration

Data collection requires the set of 7 brief FIS stimulus clips (1-2 minutes each) and some method for recording the audio responses of participants. Recording of the responses must be set up separately by the researcher as there is no means for recording audio within the FIS program itself.

Until recently, data responses were collected from within a Visual Basic computer program that had guided participants through the necessary clips but unfortunately the program stopped working under Windows Vista. The current method is through the DVD of stimulus clips that accompanies this manual. Participants should be able to work through the menus in private and independently so long as a few precautions are attended to.

1. One of the assumptions of the method is that therapist's responses are more fresh and

genuine when they don't have time to review the videos in advance. Thus, it is best to load the opening menu and leave participants to do the task (instead of letting them take the disk with them).

2. It will be necessary to set up your recording device and begin recording when you leave a participant with the program. You can use an external digital recorder so long as you can manage to edit out the clips later. I prefer to use an audio recorder that runs at the same time on the same computer that the FIS program is running along with a headphone / microphone combination. For recording the participant's audio, I use "Audacity" which is a free open-source program for Windows. Using Audacity (and similar audio recorder programs), it's relatively easy to go back and edit out only the responses at a later date. You could always leave all the responses in one file too and let your coders find them. In any case, the graphical display of vocal frequency allows you to locate the responses relatively quickly. Audacity can be downloaded for free at "audacity.sourceforge.net" (or just type "audacity" on Google).

Psychometric Considerations.

Item Development. The guiding principle for the FIS item development was to select those areas that have been well supported by process research. Items were supplemented to some extent by common factors clinical theory. For example, the relationship between Collaboration and the Alliance and outcome is supported by mounds of empirical data, while the relationship between persuasiveness and outcome is built largely around clinical observations and theory. Item development was partly based on the perceived ability to have an item set that could be clearly and reliably identified in participants' audio taped responses. Also, items evolved in the process of selecting video clips.

Raters and Training. Raters for FIS studies have been mostly graduate students and doctoral-level researchers, though ratings have been performed by undergraduate raters. It is assumed that the level of professional training is not as important as a basic understanding of the common factors involved. It is not clear if it is necessary to possess the very FIS that are being rated in order to reliably rate FIS. Two initial studies were conducted with doctoral level raters who were grounded in a common factors and humanistic understanding of psychotherapy. For those studies, training and most of the ratings took place over a marathon weekend in which most of the first day was devoted to training and sample ratings and the second day was spent rating (some additional time was needed to complete the ratings).

Based on those experiences, FIS ratings were expanded to graduate student and undergraduate raters. Our first experience was that inter-rater reliability was achieved, but a larger number of raters was needed in order to secure good reliability. A number of other explanations may have accounted for the need for more raters beyond training. For example, training and the ratings was much more graduate (occurring over a period of approximately 6 months) and there sometimes were long lags between rating sessions.

Reliability. Inter-rater and internal reliability for the FIS items now has been assessed in a several studies. Anderson, Crowley, Himawan, Holberg, & Uhlin (2013) found inter-rater

reliability for the initial pool of 10 individual FIS items ranged from .65 to .84 and Anderson, Ogles, Patterson, Lambert, & Vermeersch (2009) obtained inter-rater reliabilities for all items of $r > .70$. As noted above, these two studies employed doctoral level raters who were well-versed in identifying common psychotherapy processes. In those studies, both training and rating of FIS occurred relatively quickly (mostly over a weekend).

Ratings conducted by graduate students thus far have required a composite of more raters in order to obtain acceptable levels of inter-rater reliability. Janzen (2007) used 8 FIS items with graduate student raters and reported intra-class correlations from .71 to .93 for individual items and .80 for the total FIS score. McClintock et al., (2012) used a combination of four raters (2 graduate, 1 undergraduate and 1 doctoral-level raters) and found ICCs that ranged from .79 to .86 for the 8 FIS items and an ICC of .86 for the FIS total score.

Inter-rater reliabilities for FIS-IS, which is the adaptation of FIS items to therapy sessions, have been high. Uhlin's (2011) development of the FIS-IS reported inter-rater reliabilities all $> .90$ when using two advanced graduate student raters. Armstrong (2013) conducted ratings with one advanced and one pre-master's level graduate students and reported that training in the FIS-IS ratings involved 26.5 hours. Inter-rater reliability for this study was also high (with ICCs ranging from .75 to 1.0 for the FIS items. For the ratings in the study, Armstrong reported inter-rater reliabilities to also be high (ICCs between .86 and .96.).

The 8 FIS items has been found to be a single construct and internally consistent. McClintock et al. (2013) attempted to factor analyze the FIS items by combining 3 FIS studies for a sample of 116 therapists. Some indices of the factor analyses was suggestive of two separate FIS Factors, however, a one Factor solution was superior and explained 70% of the variance. The items from this composite sample were moderately to highly correlated with correlations ranging from .43 to .89 between the 8 FIS items.

Construct Validity

Construct validity is traditionally thought of as being composed of concurrent and predictive validity. In much of personality, social, and clinical psychology, the demonstration of concurrent validity occurs first, followed by demonstrations of the predictive power of those constructs. However, FIS has been applied to predictive problems first. This is mostly because the scale was developed from pragmatic purposes of identifying therapist *skill* or *aptitude* and it is unclear where FIS measurement falls in terms of personality traits and states.

Concurrent Validity

Evidence for concurrent validity has been mixed. Two of the predictive studies of the FIS in therapy also employed personality measures that were hypothesized to be similar to FIS. These included measures of empathy, sociability, social skills, and psychological-mindedness. From the Anderson, Crowley, Himawan, Holberg, & Uhlin (2013) sample, FIS was strongly correlated with measures of social skills ($r = .55$), empathy ($r = .52$), and sociability ($r = .52$).

Janzen (2007) found that therapist FIS were related to attachment style and that an interaction of FIS and attachment predicted therapist interventions. When examining relationship building incidents it was found that there were relatively greater amounts of FIS persuasiveness and hopefulness. Some interesting findings include the fact that attachment avoidance was related to FIS therapist hopefulness and that attachment anxiety was related to

therapist collaboration. Janzen also found a relationship between total FIS score and attachment anxiety. Uhlin (2011) found that the presence of therapist FIS-IS predicted an *increase* of interpersonal problems at termination, indicating that the actual amount of therapist FIS in session was indicative of increasing indications of client interpersonal problems. Together, Jenzen's (2007) and Uhlin's (2011) findings might suggest that therapists' FIS increases with problematic interpersonal situations, such as when the client is interpersonally insecure in their attachments or when the client is experiencing increased interpersonal problems. Of course, these findings do not speak to the directionality of this relationship.

However, FIS was unrelated to these same measures in Anderson, Ogles, Patterson, Lambert, & Vermeersch (2009) as well as Anderson, McClintock, Song, Himawan, & Patterson (2013). One reason that FIS correlations with these measures has not been consistent may be because of the differences in method variance. All of the trait measures in these studies were paper-and-pencil self-report measures whereas the FIS is an observational and performance-based measure.

Uhlin (2011) provided some evidence for the FIS construct validity by using observational ratings of different forms of FIS (performance task versus in-session). When comparing the predictive FIS assessment ratings with the in-session ratings of therapists, these two forms of FIS were moderately related ($r = .49$).

Predictive Validity

Anderson, Crowley, Holmberg, Himawan, and Uhlin (in review) selected graduate students to be therapists based on having high vs. low facilitative interpersonal skills, as assessed both by self-report measures of empathic ability and judgments of behavior in videotaped interactions with a standard client. Half of the therapists of each facilitative level were clinical psychology doctoral students with at least two years of clinical training, and half were students in a non-helping doctoral program (e.g., biology, history). Clients, who were selected to have diagnosable problems but were not in therapy, were seen for seven sessions. Those therapists with high facilitative interpersonal skills had higher client outcomes and higher client- and therapist-rated working alliance than did therapists with low facilitative interpersonal skills. Importantly, the high facilitative doctoral students from non-helping disciplines were just as effective as were the high facilitative clinical psychology doctoral students. Anderson, Ogles, Patterson, Lambert, and Vermersch (2009) used FIS as a continuous score in ratings from therapists at a Counseling Center and found that higher FIS therapists had clients who were more likely to report linear decreases in symptoms over time than lower FIS therapists. Based on these data, we would expect that FIS would predict the overall ability of relative novices entering into helping skills training and that the rate of learning helping skills over time would be greater among those who display higher initial levels of FIS.

Finally, the issue of training was again examined in a study in which the therapist FIS measure was administered prospectively, but therapists' first training cases were used (Anderson, McClintock, Song, Himawan, & Patterson, 2013). These naturalistically observed cases, however, were not linearly predicted by therapist FIS. Instead, a curvilinear pattern emerged in which clients treated by therapists with higher FIS had more accelerated improvements during approximately the first half the therapy sessions when compared to clients treated by lower FIS therapists. However, the quadratic equation also revealed that the higher FIS therapists lost their

advantage in later sessions and the initial rapid gains of clients with higher FIS therapists were lost in longer-term treatments (relative to lower FIS therapists).

Armstrong (2013) used a measure of therapist FIS in the McGill Psychotherapy Training project and found that therapist FIS related to client ratings on the Session Evaluation Questionnaire depth, smoothness, and arousal scales. Specifically, Armstrong found that therapist FIS items on verbal fluency, emotional expression, persuasiveness, and hopefulness were most predictive of these session outcomes.

References

- Anderson, T., Crowley, M. E., Himawan, L., Holberg, J., Uhlin, B. (2013). A Controlled Study of Therapist Facilitative Interpersonal Skills and Training Status on Alliance and Outcome. (current revise and resubmit status)
- Anderson, T., McClintock, A. S., Song, X., Himawan, L., Patterson, C. (2013). Therapist Facilitative Interpersonal Skills as a Prospective Predictor of Outcome and Alliance. Ohio University, Athens, Ohio, Manuscript in preparation.
- Anderson, T., Ogles, B. M., & Weis, A. (1999). Creative use of interpersonal skills in building a therapeutic alliance. *Journal of Constructivist Psychology, 12*, 313-330.
- Anderson, T., Ogles, B.M., Patterson, C. L., Lambert, M. J., & Vermeersch, D. A. (2009). Therapist Effects: Facilitative Interpersonal Skills as a Predictor of Therapist Success. *Journal of Clinical Psychology, 65*, 755-768.
- Armstrong, C. R. (2013). *Towards an understanding of the theoretical relationship: Narrative processes and Facilitative Interpersonal Skills in psychotherapy provided by trainee therapists*. Unpublished doctoral dissertation. McGill University, Montreal.
- Janzen, J. (2007). *Towards developing strong early therapeutic relationships: Client attachment and therapist responsiveness in relationship building incidents*. Unpublished doctoral dissertation. McGill University, Montreal.
- McClintock, A. S., Song, X., Jameson, G., Anderson, T., Patterson, C., Goldman, G. A., Uhlin, B., MacFarlane, P., Goldman, E. D. (2012). Reliability of therapist facilitative interpersonal skills for brief responses to “thin slice” client video simulations. Paper presented at the annual meeting of the International Society for Psychotherapy Research, Virginia Beach, VA, June 2012.

Uhlen, B. D. (2011). *In-session rated Facilitative Interpersonal Skills (FIS-IS): Their relationship to pretreatment assessment of FIS, alliance, and outcome*. Unpublished doctoral dissertation. Ohio University, Athens, Ohio.

Facilitative Interpersonal Skills Rating Scale
Timothy Anderson & Candace Patterson

Ratings for each item are made on a 5 point Likert-type scale. The rating scale ranges from Not Characteristic ("1") to Extremely Characteristic ("5"). More elaborate descriptions of each rating level are provided to help identify the correct rating level.

Response Set: Clearly, people differ in how they evaluate the skillfulness of helper interventions. The descriptions of these items are lengthy in order to provide the context for what is intended by each particular FIS domain / item. Items are written in order to assist the rater in using specific evidence from the tape to inform rating decisions. In rating a response, instances of an "average" level of a helping behavior would merit a rating of 3. Ratings of 3 are thought of as the default rating for all items and are considered ordinary helping or facilitative interpersonal skills. Thus, a 3 should be the starting point for ratings and the participant's response may influence you to increase or decrease your rating from a 3.

PART I

1. Verbal Fluency. This item is a rating of the extent to which the participant is verbally capable and at-ease in communicating. The response is delivered in a relaxed manner and without significant signs of anxiety (e.g., broken speech, extended and awkward pauses, and clarity in communication). However, the content of what is said is not rated, but rather how it is spoken.

- 5 The participant is at great ease and communicates ideas with no anxiety, reflecting a desire to "approach" the other. The verbal quality of the response may have a "melodic," rhythmical quality and is easy to follow; the response is fluent.
- 4 The response is fluent, and there is little that is difficult to follow.
- 3 A moderate level of verbal fluency indicates that the participant's response is conversational and mostly easy to follow.
- 2 Fluency is disrupted by the participant's anxiety and avoidance of verbal expression. The respondent may be obviously anxious and struggling to formulate a response. At times, the communication may be choppy, even halting. [Note: In some rare instances a response could represent an avoidance of the interpersonal situation through anxious rambling. It would need to be clear that the participant's rambles are the result of anxiety over communicating with another].
- 1 The participant has great difficulty verbalizing a response (e.g., obviously anxious, sounds shaky or timid), reflecting a clear avoidance or anxiety. The participant may lack confidence and is clearly uncertain or even difficult to follow.

2. Hope & Positive Expectations. This item rates expressions of hope, optimism, and positive expectations for change. Staats (1989, 2001) defines hope as the interaction between wishes and expectations. The interpersonal skills needed for hope involve facilitating a) personal *agency* and b) building the *pathways* needed for attaining desired goals and expectations (Steed, 2002). Hope is related to persuasiveness and collaboration in the sense that hope and positive expectations are often built through offering a rationale, friendliness, and enthusiasm. As defined here, hope focuses more on building client agency for actions that will facilitate meeting the client's goals whereas persuasion is based more on a plausible explanation (which may or may not include hope).

- 5 The participant's response expresses clear hope about the client's future and/or positive expectations about therapeutic work. In addition, for a response to be coded as a "5" there needs to be an allusion to building the client's *agency* as well as *how* the client might participate or do something that will help move toward his/her desired goals (i.e., pathways).
- 4 A general sense of optimism about the client's situation is detected. Specifically, the participant's response is directed toward building the client's *agency* OR facilitating the building of pathways to meet the client's goals.
- 3 The response is ordinary OR the optimism of the response is not discernable. There may be some *hopefulness* expressed, but with little confidence or reason for being hopeful.
- 2 The participant responds with some hopelessness, including subtle expressions of feeling unable to help the client.
- 1 The participant's response is hopeless or is even pessimistic. For example, the participant may address only issues or concerns beyond the control of the other or subtly suggests that the other cannot change or improve his/her problems.

3. Persuasiveness. Persuasiveness is the capacity to induce the other to accept a view that may be different from his or her own view. It involves that ability to convey a clear, organized understanding about the meaning of the other's source of distress. Persuasiveness implies an ability to communicate what Jerome Frank called a "believable myth." This capacity implies that the persuasive therapist must be convincing in communicating this belief-system.

Rating Notes: For rating purposes, the response does not necessarily need to convey an entire world view, but a point of view that is implied to be at least slightly different from the client in the video clip. High ratings require that the participant provide a clear belief in a *point of view* or rationale. It is necessary that the rationale be relevant to the other's problems and at least somewhat novel to the other's experience.

For this item, the rater should disregard personal beliefs about the validity of the participant's rationale, but instead rate the extent to which the participant might persuade another (i.e., ability to "sell" their rationale).

- 5 The participant is highly persuasive. Persuasive persons may speak with great confidence, certainty, and authority. Advice may or may not be given, but the participant must offer some rationale or re-framing of the other's experience.
- 4 The participant speaks persuasively. The rationale may be more implicit and it is even possible that the rationale, though present, may be unclear, superficial, or marginally relevant to the other's problems.
- 3 The participant's response conveys little sense of persuasiveness.
- 2 The participant is unpersuasive. Unpersuasive responses may be characterized by either
 - a) a rationale that lacks *credibility* and there is little reason to believe that it could be convincing. It is important here to try to be aware of your personal biases in judging credibility. As a rule, you can accept most explanations offered as being credible unless there is a clear logical flaw in the *process of explaining* their particular belief.
 - b) a response that is expressed with a lack of confidence, lethargy, or uncertainty by the respondent will be low in persuasiveness. *Even responses that don't contain a rationale may be coded as low in persuasiveness*
- 1 The participant's response is unorganized, incoherent, and difficult to follow. The participant may also not know what to say.

PART II

4. Emotional Expression. This item rates the energy and emotion in the participant's response. This item rates the extent to which the participant's response is delivered with effective expressions of emotion.

- 5 There is affect and prosody in the participant's voice. The response is delivered in a highly emotional and engaging manner. The primary criterion is that the vocal expression conveys emotion. There may be a more focused delivery of emotional intonations to emphasize meanings that influence other processes (e.g. persuasion). The participant may even be somewhat provocative or challenging in delivering an emotion-based response toward the client in the video clip. However, a "5" should not be rated if the affect is primarily demeaning or hostile toward the other (in which case a "3" would be the maximum rating possible).
- 4 The participant is emotionally expressive at a moderate level. There is more emotion than found in ordinary speech, but it is not as focused in its delivery as the maximum rating of 5.
- 3 The participant has prosody, but it is the amount of emotion that one might find in ordinary conversation.
- 2 The participant may display some sense of interest or curiosity, but the response is not emotionally engaging. Prosody is somewhat less than typical to casual conversation.
- 1 The participant speaks with little or no affect and may be dull or boring (e.g., speaking in a near monotone voice and without intensity).

5. Warmth, Acceptance, & Understanding. This item is a rating of the ability of the participant to care for and accept the other. Therapist behaviors/attitudes that might indicate an absence of acceptance and understanding include: a judgmental attitude, condescension, rudeness, disapproval, guilt-induction, exasperation, or annoyance. Often it will be necessary to avoid rating what the participant is doing (e.g., giving advice), but rate how it is being done. Note that accepting does not necessarily mean approval, but rather a caring attitude and determination to help the other.

- 5 The participant expresses clear and obvious warmth, concern and acceptance. The participant may, for example, make a compassionate attempt to relate to the other's experience.
- 4 The participant's response is genuinely nonjudgmental and gently explores the other's thoughts, feelings, alternatives for dealing with future situations, etc. The participant appears concerned for and respectful of the client.
- 3 There is an "ordinary" level of courtesy and warmth in the response OR the participant's opinion of the other may not be clearly discernable from the response.
- 2 The participant conveys a subtle lack of respect, acceptance, or concern of the other (e.g., sarcasm, exasperation, annoyance).
- 1 The participant has an obvious lack of respect, acceptance, or warmth for the other (e.g., clearly pejorative comments, judgmental attitude, condescension, disapproval, guilt induction, blaming the other).

6. Empathy. The capacity to respond with an expressed understanding of the subjective experience of the client. The response must also convey an *accurate* understanding of the thoughts and emotions expressed in the video clip. Therefore, it is especially important that the rater have an accurate understanding of the client's experiences in the video clips.

- 5 Participant alludes to the client's experience so that it is clear that he/she has not only listened, but obtained an exceptional comprehension of what the other is experiencing. In order to receive a "5" the participant must infer something about the other's experience that is not explicitly stated by the other but is clearly identifiable in the client's nonverbal expression.
- 4 Participant comments accurately on the other's experience but not to the extent required to receive a "5" rating. The distinction between the 4 and 5 ratings are matters of intensity.
- 3 Participant is generally accurate about the other's experience but only perceives the more obvious aspects of the other's experience or concerns.
- 2 Participant does not communicate an awareness or understanding of the other's experience, and/or there are minor distortions of the other's experience. Some aspects of the participant's response may be irrelevant to the other's concerns (when clearly not an attempt to change the other's focus).
- 1 Participant clearly distorts the other's experience. That is, the participant misidentifies a significant component of the other's complaints, beliefs, emotions, etc. Give a rating of 1 if the response indicates a clear disregard of the other's experience.

7. Alliance Bond Capacity. This item rates the participant's capacity to provide a collaborative environment, one in which there is recognition of the need to work with the client jointly on problems.

- 5 Specific actions on the part of the participant help create a collaborative atmosphere. There should be a sense that the participant is attempting to work with the other to create a "we-ness" that is implied in the participant's behavior (e.g., participant checks with the other by asking questions about the "fit" of interpretations, conclusions, goals, etc.).
- 4 Some effort to collaborate is made but not as strong as a "5" (e.g., subtle invitations to engage in working with the client).
- 3 The participant neither undermines nor attempts to enhance a collaborative effort.
- 2 The participant may slightly undermine the building of a collaborative atmosphere, although it may be unintentional or superficial.
- 1 The participant actively undermines a mutual collaboration. The participant may respond in a way that is over-involved or reactive (e.g., moralistic lecturing, "preaching" to the other, assuming all responsibility). The rupture may also involve withdrawal or under-involvement in the participant's response (e.g., putting all the responsibility for change on the other).

8. Alliance Rupture-Repair Responsiveness.

Background: Each client in video clips is expressing an interpersonal issue that involves the patient-therapist relationship. Each video clip places the participant in the middle of alliance rupture episodes. Further, these rupture episodes take place at different locations within the interpersonal circle, which requires interpersonal flexibility for the therapist. The interpersonal problem with the client-therapist relationship threatens the development of the alliance.

This item rates the extent to which the therapist appears responsive to the interpersonal issue. In some cases, the problem is clearly stated as when Suzie angrily berates the therapist for being ineffective. In other cases, the problem is more implicit such as when Lauren idealizes the therapist to the extent of leaving herself overly vulnerable to disappointment.

- 5 Participant makes attempts repair the interpersonal issue by engaging the client in a direct discussion of the immediate moment-to-moment interaction. This may include how *specific relational messages* are being expressed by the client in the video clip. Optimal responses will include attempts to not only allude to the interpersonal tension, but make some attempt to repair that interpersonal issue.
- 4 Participant recognizes the other's interpersonal issue, and may discuss this further in more general terms (or discuss some secondary element of the other's issue or the relationship).
- 3 There may be more casual recognition of the interpersonal situation, but the response does not draw for further discussion of the issue or the relationship.
- 2 Participant addresses an issue to discuss that it is tangentially related to the interpersonal issue presented, but directs the discussion away from the present relationship situation.
- 1 Participant reacts to the interpersonal tension in a way that is nonproductive or in a way that likely exacerbates the rupture (e.g., responding negatively to a hostile client; responding to a controlling client with counter-control). Low scores also may be given when the participant fails to respond to the interpersonal issue involved in a way that indicates that the participant is avoiding the interpersonal issue or the relationship altogether.

Addendum: Interpersonal Issues for the Stimulus Clips

For coding Alliance Rupture-Repair Responsiveness, the coder must keep in mind the unique interpersonal issue that is occurring between therapist and client in the stimulus clip. Generally, responses which exacerbate the interpersonal problems are those in which the participant / therapist enacts what is problematic in the relationship. This can be obvious – as responding to Suzie with hostility – but it can also be less obvious – as responses that give too much direction to Bonnie. A general rule of thumb is that hostile responses are weighed more heavily as furthering a rupture, whereas responses that enact problematic submissiveness or dominance require more extreme examples. For example, a participant / therapist may offer a suggestion to Bonnie about what she might talk about without significantly deepening the rupture.

Below are some brief guidelines about what unique interpersonal problem is being expressed within each stimulus clip:

1. John: The interpersonal issue is one of Focus. John is highly Focused on the Other. To some extent, this is ordinary concern over treatment and diagnostic labeling that might be expected in many therapeutic relationships. However, in this brief exchange the interpersonal tensions are focused on what the therapist thinks, albeit John's role as a client is to talk about his own concerns. Currently, John's concerns are what the therapist is feeling and thinking about him. Thus, one optimal response might be one that recognizes these concerns while persuasively encouraging him to focus further on his own thoughts and feelings.
2. Bonnie. Bonnie is a passive, submissive, and dependent client who wants the therapist / participant to take charge. While some mild, vague suggestion of discussion topics should not be considered much of a deepening of this rupture, those responses where the participant provides considerable direction would be deepening the "rupture." Sometimes a participant / therapist will kindly provide some suggested topics, however, it is important that there are also attempts to address the fact that Bonnie is attempting to avoid talking about her thoughts and feelings. Optimal responses for responses to Bonnie include some engagement with what Bonnie is experiencing in the moment and attempts to explore what makes it difficult for her to talk on her own. Especially helpful might be alluding to what Bonnie says about why the therapist's actions (or lack of actions) may be contributing to her blocking.
3. Les. This client is also passive, but unlike Bonnie, he is more self-involved in his avoidance and he is withdrawn. Les' internal Focus is almost the opposite of the other focus found in clips for John and Hillary. Because he shuts the other person out (everything is because of him), there is some temptation to respond with a pejorative communication. It may also be somewhat difficult to avoid being exasperated with his confusion. Interestingly, this clip was initially chosen because we thought it was only mildly negative, however, in a sample of independent raters we found that the negative reactions toward Les was actually *greater* than some of the more transparently hostile

stimulus clips! Thus, avoiding the interpersonal problem of a hostile response is one way to begin repairing the rupture. However, as much concerning is the overly cognitive and detached manner of Les. Remaining at this highly cognitive, logical level of communication will only maintain this interpersonal problem, whereas the ability to find a more emotive, warm response could help to provide a helpful contrast.

4. Suzie. This client is so hostile and attacking that it's difficult to avoid expressing some frustration, even if it's subtle. A second difficulty would be the temptation to be more controlling, which is what Suzie is requesting. The potential pitfalls of deepening this rupture, therefore, is quite obvious.

5. Lauren. Lauren is making a request for ordinary level of warmth and understanding from the therapist. Somewhat similar to the "John" video clip, Lauren is trying to understand the roles of therapy with particular attention to the therapist's role. The interpersonal problem here is really being explained through her failed relationship with her previous therapist. Lauren obviously has positive feelings toward the current therapist, but the possibility that the therapist might become disinterested implies that Lauren may not fully be able to be comfortable disclosing her problems to the present therapist. While that may not seem likely, the "repair" of this rupture situation would involve demonstrating to Lauren attentiveness and warm engagement. While "warmth" is rated on another item, any sign of dis-engagement will likely exacerbate the rupture with Lauren.

6. Hillary. At first, it may seem that there is no interpersonal problem with Hillary. After all, her feelings for the therapist are unconditionally positive. However, the extent of Hillary's idealization of the therapist is itself the interpersonal issue, and hence the source of what is coded for the alliance rupture on this stimulus clip. Specifically, the attention to the therapist's positive qualities may distract the client from focusing on her own experiences. Hence, examples of responses that would address this "rupture" would be 1) attempts to draw attention away from the therapist and onto the client's internal states or 2) gentle attempts by the therapist to step down from the idealized role (but without negativity).

7. Jack. This client may be the most difficult in terms of avoiding hostility. While Suzie is clearly more hostile, Jack is a more disaffiliative character and thus is likely to pull for more hostility. A high response would avoid frustration but also convey, in a friendly manner, that Jack will not set the entire agenda. Assuming some affiliative - control without getting into a power struggle is a great test of one's interpersonal abilities!