The Therapeutic Relationship: A Study on the Value of the Therapist Client Rating Scale

Blaauw, Eric; Emmelkamp, P M G

Published in:
Behavioural and Cognitive Psychotherapy

DOI:
10.1017/S1352465800011784

Publication date:
1994

Behavioural and Cognitive Psychotherapy, 1994, **22**, 25–35

The Therapeutic Relationship: A Study on the Value of the Therapist Client Rating Scale

Eric Blaauw and Paul M.G. Emmelkamp

University of Groningen, The Netherlands

This article reports on some psychometric features of the Therapist Client Rating Scale (TCRS), an instrument that claims to measure the therapeutic relationship in behaviour therapy sessions. A study is described in which the TCRS was completed after each therapy session by 28 obsessive-compulsive patients undergoing behaviour therapy, as well as by the therapists. The perception of patient behaviour correlated significantly with the treatment outcome. Further examination on the reliability and validity of the TCRS is recommended.

Within the area of behavioural therapy, the therapeutic relationship has received relatively little attention. Only recently has the importance of the therapeutic relationship been recognized in the behavioural therapeutic literature (Wilson and Evans, 1977; DeVoge and Beck, 1978; Morris and Magrath, 1983; Sweet, 1984). There are now reports of some studies that show correlations between the therapeutic relationship and the effect of behaviour therapy in the treatment of phobic patients and of obsessive-compulsive patients.

In a study by Emmelkamp and van der Hout (1983), agoraphobic patients undergoing group treatment with exposure *in vivo* completed the Dutch version of the Barrett-Lennard's Relationship Inventory (Lietaer, 1976). The combined patient and therapist score showed a significant positive correlation with therapy outcome. Because the evaluation of the therapeutic relationship took place after completion of therapy, the effect of therapy may have influenced the patients in their perception of the therapeutic relationship.

In a study by Williams and Chambless (1990) 33 agoraphobic patients, engaged in therapy with exposure *in vivo*, completed the Therapist Rating Scale (Williams, 1989) after the fourth therapy session. A significant relation

Reprint requests to Eric Blaauw, University of Leiden, Department of Clinical, Health and Personality Psychology and Department of Social and Organisational Psychology, Wassenaarseweg 52, 2333 AK Leiden, The Netherlands.

was found between rate of improvement of the complaints on the one hand and the therapist's characteristics of "modelling self-confidence" and "caring/involved" on the other. By evaluating the therapeutic relationship after the fourth therapy session, the effect of therapy is unlikely to influence these judgements. However, because of probable psychometric limitations of the Therapist Rating Scale, less factors emerged than were originally intended. Also, an important restriction of range in the evaluations of the therapeutic relationship appeared, in the sense that the evaluations by the patients of the therapist's characteristics were all positive.

Rabavilas, Boulougouris and Perissaki (1979) described a study of 13 phobic and 23 obsessive-compulsive patients. They assessed the therapeutic relationship by using a specially designed rating form. Significant relationships between improvement of the patients and the number of therapist qualities (e.g. respect, understanding, interest) were found. Because, however, the therapeutic relationship was measured at follow-up (after 1.4 years in average), it is difficult to distinguish the effect of therapy from the therapeutic relationship.

Hoogduin, De Haan and Schaap (1989) conducted two studies on obsessive-compulsive patients in which significant correlations were found between the therapeutic relationship and outcome of treatment. In the first study, the Barrett-Lennard Relationship Inventory was completed after the tenth session by 60 obsessive-compulsive patients (patient form) and their therapists (therapist form). Data from both patient and therapist forms revealed significant correlations with the outcome of therapy. In the second study, 25 patients and therapists assessed the therapeutic relationship after the second and after the tenth session. Outcome of treatment correlated significantly with the therapist form, measured after the second session, and with both the therapist form and the patient form, measured after the tenth session.

The importance of the therapeutic relationship in behaviour therapy has thus been demonstrated in a number of studies. Some critical remarks could, however, be made. Firstly, the therapeutic relationship explained only a small amount of variance in the effect of therapy. Secondly, assessment of the therapeutic relationship in a late phase of treatment is likely to be contaminated by the effect of treatment. Thirdly, the instruments used to measure the therapeutic relationship, were based on therapeutic orientations other than the behavioural orientation. Both the Barrett-Lennard Relationship Inventory and the Therapist Rating Scale were constructed from a client-centered point of view. As these instruments specifically aim at factors that are important for these orientations, they may be less suitable to measure the therapeutic relationship in behaviour therapy.

The Therapist Client Rating Scale (TCRS; Bennun, Hahlweg, Schindler and Langlotz, 1986) was constructed to measure, in a systematic manner, the relationship between patient and therapist in behaviour therapy sessions. The TCRS aims to measure the therapist's perception of behaviour of the patient (therapist form) and the patient's perception of behaviour of the therapist (patient form). The TCRS was developed in a study with German patients, diagnosed as neurotic or as having a psychosomatic disorder, and cross-validated in a study with English patients who presented with a variety of psychological problems.

The research project presented here was conducted to evaluate the qualities of the Dutch version of the TCRS and to examine to what extent the TCRS can predict outcome of therapy in the treatment of patients with obsessive-compulsive behaviour.

Method

Subjects

The sample consisted of 28 patients (21 women and 7 men). Their average age was 29.2 years. All met DSM-IIIR criteria (American Psychiatric Association, 1987) for obsessive-compulsive disorder.

Therapists

Prior to treatment, four or five sessions were provided by two experienced behavioural therapists. These sessions were meant to gather information in order to create a functional analysis of the complaints and devise a treatment programme. Thereafter, treatment was administrated by graduate clinical psychology students. All these students had completed behaviour therapy courses and were trained in treating obsessive-compulsive disorder. Twice a week group sessions were held, in which therapy sessions were discussed. All therapy sessions were audiotaped and overheard by a member of the research team.

Treatment

Treatment consisted of 15 sessions of individually tailored self-controlled *in vivo* exposure and response prevention. In the second treatment-condition, treatment was tailored to the individual needs of the patients and consisted of *in vivo* exposure and other procedures based on the functional analysis made prior to treatment; e.g. assertiveness-training, training in social skills, cognitive treatment, and cognitive-behavioural treatment for depression. Each session lasted from 45 minutes to one hour. The first ten sessions were held twice a week and the last five sessions once a week. Twenty-two

patients participated in the study by Emmelkamp, Bouman and Blaauw (1994), and 6 patients were treated who were not part of that study. Nineteen of these 28 patients participated in both studies.

Assessment questionnaires

Anxiety Discomfort Scale (Emmelkamp, 1982). For each patient five individually registered main obsessive-compulsive situations were rated on 0–8 (range 0–40) scales for anxiety/discomfort by therapist and patient. Prior to analysis, the ratings of therapist and patient were pooled (Pearson r between the two ratings was 0.92). Patient improvement was assessed by the percentage of residual gain from pre- to post-treatment.

Self-rating Depression Scale (SDS; Zung, 1965). This rating scale consists of 23 items (range 23–92), of which the combined score measures the severity of depression. Patient improvement was assessed by the percentage of residual gain from pre- to post-treatment.

Inventarisatielijst omgaan met anderen (Dam-Baggen and Kraaimaat, 1986). The IOA is a rating scale consisting of two forms. One form measures patient's anxiety when engaging in a specific type of social interaction. The other form measures the frequency by which the patient currently engages in these kinds of interaction. In this study only the subscale "giving criticism" of the frequency form of the IOA was used.

Therapist Client Rating Scale (TCRS; Bennun *et al.*, 1986). The TCRS consists of two versions; the therapist form measures patient behaviour in behaviour therapy sessions and the patient form measures therapist behaviour in therapy sessions. Both forms are made up of 29 items with each item scaled from 1 to 6 (e.g. 1 = very talkative to 6 = very quiet). The therapist form comprises three scales: 1) positive regard; 2) self-disclosure/engagement; and 3) cooperation/goal orientation. The patient form also consists of three scales: 1) positive regard/interest; 2) competency/experience; and 3) activity/direct guidance. To use the TCRS in The Netherlands, the English version of TCRS was translated into Dutch. In order to establish an accurate translation, five independent translations were made, after which dissimilarities were solved by reaching inter-subjective agreement.

Procedure

After referral, the patients were invited to an intake session in which the diagnosis was made. When assigned to treatment, the IOA (Dam-Baggen and Kraaimaat, 1986) was assessed. Patients then had five sessions with an experienced behaviour therapist. These sessions were meant to gather information regarding the complaints. After these five sessions the Anxiety Discomfort Scale (Emmelkamp, 1982) and the SDS (Zung, 1965) were

completed. The patients were then assigned to a student therapist. Some days after the last therapy-session, the Anxiety Discomfort Scale (Emmelkamp, 1982) and the SDS (Zung, 1965) were assessed again.

The TCRS (Bennun *et al.*, 1986) was introduced in the first session. The (experienced) therapist informed the patient that neither he, nor the therapist that would be assigned at a later stage, were to see the ratings. At the end of each session, the TCRS was given to the patient (provided with date, identification number and session number) whereupon the therapist left. Patients completed the TCRS (patient form) privately and returned it by mail to the supervising psychologist. The therapists also completed the TCRS (therapist form) after each session. In this way, 20 patient ratings and 20 therapist ratings were collected for each patient. Nineteen patients completed the TCRS several times, although some of them had missing data on some of the items.

Results

Distribution of the ratings

Because all the items of the patient form of the TCRS and nearly all the items of the therapist form of the TCRS showed extremely positive scores, the distribution did not approach normality. The statistical components of normality (skewness and kurtosis) showed a significant pile-up of scores in the left part of the distribution (merely positive evaluations). In order to accomplish normality, the scores were trichotomized. Conversing the scores in 1 → 1, 2 → 2, and 3, 4, 5, 6 → 3 improved normality drastically (see Table 1). Of the therapist form, the indicators for normality showed

TABLE 1. Distribution of the ratings

	Before trichotomizing		After trichotomizing	
Variable	kurtosis	skewness	kurtosis	skewness
Therapist form:				
Positive regard	3.38	1.31	−0.39	0.33
Selfdisclosure/engagement	0.49	0.78	−0.70	−0.04
Cooperation/goal orientation	1.37	1.04	−0.49	−0.04
Factors combined	2.16	1.04	−0.28	0.10
Patient form:				
Positive regard/interest	28.60	3.89	3.71	2.06
Competence/experience	3.4	1.73	2.18	1.66
Activity/direct guidance	0.10	1.13	0.35	1.16
Factors combined	1.12	1.37	1.33	1.49

satisfactory values (skewness and kurtosis both approximately zero) but the patient form still did not show a normal distribution as indicated by neither skewness nor kurtosis being equal to zero. Scores were still peaked and lying in the left part of the distribution (positive evaluations). Since other trichotomizations and non-linear transformations did not improve normality above the initial trichotomization, it was decided to use this transformation in analysing the data.

Confirmatory factor analysis

Confirmatory factor analysis was performed to investigate the extent to which factors of the TCRS, emerged in a German sample and cross-validated in an English one (Bennun *et al.*, 1986) also could be discerned in the present study. For each factor the current reliability and amount of explained variance as well as the correlations between the factors were analysed.

The reliabilities of the scales (given in Cronbach's alpha) and the percentages of explained variance are presented in Table 2. A high Cronbach's alpha indicates a reliable scale. A Cronbach's alpha of 0.90 is considered (very) high. For this reason, consistency of the items of both the therapist form and the patient form can be called satisfactory. Also the amount of explained variance per scale can be regarded as good, indicating that the scales as found by Bennun *et al.* (1986) did emerge in the present study.

Correlations between the scales of the TCRS are presented in Table 3. As can be seen, all scales show significant intercorrelations, meaning that

TABLE 2. Reliabilities and percentages explained variance

Variable	Reliability (Cronbach's alpha)	Percentage explained variance
Therapist form:		
Positive regard	0.87	31.6
Selfdisclosure/engagement	0.78	27.6
Cooperation/goal orientation	0.83	29.7
Factors combined		47.3
Patient form:		
Positive regard/interest	0.93	41.2
Competence/experience	0.85	40.6
Activity/direct guidance	0.89	36.5
Factors combined		52.9

TABLE 3. Correlations between the TCRS scales

Therapist form	Selfdisclosure/ engagement	Cooperation/ goal orientation
Positive regard	0.73*	0.76*
Selfdisclosure/engagement	—	0.61*
Patient form	**Competence/ experience**	**Activity/direct guidance**
Positive regard/interest	0.90*	0.77*
Competence/experience	—	0.84*

* $p < 0.05$.

they are not independent from one another. It has to be concluded that the scales of the TCRS are not measuring separate behaviour dimensions.

Time analysis

In order to investigate whether the ratings of dimensions of the therapeutic relationship changed as therapy progressed, these ratings were analysed using ANOVA. The ratings of sessions 3, 8, 13 and 18 were used in this anlaysis. None of the subscales or the combined subscales of both the therapist form and the patient form showed significant changes in time ($p < 0.05$). Ratings did not change as therapy progressed.

Correlations with outcome

Since ratings did not change as therapy progressed (no time effect was found), the ratings of the different sessions were combined to one score. In order to examine whether the therapeutic relationship influenced therapy outcome, Pearson correlations were computed between the TCRS scales and the two improvement measurements. Cases were dropped from analysis when more than 20 per cent of the items of the TCRS were missing or when one of the measurements of outcome was missing. The correlations between the TCRS scales and percentage of improvement in anxiety/discomfort and depression are presented in Table 4.

The patient factor (therapist form) "positive regard" correlated significantly with patient's improvement in feelings of anxiety/discomfort ($p < 0.05$). This means that when patients were perceived by the therapist as showing positive regard in therapy, they were more likely to improve in their feelings of discomfort and anxiety when entering a (previously) anxiety provoking situation. None of the other scales of both the therapist form and the patient form showed significant correlations with improvement in

TABLE 4. Correlations between the TCRS scale and improvement in obsessive-compulsive behaviour and depression

	Anxiety discomfort			SDS		
Variable	corr.	*p*	*n*	corr.	*p*	*n*
Therapist form:						
Positive regard	0.61	.01	15	0.39	.07	16
Selfdisclosure/engagement	0.10	—	14	−0.04	—	15
Cooperation/goal orientation	0.02	—	14	−0.09	—	15
Factors combined	0.36	—	14	0.12	—	15
Patient form:						
Positive regard/interest	0.19	—	14	0.30	—	15
Competence/experience	0.11	—	15	0.22	—	16
Activity/direct guidance	0.32	—	14	0.41	.07	15
Factors combined	0.24	—	14	0.34	—	15

obsessive compulsive behaviour ($p < 0.05$). No significant correlations were found between TCRS scales and improvement in feelings of depression.

Conclusion

All factors of both the therapist form and the patient form of the TCRS (Bennun *et al.*, 1986) were replicated in the present study in that the reliabilities and the percentages of explained variance per factor were satisfactory. Correlations between the factors of each form indicated that these factors are not independent. Also a significant restriction of range occurred in the therapist ratings as well as in the patient ratings. A significant positive correlation was found between the patient factor "positive regard" of the TCRS (therapist form) and outcome of therapy, as measured by the Anxiety Discomfort Scale (Emmelkamp, 1982).

Discussion

In the present study, all patients rated their therapist as scoring very high on each dimension of the TCRS. The therapists also perceived their patients as showing adequate patient behaviour as measured by the TCRS, although they scored less highly. Because Bennun *et al.* (1986) did not report means or standard deviations of the items, it is not known from their study whether the results showed the same tendency towards (solely) positive ratings. Williams and Chambless (1990), however, did report a significant restriction of range in their study of the influence of the therapeutic relationship assessed by the Therapist Rating Scale on therapy outcome: again only

positive evaluations of therapist characteristics as rated by the patients were found.

Though, of course, there is a chance that the positive ratings of therapist behaviour as judged by the patients were a correct transcription of the behaviour that actually took place, it is more likely that other factors are involved. Firstly, it is possible that the positive ratings were influenced by the social-desirability response set. Secondly, it can not be excluded that some patients may not have been convinced that their therapist was not to see their ratings. Thirdly, it is possible that some obsessive-compulsive patients show difficulties in criticizing other people. In order to check this hypothesis, the relation of the ratings of the therapeutic relationship and the scores on the subscale "giving criticism" of the IOA (Dam-Baggen and Kraaimaat, 1986) were analysed. The IOA is a questionnaire measuring, amongst other aspects, patients' feelings of discomfort when criticizing other people. Although some patients showed difficulties in giving criticism no significant relationship was found between feelings of discomfort when criticizing other people and the scores on the TCRS. Fourthly, the "leniency" effect (the tendency to rate each consecutive item in the same manner as the previous ones, when all previous items were rated the same) may also have played a role in the positive ratings. This assumption is supported by the fact that the means and standard deviations of items with a different polarity are higher than the other items. Reliability analysis also showed that the items with a different polarity suppress Cronbach's alpha, albeit only to a moderate extent. Apparently these items were not recognized as being stated in an opposite manner from the others, lending support to the "leniency" effect hypothesis. Whatever the explanation of the very positive ratings, this significant restriction of range caused a far from normal distribution, even after trichotomizing the scores. This may have influenced the psychometric analysis.

Time analysis showed that neither the ratings of the therapist behaviour nor the ratings of the patient behaviour changed as therapy progressed. Considering the fact that from the start the ratings were extremely positive, the only change that might have occurred would have been towards a more neutral or negative direction. This did not happen; throughout the whole therapy, the therapists and patients rated each other's behaviour as very positive.

The finding of the significant correlation between the TCRS subscale "positive regard" (therapist form) and patients' improvement in feelings of discomfort or anxiety when entering a (previously) anxiety provoking situation, indicates that patient behaviour in therapy sessions is important in regard to a favourable therapy outcome. The finding that one of the

subscales of the therapist form showed a significant link with therapy outcome, whereas none of the subscales of the patient form did, may be due to the better approach of a normal distribution of the ratings of the therapist form. The fact that we found a significant correlation between the subscale "positive regard" of the TCRS (therapist form) and proportional reduction of anxiety and discomfort, but that we did not find significant correlations between any factor of the TCRS and reduction of feelings of depression (SDS), may be due to the aim of the therapy sessions. The aim of treatment was to decrease the obsessive-compulsive symptoms. Reduction of depressive feelings was only a secondary goal.

The findings presented in this article indicate that further examination of the psychometric qualities of the TCRS is necessary. It is recommendable to scrutinize the advantages and disadvantages of the Likert type of scaling used in the TCRS. Because the TCRS has clear advantages above the Barrett-Lennard Relationship Inventory—its "brief" size makes it easy to assess the therapeutic relationship after each therapy session and the TCRS was constructed within a behavioural therapeutic orientation—further examination of the psychometric qualities of the TCRS may prove profitable.

References

AMERICAN PSYCHIATRIC ASSOCIATION (1987). *Diagnostic and Statistical Manual of Mental Disorders* (3rd edition, revised). Washington, DC: American Psychiatric Association.

BENNUN, I., HAHLWEG, K., SCHINDLER L. and LANGLOTZ, M. (1986). Therapist's and client's perception in behaviour therapy: the development and cross-cultural analysis of an assessment instrument. *British Journal of Clinical Psychology* **25**, 275–285.

DAM-BAGGEN, R. VAN and KRAAIMAAT, F. (1986). De betrouwbaarheid en validiteit van de inventarisatielijst omgaan met anderen. *Gedragstherapie* **19**, 229–248.

DEVOGE, J.T. and BECK, S. (1978). The therapist-client relationship in behaviour therapy. *Progress in Behavior Modification, Volume 6*, New York: Academic Press.

EMMELKAMP, P.M.G. (1982). *Phobic and Obsessive-compulsive Disorders: Theory, Research and Practice*. New York: Plenum.

EMMELKAMP, P.M.G. and HOUT, A. VAN DER (1983). Failure in treating agoraphobia. In E.B. Foa and P.M.G. Emmelkamp (Eds). *Failures in Behavior Therapy*. New York: Wiley.

EMMELKAMP, P.M.G., BOUMAN, T. and BLAAUW, E. (1994). Individualized versus standardized therapy: a comparative evaluation with obsessive compulsive patients. *Clinical Psychology and Psychotherapy*, in press.

HOOGDUIN, C.A.L., HAAN, E. de and SCHAAP, C. (1989). The significance of the patient-therapist relationship in the treatment of obsessive-compulsive neurosis. *British Journal of Clinical Psycholgy* **28**, 185–186.

LIETAER, G. (1976). Dutch revision of Barrett-Lennard's Relationship Inventory for individual therapeutic relations. *Psychologica Belgica* **16**, 73–94.

MORRIS, R.J. and MAGRATH, K.H. (1983). The therapeutic relationship in behaviour therapy. In M.J. Lambert (Ed). *Psychotherapy and Patient Relationship*. Homewood, Illinois: Down-Jones Irwin.

RABAVILAS, A.D., BOULOUGOURIS, J.C. and PERISSAKI, C. (1979). Therapist qualities related to outcome with exposure *in vivo* in neurotic patients. *Journal of Behavior Therapy and Experimental Psychiatry* **10**, 293–294.

SWEET, A. (1984). The therapeutic relationship in behavioural therapy. *Clinical Psychological Review* **4**, 253–272.

WILLIAMS, K.E. (1989). The impact of client-perceived therapist characteristics on exposure therapy for agoraphobia. (Master's thesis, The American University, 1988). *Masters Abstracts International* **27**, 310.

WILLIAMS, K.E. and CHAMBLESS, D.L. (1990). The relationship between therapist characteristics and outcome of *in vivo* exposure treatment for agoraphobia. *Behavior Therapy* **21**, 111–116.

WILSON, G.I. and EVANS, I.M. (1977). The therapist-client relationship in behavior therapy. In A.S. Gurman and A.M. Razin (Eds). *Effective Psychotherapy*. Oxford: Pergamon Press.

ZUNG, W.W.K. (1965). A Self-rating Depression Scale. *Archives of General Psychiatry* **12**, 63–70.