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# A Pilot Study Assessing Outcomes for the High 8 Socially Uninhibited Subtype After Treatment with Focused Brief Group Therapy

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**A PILOT STUDY ASSESSING OUTCOMES FOR THE HIGH 8 SOCIALLY  
UNINHIBITED SUBTYPE AFTER TREATMENT WITH FOCUSED BRIEF  
GROUP THERAPY**

**PROFESSIONAL DISSERTATION**

**SUBMITTED TO THE FACULTY**

**OF**

**THE SCHOOL OF PROFESSIONAL PSYCHOLOGY  
WRIGHT STATE UNIVERSITY**

**BY**

**Kacey D. Greening, Psy.M.**

**IN PARTIAL FULFILLMENT OF THE  
REQUIREMENTS FOR THE DEGREE  
OF  
DOCTOR OF PSYCHOLOGY**

**Dayton, Ohio**

**July, 2014**

**COMMITTEE CHAIR: Martyn Whittingham, Ph.D.**

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**WRIGHT STATE UNIVERSITY**  
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June 26, 2013

I HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER MY SUPERVISION BY **KACEY GREENING** ENTITLED **A PILOT STUDY ASSESSING OUTCOMES FOR THE HIGH 8 SOCIALLY UNINHIBITED SUBTYPE AFTER TREATMENT WITH FOCUSED BRIEF GROUP THERAPY** BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PSYCHOLOGY.

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Martyn Whittingham, Ph.D.  
Dissertation Director

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Associate Dean

## **Abstract**

A pilot study was completed to determine the effectiveness of Focused Brief Group Therapy (FBGT; Whittingham, 2008) in a college counseling center. The study focused on individuals with elevated scores on scale 8, also known as the socially uninhibited subtype, of the Inventory of Interpersonal Problems. This scale has been described by researchers as potentially problematic in treatment (Burlingame, 2005) and also appeared in high numbers as referrals at a mid-western college counseling center. Pre-existing data from the Inventory of Interpersonal Problems (IIP-32; Horowitz et al., 2000) and the Counseling Center Assessment of Psychological Symptoms (CCAPS; Center for Collegiate Mental Health, 2012) was analyzed prior to and after completion of FBGT. It was hypothesized that upon completion of group therapy there would be statistically significant decreases in the following domains: Scale 8 and Total Interpersonal Distress on the Inventory of Interpersonal Problems, as well as the Depression Scale on the Counseling Center Assessment of Psychological Symptoms. Results indicated a total population decrease on Scale 8 and Total Interpersonal Distress scale on the IIP-32 but not on the CCAPS scales. Future research should assess typical patterns of distress and change for this population to optimize treatment outcomes.

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## Chapter 1

College students are often at a unique developmental period in their lives and may be experiencing a number of changes, transitions, and demands. Students who seek help from their university counseling center may join therapy groups to address these developmental and transitional tasks. From a developmental perspective, DeLucia-Waack (2009) suggested that some college students may not have experience with significant life events, which may prevent them from identifying their contribution to unhelpful interpersonal patterns. Some students may not be aware of their impact on others and they may not have had the opportunity to receive interpersonal feedback. Given that college students are often preoccupied with issues such as identity formation, forming and maintaining social relationships, and dating and working in groups, group therapy is a modality highly suited to this developmental stage (Kincade & Kalodner, 2004).

Given the social and interpersonal needs in a college population, process groups offer quite an appeal to many university counseling centers (Johnson, 2009). There is empirical support that connects attachment security to managing the transition to adulthood, overall regulation of affect, and a wide variety of mental health concerns (Marmarosh, 2009). Process groups can help provide a safe environment to hear feedback from others, learn how behaviors impact others, and to improve interpersonal relationships. Further, there is a strong connection between attachment security and the process of separating from home while adjusting to university life, which makes process

groups a particularly relevant treatment modality for college students (Marmarosh, 2009).

Focused Brief Group Therapy (FBGT) was developed by M. Whittingham to meet the needs of a university counseling center for a brief dynamic model that could be effective for a range of presenting problems in less than eight sessions. It was noted that clients with high 8 profiles tended to struggle in group therapy, which will be discussed in more detail below (personal communication, May 23, 2013). In addition, clients with high 8 profiles are characterized by rapid and intense self-disclosure, which can be problematic in group (Burlingame, 2005; Yalom, 2005). In response to this growing subset of clients, Focused Brief Group Therapy has developed protocols to better manage and improve treatment outcomes. Given the unique needs of scale 8 clients in a group setting, this research study aimed to assess the efficacy of FBGT, particularly since inoculation and pre-group preparation are integral components of FBGT.

## **Chapter 2**

### **Literature Review**

#### **The Socially Uninhibited Interpersonal Subtype**

This study assessed one particular interpersonal sub-type, more specifically the scale 8 subtype on the Inventory of Interpersonal Problems (IIP-32). The clinical database showed that clients with scale 8 elevations frequently attended group treatment in the college counseling center from which this sample was drawn. Upon initial review of the data by this researcher, clients with scale 8 elevations were the second most common subtype in the database.

On the Inventory of Interpersonal Problems, scale 8 is called the “Intrusive/Needy” subtype and is characterized by sociability and extroversion (Horowitz, Alden, Wiggins, & Pincus, 2000). In Focused-Brief Group Therapy, which will be discussed in more detail below, scale 8 is called the “Socially Uninhibited” subtype in an effort to avoid pejorative labeling (Whittingham et al., 2013). Figure 1 is a visual representation of the new labels for the Circumplex that were created in FBGT.

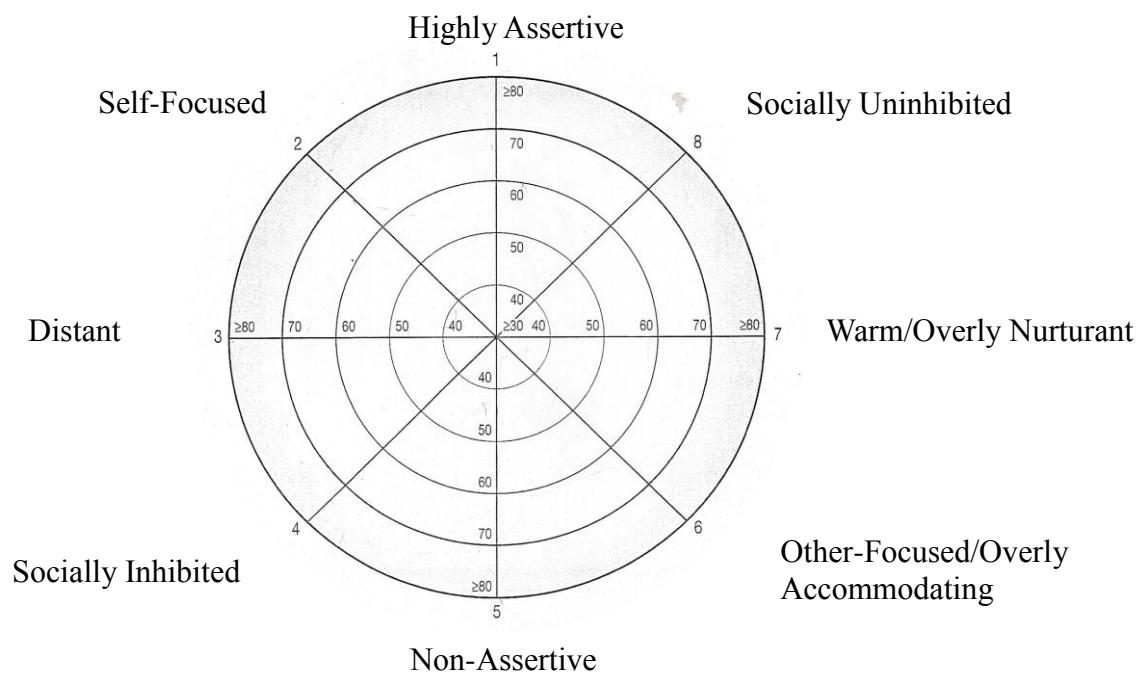


Figure 1. New labels for the circumplex in focused brief group therapy.

Clients who present with the socially uninhibited subtype (scale 8) typically report a strong need to feel engaged with other people and find it difficult to spend time alone. They often open up and share personal things very quickly and may have a hard time setting boundaries or respecting the boundaries of others. In addition, clients with high scores on scale 8 of the IIP often had histrionic traits or personalities (Horowitz, Alden, Wiggins, & Pincus, 2000). While elevations on scale 8 of the IIP can be an indicator of interpersonal distress, it is important to note that having an interpersonal style characterized by sociability and extroversion is not inherently problematic. In fact, it can be very healthy and helpful in developing and maintaining friendships and other relationships. It only becomes problematic when the interpersonal style becomes rigid

and inflexible, which limits the repertoire of interpersonal responses that are available to clients (Kiesler, 1996; Teyber & Holmes-McClure, 2011; Whittingham et al., 2013).

As was noted above, interpersonal styles become problematic when they are rigid and inflexible. Thus, Teyber & Holmes-McClure (2011) identified three unhelpful interpersonal coping strategies. One of these unhelpful interpersonal coping strategies, “moving towards,” reflects some of the difficulties that accompany the socially uninhibited subtype. The moving towards approach can take the form of clients who repeatedly seek approval from and intimacy with others. It can also describe clients who sometimes unintentionally overwhelm others with their intense need for engagement, connection, and validation. Clients who present with the socially uninhibited subtype often engage in these unhelpful behaviors in an effort to feel close to others, but they don't always see the impact of their behaviors on other people.

The existing body of research can help provide a framework for understanding the attachment style of clients with the socially uninhibited subtype, as well as the challenges they present. Attachment styles and interpersonal styles are closely related (Horowitz et al., 2000; Teyber & Holmes-McClure, 2011). For example, the scale 8 (socially uninhibited) subtype is similar to the preoccupied attachment style. Teyber & Holmes-McClure (2011) suggested that preoccupied clients are often intense and revealing in initial sessions. Also, there is typically a high level of communication and emotional expression in session, which stems from their desire to feel close to the clinician. Preoccupied clients often feel overwhelmed and have the tendency to overwhelm others.

Yalom and Leszcz (2005) argued that self-disclosure is the mechanism that underlies all therapeutic factors in group psychotherapy. However, rapid and intense self-

disclosure can impede the group process. While self-disclosure has the potential for therapeutic gain, involving the expression of emotions and the willingness to take risks, it also requires the ability to reflect on these experiences and to inhibit behaviors when appropriate for the group as a whole. This can be difficult for clients with preoccupied or socially uninhibited styles because they tend to seek intimacy with others, worry that others do not love or want to be with them, and sometimes scare others away with their intense need for closeness (Shechtman & Dvir, 2006). Further, Teyber & Holmes-McClure (2011) suggested that while clients with preoccupied attachment styles are more likely to engage in self-disclosure, which can be very helpful in a group setting, their disclosure is often too indiscriminant and unfiltered to be productive or well received when meeting someone for the first time.

**The Impact of Scale 8 Clients on Group Dynamics.** Clients with scale 8 profiles can impact the group process in a number of ways. Yalom and Leszcz (2005) argued that self-disclosure is the mechanism that underlies all therapeutic factors in group psychotherapy. However, rapid and intense self-disclosure can impede the group process. While self-disclosure has the potential for therapeutic gain, involving the expression of emotions and the willingness to take risks, it also requires the ability to reflect on these experiences and to inhibit behaviors when appropriate for the group as a whole. This can be difficult for clients with preoccupied or socially uninhibited styles because they tend to seek intimacy with others, worry that others do not love or want to be with them, and sometimes scare others away with their intense need for closeness (Shechtman & Dvir, 2006). Further, Teyber & Holmes-McClure (2011) suggested that while clients with preoccupied attachment styles are more likely to engage in self-disclosure, which can be

very helpful in a group setting, their disclosure is often too indiscriminant and unfiltered to be productive or well received when meeting someone for the first time.

Clients with scale 8 profiles can unintentionally threaten the sense of safety and trust within the group. For instance, by taking pictures or asking group members out to dinner, group members may become concerned about their confidentiality, privacy, and boundaries. Additionally, clients with socially uninhibited styles may elicit responses from others whereby other group members allow clients with scale 8 profiles to monopolize the group time because they are too anxious or afraid to challenge or give interpersonal feedback to clients with scale 8 profiles. On the other hand, clients with socially uninhibited styles can have a positive impact on the group and can contribute to diversity in group composition. Additionally, with pre-group preparation, clients with scale 8 profiles can model courage for other group members regarding how to take risks and how to disclose personal information in a group format (Shechtman & Dvir, 2006; Whittingham et al., 2013; Yalom & Leszcz, 2005).

**Inoculation and Goal Setting.** The Group Selection Questionnaire (GSQ) demonstrated that individuals who tend to score high on the domineering scale, which is closely related to scale 8 on the IIP-32, tend to have poorer symptomatic change in early sessions (Cox, Burlingame, Davies, Gleave, & Barlow, 2004). Burlingame et al. (2012) revised the GSQ and noted that clients who score high on the domineering scale should not automatically be screened out of group therapy altogether. Instead, they may need pre-group preparation to help them succeed in group therapy. Further, Krogel and colleagues (2009) suggested that some clients who do not appear to be a good match for group therapy may be the very ones who could benefit from group therapy the most.

Rather than screen out all clients with the socially uninhibited subtype, thoughtful consideration should be given after looking at clients' individual scores, learning about their goals, and preparing them for the group experience.

At one college counseling center where Focused Brief Group Therapy is being utilized, group members with scale 8 elevations are not excluded based on their elevation alone. In fact, they participate in a group screening and engage in pre-group preparation to determine if group could be a fit for them (M. Whittingham, personal communication, August 15, 2012). Focused Brief Group Therapy will be discussed in more detail below, but one significant aspect of FBGT is “inoculating” or preparing clients with the socially uninhibited subtype for group therapy. The practice of inoculating clients stemmed from previous treatment failures. For instance, M. Whittingham noted that when these clients were not prepared or inoculated for group therapy, they often disclosed in an intense manner, and they tended to dominate and overwhelm other group members. This dynamic often elicited fear and withdrawal from other group members, which in turn, amplified these clients' fears of being alone and their urgency to seek intimacy and closeness. Further, M. Whittingham explained that after multiple treatment failures with this population, it became clear that an intervention was needed. Therefore, pre-group preparation or inoculation was provided to help this population have helpful and productive group experiences. (personal communication, August 15, 2012).

It can be anxiety provoking to join a group, and engaging in interpersonal change can elicit new responses from others (Rutan & Stone, 2001; Yalom & Leszcz, 2005). In fact, interpersonal change often threatens homeostasis by disrupting pre-existing patterns, which can actually increase distress before relief can be experienced (Teyber & McClure,

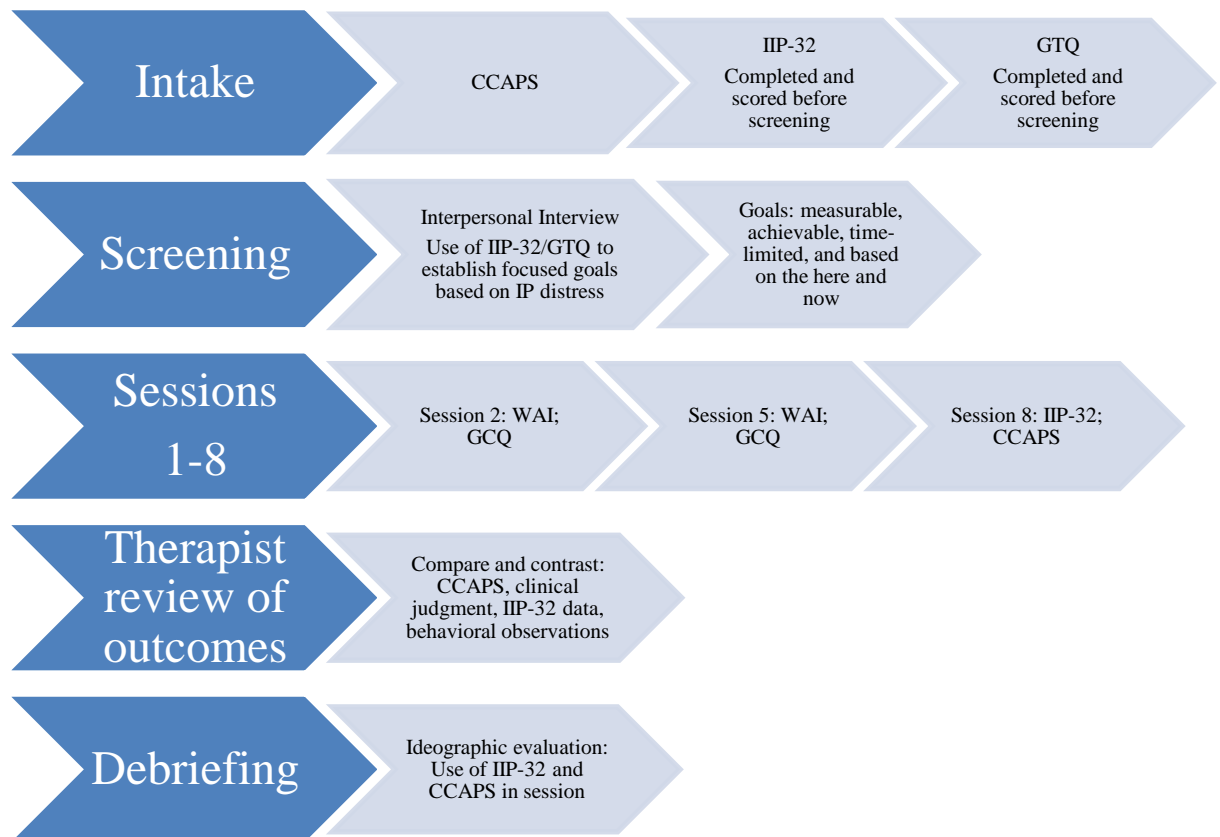


2011). Thus, inoculation can help prospective group members modulate the anxiety that usually accompanies entry into a group through clarification and demystifying the group experience (Rutan & Stone, 2001). In Focused Brief Group Therapy, clients with scale 8 elevations have the opportunity to learn about their interpersonal style, anticipate difficulties, and reduce their anxiety about the group process. M. Whittingham suggested that it is important to provide inoculation for clients with scale 8 elevations, as well as set goals in a way that doesn't feel pathologizing or punitive. Inoculation is a process whereby the therapist reviews the client's IIP-32 scores and discusses the scores with the client. After inviting clients to compare their typical patterns of interaction with that of other high 8 clients, they can gain insight regarding the impact of their pattern of rapid self-disclosure. For example, therapists can help clients with scale 8 elevations by normalizing and validating their desire to be close to other people. Therapists can also praise the intention of these clients to be close to others, while encouraging them to modify their behaviors (e.g., match their self-disclosure to the middle-most disclosing group member rather than disclosing too quickly and intensely). This allows clients with scale 8 elevations to experience successful connections with other group members that are not sabotaged by inappropriate and early self-disclosure (personal communication, May 22, 2013).

### **Focused Brief Group Therapy (FBGT)**

Focused Brief Group Therapy (FBGT) was developed by Whittingham (2008-2013). It was given the name of Focused Brief Group Therapy because it specifically targets the client's highest level of interpersonal distress (M. Whittingham, personal communication, April 30, 2013). Focused Brief Group Therapy consists of eight to

fourteen sessions and includes an intake, group screening, group therapy sessions, and a debriefing. See Figure 2 below, which provides a visual depiction of the structure of Focused Brief Group Therapy.

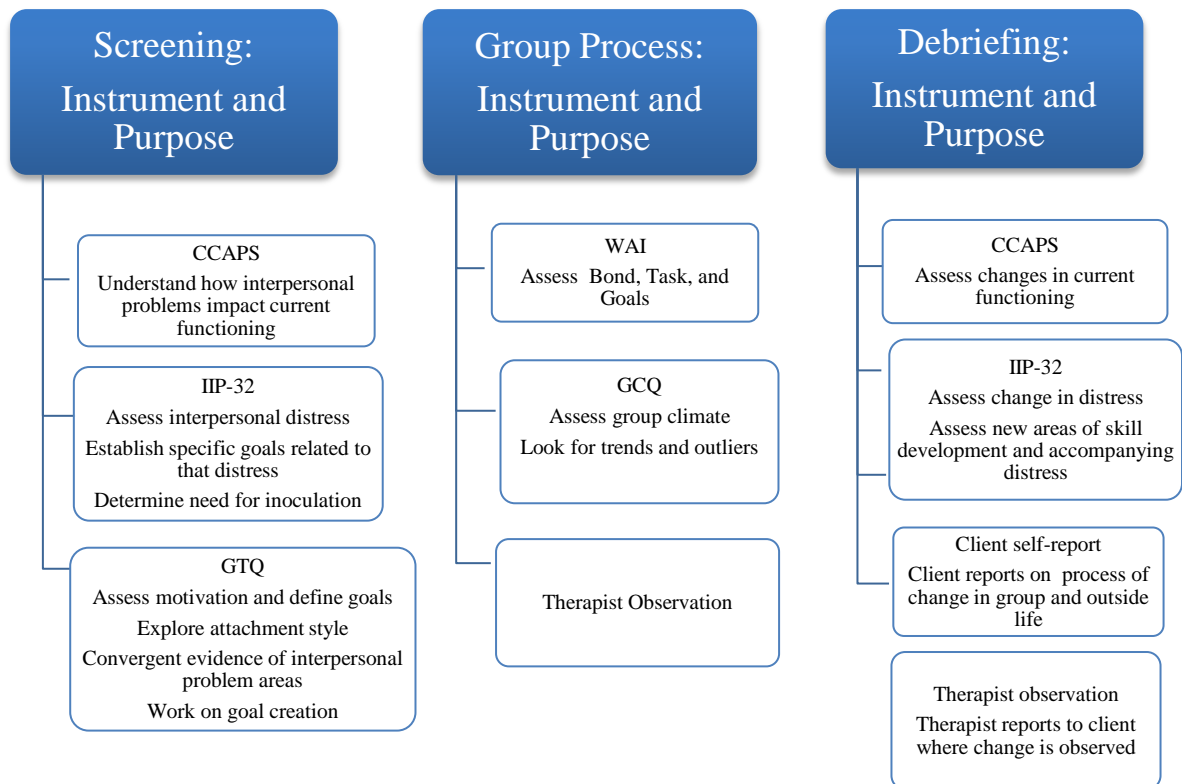


*Figure 2. The structure of focused brief group therapy.*

Focused Brief Group Therapy is an assessment-informed approach. Therefore, assessing clients prior to them entering the process group is an important component in FBGT. To better determine the client’s specific area of interpersonal difficulty, the IIP-32 (Horowitz et al., 2000) screener is completed before clients enter the process group. Once the results of the screener are determined, the client and the therapist will discuss these results and come to an agreement on an interpersonal focal area. During the discussion of

the IIP-32, the client and the therapist gain a better understanding of the client's primary area of interpersonal distress, which will then provide a focus for treatment and inform treatment goals. As was previously mentioned, clients with socially uninhibited subtypes can often benefit from learning to inhibit themselves and to experiment with new behaviors that will elicit positive responses from others. This further highlights the importance of pre-group preparation and inoculation for these clients (Whittingham et al., 2013).

Additionally, outcome measures are also an important aspect of FBGT and are used to track progress and measure change. Instruments from the CORE-R Battery and the CCAPS are utilized in FBGT, with an emphasis on the IIP-32. In FBGT, the IIP-32 can help focus treatment goals, generate a working alliance, predict group-threatening behaviors, assess group composition and dynamics, and measure change. The value of assessment in FBGT is crucial because it was designed to prevent dropouts, maximize group success and cohesion, and enhance motivation by setting concrete and achievable goals. See Figure 3 below for a visual depiction of the assessment purposes in Focused Brief Group Therapy.



*Figure 3. Assessment purposes in focused brief group therapy.*

The underlying treatment model of FBGT is based on interpersonal and behavioral theories with an emphasis on interpersonal subtypes (e.g., socially uninhibited) that are ordered around a circumplex. Thus, FBGT is interpersonal in nature, allowing clients to experiment with new ways of interacting, sharing fears or concerns they may have about their interpersonal interactions, and receiving feedback from others about the impact of their behaviors. A primary goal in Focused Brief Group Therapy is creating interpersonal flexibility (O'Connor & Dyce, 1997). Rather than suggesting personality change, the goal is to increase the range of behavioral options a client has available to them. Thus, FBGT helps clients identify a focal area of interpersonal distress

and then seeks to help clients gain more interpersonal flexibility in how they respond and interact with others, which empowers clients by increasing their repertoire of interpersonal skills and responses (Whittingham et al., 2013).

Focused Brief Group Therapy is an integrated interpersonal approach that relies on the principle of behavioral activation. It is important to help clients set goals that are concrete, time-limited, and achievable. For instance, some appropriate goals for socially uninhibited clients might include: letting others have a turn to speak first, waiting a few sessions before sharing a very personal experience, or asking for feedback from others regarding how much time they used in the group. Burlingame, Fuhriman and Mosier (2003) suggested that the acquisition of information and the practice of relevant behaviors are necessary for any treatment gains. Thus, FGBT mobilizes this factor by helping clients focus on behavior change in the here and now and during the life of the group. Focused Brief Group Therapy also draws on the power of the group to activate interpersonal schemas that clients have about themselves and the world in an attempt to modify rigid interpersonal schemas via feedback loops (Whittingham et al., 2013).

Focused Brief Group Therapy is a multiculturally-sensitive approach that combines insight regarding interpersonal distress with ideographic validity checks. For example, is this the problem? Do you want to change it? In what contexts would you like to see it change? Would you like to tell other people about it? What goals would be in alignment with your own values and background? Therefore, clinicians should consider how cultural backgrounds are contributing to interpersonal distress and be mindful of how they formulate goals with clients (Whittingham et al., 2013). For example, clients may not want to change their interpersonal behaviors if they are behaving in ways that

are consistent with their cultural values and background. Alternative and creative solutions should be explored with diverse clients so they can feel authentic and have the chance to succeed in group environments. Eason (2009) suggested that a failure to be proactive in offering culturally-sensitive group counseling services to students from diverse backgrounds will only exacerbate the difficulties already present in college counseling centers.

**Diversity Considerations.** To better illustrate the impact of cultural variables on scale 8 presentations, a few examples will be presented. Torres-Rivera (2004) described the value of personalismo in Latino culture. Personalismo is the preference for personal contacts rather than detached or institutional ones, and this value would be important to consider if a Latino client presented with an elevated scale 8. In Latino communities, it is often seen as a sign of respect and affection to want to develop personal and intimate relationships with others. Therefore, if a Latino client shared intimate or personal information in a group setting or asked to hug another group member, it may be culturally appropriate for them to do so. If group leaders and group members do not understand or respect this cultural value and instead pathologize or view the client as intrusive, then it may create an environment of oppression and prevent authentic connections and growth for clients from different cultural backgrounds.

Dipeolu, Kang, & Cooper (2007) discussed their experiences running a group for international students. They suggested that in many non-Western cultures the personal and professional are less distinct and may be paired. Due to potential differences in cultural values, it is crucial to carefully interpret interpersonal scales from the lens of the cultural context in which clients were raised. For example, Dipeolu, Kang, & Cooper

(2007) indicated that one of their international group members frequently asked for a ride to the counseling center to attend group sessions. Within the group member's cultural context, this request was reasonable and financially necessary. However, in a group with students primarily from western cultures, this request may be viewed as intrusive or lacking boundaries. In addition, it was noted that some international group members expected to spend time and socialize with other group members outside of group sessions. In many Latino and Native American cultures, the boundaries between family and friends and co-workers are less distinct (Dipeolu, Kang, & Cooper, 2007). Thus, a scale 8 elevation may be reflective of their cultural values not necessarily of a problematic interpersonal style.

In sum, it is essential to interpret interpersonal behaviors within a culturally-sensitive context rather than pathologizing and repeating oppressive dynamics in the group process. The aim of Focused Brief Group Therapy is to collaborate with group members in understanding the context of their interpersonal behaviors and to aid group members in setting culturally appropriate goals. What is most important is empowering clients with choices and options to broaden their repertoire of interpersonal skills and to enhance their relationships with others (Whittingham et al., 2013).

### **Documenting and Tracking Change in Focused Brief Group Therapy**

For decades, researchers and practitioners in the field of clinical psychology have been grappling with questions related to the change process in therapy. For example, Gordon Paul (1967) posed the question, "How much of which psychotherapy by whom is most effective for which patient with what type of problem?" Throughout the history of psychology, clinicians have sought to capture and document the necessary conditions in

treatment for change to occur. Further, a new practice has developed in the past few decades in which clinicians must document change and track the progress of therapy. While it is widely accepted that documenting change is a necessity, determining exactly what constitutes “change” is a continual debate within the field.

Researchers and practitioners in the field of clinical psychology are still attempting to determine which factors are most important when trying to help a client as she/he decides to engage in the change process. Some researchers and practitioners have proposed theories to locate better models of treatment and more effective interventions to foster change (Howard, Kopta, Krause & Orlinsky, 1986; Krause, Howard & Lutz, 1998). Others have used their clinical experience as bench markers for identifying and understanding the occurrence of change (e.g. French & Raven, 1959; Prochaska & Velicer, 1997; Yalom & Leszc, 2005). Consequently, several tools have been created to measure change over time, and practitioners have developed new theories regarding why change does or does not occur in therapy. Focused Brief Group Therapy utilizes data points from the IIP-32 and the CCAPS to measure change for clients with scale 8 elevations. Tracking progress and change in clients with socially uninhibited interpersonal styles is particularly important given that they have a tendency to struggle in group therapy. In addition, it is helpful to see where change occurs for these clients to improve sensitivity to intervention methods and improve treatment outcomes (Whittingham et al., 2013).

### **The Importance of Pre-Group Preparation and Post-Treatment Assessment**

The therapeutic change process can become more complex when occurring within a group psychotherapy setting. For example, the group facilitator is required to attend to



the needs of numerous group members, who each may have very different goals for therapy, may be in different stages of change, and may have unique interpersonal qualities and styles. Due to the complexity of psychotherapy groups, pre-group preparation is crucial. A growing body of research has provided support for the potential benefits of pre-group preparation (Rutan & Stone, 2001; Yalom & Leszcz, 2005), as well as for pre-group screening tools (Burlingame, 2005; Horowitz et al., 2000).

As was previously mentioned, gathering information in the FBGT approach before a client begins group therapy is helpful for both the therapist and the client. Pre-group preparation helps the therapist to better understand the client's goals, motivations, and interpersonal style. Pre-group preparation also helps the client in a number of ways. For instance, pre-group preparation: 1) allows the therapist and client to start forming a trusting therapeutic alliance, 2) reduces a client's anxiety and misconceptions about group psychotherapy, and 3) typically provides instruction and other information about the details and expectations regarding group therapy, which fosters goal consensus between the client and therapist (AGPA, 2007). All forms of group treatment report benefits from pre-group preparation (Rutan & Stone, 2001), and pre-group treatment is one important aspect of psychotherapy and research that can help determine how change occurs (AGPA, 2007).

Burlingame, Fuhrman, and Johnson (2002) investigated pre-group preparation and selection. Their findings indicated that pre-group preparation tended to increase the effectiveness of group therapy and improve retention rates, which corroborates previous research. Additionally, Strauss et al. (2008) found that prepared group members tended to be more focused on goals, experienced greater cohesion, demonstrated less anxiety

towards the group, and had more faith in the process. For short-term process groups, it is particularly important to screen well to prevent toxic dynamics from undermining and destroying the group before it has had a chance to begin (Yalom & Leszcz, 2005). This is particularly important for clients with socially uninhibited subtypes because they tend to struggle in group if not prepared beforehand (M. Whittingham, personal communication, August 15, 2012).

The following sections of this report will examine the use of a group screening tool called the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Bauer, Ureno, & Villasenor, 1988; IIP-32, Horowitz et al., 2000), which is an outcome measure in the CORE-R Battery, and the Counseling Center Assessment of Psychological Symptoms (CCAPS; Center for Collegiate Mental Health, 2012). Both of which are used in Focused Brief Group Therapy.

### **CORE-R Battery**

The original CORE battery was used as a pre-group screening tool and was developed by the American Group Psychotherapy Association (AGPA). The combination of instruments included in the CORE battery were used to help AGPA members evaluate intervention effectiveness and to generate some initial perceptions of the clients before they enter group therapy (Strauss, Burlingame, & Bormann, 2006). The CORE-R is useful because it can help group leaders at all phases of group work, including the selection of group members, the assessment of group processes, and the assessment of client outcomes (Strauss et al., 2008).

**Outcome Measures.** One portion of the CORE-R includes five measures that evaluate client outcomes. The CORE-R was created with the intention of being

economical, brief, easy to administer, and sensitive to change issues (Burlingame et al., 2006). The measure that is used in Focused Brief Group Therapy is an abbreviated version of the Inventory of Interpersonal Problems (IIP-32; Horowitz et al., 2000). The IIP-32 is used to assess specific problems in interpersonal behaviors. This measure will be explained in more detail below because it is the primary focus of this study.

### **The Inventory of Interpersonal Problems (IIP)**

As was previously mentioned, The Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Bauer, Ureno, & Villasenor, 1988) is an integral component of this study. The IIP is a 127 item self-report instrument that is used to provide a better understanding of an individual's most distressing interpersonal problems. Of note, Alden, Wiggins and Pincus (1990) created an abbreviated 64 item version of the IIP using the Interpersonal Circumplex model of interpersonal behaviors (Wiggins, 1982), Additionally, a 32 item version of the IIP was created by Soldz, Budman, Demby, and Merry (1995). The IIP-32 typically functions as a screener and consists of various statements describing a range of interpersonal distress (Horowitz et al., 2000).

**Development of the IIP, IIP-64, and IIP-32.** The original IIP instrument (Horowitz, Rosenberg, Bauer, Ureno, & Villasenor, 1988) was generated from a large sample of intake interviews and videotaped therapy sessions and was based on client statements regarding interpersonal problems (Horowitz, 1979). Consequently, the IIP was shaped by the collection of interpersonal problems reported by a large number of clients entering therapy. Approximately 200 interpersonal problems were initially extracted from these various interviews and were often described as interpersonal skill deficits and inhibitions (I can't... It's hard for me to do...) or compulsions (I do ...too

much... I can't stop doing...") (Horowitz et al., 2000). The IIP consisted of the most common complaints that would be presented during the beginning stages of therapy.

The range of interpersonal problems was systematized through a multidimensional scaling procedure that yielded two dimensions. Specifically, there was a control dimension ranging from dominant to submissive and a friendliness dimension ranging from hostile to friendly (pp. 14). Hierarchical grouping of problematic behaviors allowed thematic clusters that "occupy different regions of the interpersonal space" to emerge (pp. 15). The five major themes include intimacy, socializing, assertiveness, compliance, and independence

Items on the IIP were selected by four licensed psychologists. They took 127 statements from the original pool of 200 statements. These items were then organized into two sections. The first section included those statements which contained of the phrase "It is hard for me to..." The second section included those statements which contained the phrase "These are things I do too much." Respondents then rated each statement on a 0 (not at all) to 4 (extremely) Likert scale based on how distressing the problem statement was to them (pp. 16).

**Construction of Circumplex Scales.** Horowitz (1979) administered the 127 items to students and clients demonstrating the validity of the two interpersonal dimensions that had previously been hypothesized by Interpersonal theorists. Subsequently, Alden, Wiggins and Pincus (1990) divided the area of the circumplex into eight octants that can be defined by a combination of the two dimensions discussed earlier (i.e., control and friendliness) and combined aspects of the original sixteen octants from Kiesler's (1982) Interpersonal Circle. Each of the octants had eight corresponding

statements. In other words, there were eight statements in each of the eight octants, totaling to 64 items. This 64-item measure was called the IIP-64. The eight scales (Alden et al., 1990) included: (A) Domineering/Controlling, (B) Vindictive/Self-Centered, (C) Cold/Distant, (D) Socially Inhibited, (E) Nonassertive, (F) Overly Accommodating, (G) Self-Sacrificing, and (H) Needy.

Soldz, Budman, Demby and Merry (1995) recognized the need for a shorter version of the IIP-64. Consequently, the IIP-32 (Horowitz et al., 2000) was created by selecting four items from each of the eight scales. The four items with the highest correlations between item and total scores were selected. The IIP-32 allows for more screening to take place in a smaller amount of time with psychometric properties remaining fairly consistent when compared to the IIP-64. Whittingham utilized the IIP-32 but adapted the label names to create a less pejorative set of labels to discuss with clients. Refer to Figure 1 above for a visual depiction of the new labels.

**Norming and Standardization.** The national standardization sample for the IIP series consisted of 800 cases in the United States that ranged from ages 18-89. One hundred males and 100 females were used in four different age groups: (18-24), (25-44), (45-64), and (65+). Age effects were minimal between different age ranges. However, there was a significant difference between genders, prompting the use of different gender norms for the IIP-32 (Horowitz et al., 2000).

**Reliability and Validity.** Both the IIP-64 and the IIP-32 have high total reliability coefficients, .96 and .93 respectively. They have coefficients ranging from .76 to .88 for the IIP-64 subscales, and reliability ranging from .68 to .87 for the IIP-32 subscales (pp. 25). Test-retest reliability coefficients for both forms of the IIP screeners

are moderately reliable. The IIP-64 and the IIP-32 both have a total test-retest reliability of .78, although the individual subtest scores varied in reliability between tests. The IIP-32 demonstrated correlations that ranged from .88 to .98 for the eight scale scores, which further suggests that the 32 item version provides a comparable estimate of the 64 item version (pp. 28).

To measure the validity of the IIP-64, the standard scale scores on each of the IIP scales were compared with self-report scores of several other instruments. Convergent validity was determined by using a correlation of the IIP standard scale scores with assessment scores of psychological symptomology in non-clinical client samples like those on the Beck Depression Inventory (Beck et al., 1996) and the Beck Anxiety Inventory (Beck & Steer, 1990). Correlations did not differ significantly among these two self-report measures and the IIP-64 measure, more specifically the total correlation between the IIP-64 and the Beck Depression Inventory was .48, while the total correlation between the IIP-64 and the Beck Anxiety Inventory was .44. These results and moderate strength correlations indicate that interpersonal difficulties can “be related to, but not highly predictive of, the psychological symptoms of depression and anxiety” (Horowitz et al., 2000).

The correlation between interpersonal distress and self-report of general functioning was performed by comparing the IIP-64 with the Behavior and Symptom Identification Scale (BASIS-32; Eisen, Dill, & Grob, 1994). The BASIS is a measure of general mental health functioning in psychiatric patients. The eight standard scales of the IIP were correlated with the BASIS scales consisting of: 1) Relation to Self/Others, 2) Depression/Anxiety, 3) Daily Living/ Role Functioning, 4) Impulsive Addictive Behavior

and 5) Psychosis. Across the BASIS scales, the IIP-64 standard scale scores were most highly correlated with the Total score, the Relation to Self/Others, as well as the Psychosis scale, which further support the use of the IIP as a screener for interpersonal difficulties (Horowitz et al., 2000).

**Scale Score Interpretations.** As was previously mentioned, there are 8 separate scale scores in the IIP series of screeners. These scales are useful in providing information on the nature and severity of an individual's interpersonal distress. The Total T score is an indicator of overall interpersonal distress across all 8 problems areas. If the Total T standard score is 2 standard deviations ( $SD= 10$ ) above the mean ( $T=70$ ), the individual's interpersonal distress is considered "very high" relative to the general population sampled. Along with the Total T scores, the IIP also determines Individual-Based T scores for each of the eight scales, which represent the level of distress expressed in a particular interpersonal area rather than a general level of distress across all areas. These scores help the clinician to identify specific areas of difficulty in an individual's interpersonal life. Each of the eight subscale scores help to generate specific interpretations of the client's interpersonal difficulties. Of note, a T score greater than 65 on a given scale is 1.5 standard deviations above the mean. Such scores can indicate areas of interpersonal difficulty for individuals. The following descriptions and interpretations of scales are drawn from Horowitz et al. (2000).

#### **Counseling Center Assessment of Psychological Symptoms (CCAPS-34 and CCAPS-64)**

In addition to the IIP, the CCAPS is another instrument of focus for this study. The original CCAPS assessment instrument was developed by Counseling & Psychology

Services at the University of Michigan (2001) with the rationale of creating a “high-quality, multi-dimensional assessment instrument that was free and clinically useful for college counseling centers (CCMH, 3). The CCAPS was designed for clinical, research, and administrative uses. The CCAPS-62 is a 62-item instrument containing eight subscales related to basic collegial distress areas: Depression, Generalized Anxiety, Social Anxiety, Academic Distress, Eating Concern, Family Distress, Hostility, and Substance Use. Researchers believe that this longer version is best suited for pre- and post- treatment assessment. The 34 item version contains all of the scales of the CCAPS-62 with the absence of Family Distress, and Substance Use becomes Alcohol Use. Analysis of between form reliability of subscales ranges from .92 to .98, suggesting high reliability.

**Normative Sample.** CCAPS instruments are scored compared to a normative sample derived from a clinical setting. The most recent norms studies were conducted for the 2009 iteration of the IIP measures (CCMH, 2010). This sample included a population of college students seeking services at 52 institutions (N=19,247) which were gathered as part of a pilot study. Ages ranged from 18-63 years old, with a mean of 22.6 years (SD= 5.07). Concerning gender, 64.2% of the sample was female, 35.4% were male, and .2% transgender. 72.6% were self-identified Caucasian/white, 7.0% African American, 6.0% Asian/Asian American, 4.9% Hispanic/Latino, 2.5% Other, .5% Native American, and .3% Native Hawaiian. Final normative data suggested 18.1% identified as first-year students, 19.7% as sophomores, 22.1% as juniors, 22.8% as seniors, and 14.9% as graduate students (4).



**Validity and Reliability.** Research suggests considerable support for the use of this measure in college counseling settings. Test-retest reliability, a measure of the expected stability between one administration to another in the same person, is fairly high according to CCAPS coefficients. These results suggest that the two measures assess stable constructs. CCAPS-34 also shows good test-retest reliability (CCMH, 2010).

Both the IIP and the CCAPS have shown utility in measuring quantitative outcome data for treatment in a variety of different settings. The unique combination of these two measures has not yet been utilized in the manner in which they are being utilized for the FBGT group at Wright State University's Counseling and Wellness Services. Clinicians have expanded the use of results beyond merely indicating a change from pre- to post- treatment and to integrating the results into the actual process of psychotherapy in a group setting. Using the results of pre-treatment assessment to actually inform the treatment and goal setting for a given client within a larger group context will likely increase both the efficacy and utility of interpersonal group therapy for those endorsing mental health issues due to interpersonal problems.

### **Rationale and Aim of Study**

Given that socially uninhibited clients can negatively impact the group as a whole, as well as hinder their own progress, it was crucial to build a base of knowledge for this population. Therefore, this program evaluation aimed to test the effectiveness of FBGT for clients with scale 8 profiles across a number of domains as measured by the IIP and the CCAPS. Additionally, this study aimed to examine the impact of inoculation on clients with scale 8 profiles to determine if pre-group preparation can help clients with socially uninhibited styles succeed in group therapy.

## **Chapter 3**

### **Method**

#### **Participants**

This study focused on clients who demonstrated an elevated score ( $T \geq 65$ ) on Scale 8 of the IIP-32 prior to entering FBGT at a Midwestern university ( $N=10$ ).

#### **Delimitations**

The IIP manual suggests that while T-scores  $\geq 70$  can indicate “very high” distress, T-scores  $\geq 65$  can also indicate areas of interpersonal difficulty for individuals. Given the small sample size of this study, the cut-off score for clients to be included was  $T \geq 65$ . Additionally, clients were selected based on scale 8 being their first or second highest scale. This was done to ensure that the targeted interpersonal distress area for each client was consistent with scale 8 symptom and goals.

#### **Procedure**

Pre-existing IIP-32 data was gathered and downloaded by the director of the Counseling and Wellness Services at Wright State University. Initial determination of what constituted an elevated Scale 8 profile was completed by this researcher and the dissertation chair, who is an expert on implementation of IIP-32. Once this population was determined, several scores were collected both pre and post scores. More specifically, the IIP-32 Scale 8 and Total Interpersonal Distress scores, along with the CCAPS scores of Depression, Generalized Anxiety, and Hostility were collected.

Demographic variables were also collected from pre-existing and de-identified data stored on the Counseling and Wellness Services site.

IIP-32 pre and post treatment raw scores, along with the scores from the various CCAPS domains pre and post treatment (which were listed as z-scores), were transformed into T-scores using the formula  $(z*10)+50=t$ . Total population pre and post scores were further analyzed by each domain utilizing Paired Samples T-Tests. Additionally, the Bonferroni correction was performed to reduce the chance of obtaining false-positive results (i.e., type I errors) since multiple pair wise tests were performed on a single set of data.

Then, individual client's scores were placed in a table where the presence of significant positive or negative change (i.e. statistical significant decrease) was visually transformed into a table. Significant change on individual results of the IIP and CCAPS data was determined by Reliable Change Index (RCI; Jacobson & Truax, 1991). This method is a commonly used calculation of change significance, which determines the difference between a participant's pre-treatment and post-treatment scores, divided by the standard error of the difference. This calculation yields cutoff scores, which places participants into categories of change: Significant Negative Change, Significant Positive Change, and No Significant Change. The Reliable Change Index table allowed this researcher to visualize any patterns or tendencies present across the results and participants.

## **Materials**

The materials used for this research included de-identified archival data for each participant who fit the Scale 8 pre-determined IIP-32 profile. Instruments included the

Inventory of Interpersonal Problems (IIP-32) and the Counseling Center Assessment of Psychological Symptoms (CCAPS), both of which were previously discussed in great detail.

### **Hypotheses**

The null hypotheses were as follows: there will be no difference on the total interpersonal distress scale on the IIP, as well as no difference on scale 8 on the IIP or on the depression scale on the CCAPS.

## Chapter 4

### Results

#### Population Demographics

Table 1 reports the demographics of the participants in this study. There were 10 participants included in this study. The majority of participants were Caucasian (90%), and there were more female participants (70%) than male (30%). Ages ranged from 20 to 25 years old, and the sample consisted of a majority of heterosexual participants (80%).

Table 1

#### *Demographic Description of Population*

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Characteristic	Frequency	%
Age		
20	2	20
21	1	10
22	1	10
23	3	30
24	1	10
25	2	20
Ethnicity		
Caucasian	9	90
African American	1	10
Gender		
Male	3	30
Female	7	70
Sexual Orientation		
Heterosexual	8	80
Gay/Lesbian	2	20

## Statistical Analysis

In order to analyze the efficacy of Focused Brief Group Therapy for individuals who demonstrated elevated Scale 8 scores on the IIP-32, paired-sample t tests were conducted. It was hypothesized that there would be statistically significant decreases on Scale 8 and Total Interpersonal Distress on the IIP-32, as well as a statistically significant decrease on Depression on the CCAPS (main hypotheses).

For Scale 8 on the IIP-32, there were no significant outcomes on the first analysis. Upon closer review, it was observed that one client had multiple scale elevations with T-scores  $>80$  and a considerably high Total Interpersonal Distress score ( $T > 85$ ). When this client was excluded, results revealed a statistically significant decrease on Scale 8 and Total Interpersonal Distress. Results did not yield any significant outcomes on the CCAPS. See Table 2 for a visual representation of the results of the paired sample t-tests. See the Discussion section for more detail regarding the outlier.

Cabin & Mitchell (2000) suggested that tests for the statistical significance can be biased in that some results are considered "significant" (i.e., the null hypothesis is rejected when it is actually true or a Type I error) when the results really are not significant. Thus, the Bonferroni correction was performed on this data set. Results revealed that Scale 8 of the IIP was still significant even with the more conservative Bonferroni significance level (.017). In addition to reporting statistical significance, the effect size or measure of strength was calculated with Cohen's D. Scale 8 and the Total Interpersonal Distress scale demonstrated large effect sizes (0.88 and 0.89) respectively.

Table 2

*Results of Paired Sample T-Tests*

Scale	Mean	N	SD	t	df	p<.05	Effect Size
<i>Scale 8</i>							
Pre	77.00	10	8.420				
Post	66.50	10	15.601	3.579	9	.006*	.088*
<i>Total Distress</i>							
Pre	65.40	10	8.262				
Post	58.00	10	8.287	2.570	9	.030*	.089*
<i>Depression</i>							
Pre	50.54	10	9.185				
Post	47.64	10	6.849	.740	9	.478	
<i>General Anxiety</i>							
Pre	49.71	10	9.599				
Post	50.52	10	7.532	-.207	9	.841	
<i>Hostility</i>							
Pre	52.05	10	9.264				
Post	46.43	10	6.520	1.422	9	.189	

*Note:* Statistical significance and large effect sizes are denoted by \*

Furthermore, reliable change index scores (Jacobsen & Truax, 1991) were calculated to measure clinically significant change among all clients when compared to their treatment group. Results indicated that more than half of the clients experienced

significant improvement on their scale 8 scores, as well as their total interpersonal distress scores. See Table 3 for a visual representation of the reliable change index scores.

Table 3

*Reliable Change Index Scores*

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Scale	Significant Negative Change	No Significant Change	Significant Positive Change
Scale 8	0	4	6
Total Distress	2	1	7
Depression	1	8	1
General Anxiety	1	8	1
Hostility	1	6	3

---

**Limitations**

This study was conducted at the outset of a new and growing data set. In light of this, the sample size was small (N = 10). This study consisted of primarily white, heterosexual women between the ages of 20-25, and therefore is limited in its diversity representation. Additionally, this research took place in one college counseling center so results may not be generalizable to other centers and settings. Finally, diagnostic information and additional modes of treatment were not available for clients in this study. These limitations will be discussed in more detail in the discussion section.



## **Chapter 5**

### **Discussion**

#### **Main Findings and Clinical Implications**

This pilot study aimed to study a group of clients that have been understudied thus far. This was one of the first studies to examine the intrusive scale 8 interpersonal subtype in a group setting. While intrusive and histrionic styles can be challenging in group settings, the results of this study suggest that with pre-group preparation, clients with scale 8 elevations can have positive outcomes in group therapy. Perhaps the most important point is that clients with scale 8 should not automatically be excluded from group therapy but rather a thoughtful and thorough assessment should occur between the clinician and the client. For example, a client with a pure scale 8 elevation and a mild to moderate total interpersonal distress score may be a fit for group, while a client with multiple scale elevations and a considerably high total interpersonal distress score may not be ready or able to join the group as a productive member. This pilot study indicates that having a hard and fast rule for these clients may not be the most beneficial approach for clients or the group as a whole. Thus, it is crucial to be flexible, thoughtful, and culturally-sensitive when deciding whether to include or exclude these clients in group settings.

One way to highlight the above point is to discuss the outlier in this study. Upon closer review of the data, it was observed that one client had an “exploded” profile with

characteristics that could be skewing the results. The outlier in this study demonstrated multiple scale elevations with T-scores  $> 80$  and a considerably high Total Interpersonal Distress score ( $T > 85$ ). It became clear that this client did not fit a pure scale 8 profile and was in so much distress across a number of domains that it was difficult to pinpoint what the target area of distress actually was for this client. Additionally, this client's total interpersonal distress score ( $T > 85$ ) echoes Yalom & Leszcz's (2005) point that sometimes when a client is in too much distress the client may not be able to participate in the group effectively. Furthermore, this study demonstrates that clinicians should consider client's overall interpersonal distress levels, as well as their individual scale scores, to determine if a group referral is appropriate. Clients with an exploded profile may need to engage in individual therapy first to decrease their overall interpersonal distress and to learn the skills they need to successfully function in a group environment. Research has shown that when distress levels are considerably high, such as in the case of the exploded profile, it can be helpful for clients to participate simultaneously in both group and individual therapy, which stimulates growth in complementary ways (AGPA, 2007; Yalom & Leszcz, 2005).

As Whittingham et al. (2013) previously described, it can be helpful to inoculate clients who present with the socially uninhibited subtype. While it was beyond the scope of this study to analyze data prior to implementing inoculation, previous clinical observations indicated that clients with scale 8 elevations struggled to succeed in group when not prepared. In fact, after previous treatment failures with this population, inoculation became an integral component of FBGT. Given that the mechanism of change was in the expected direction (i.e., decrease in interpersonal distress scores and

scale 8 scores) and given that FBGT specifically targets interpersonal distress and includes inoculation, the results of this study indicate that Focused Brief Group Therapy produced positive outcomes for clients with scale 8 profiles. It is possible that inoculation may help prepare clients with scale 8 profiles who have typically struggled in group settings.

McAleavey et al. (2012) discussed the challenges of discriminating between clinical and non-clinical populations when using the CCAPS in college counseling centers. For example, McAleavey et al. (2012) described that the cut off scores on the CCAPS that are frequently used in counseling psychology may not profitably be applied to such broad groups as “clinical” and “nonclinical.” However, they pointed out that the depression cut off score may usefully be applied in research and clinical settings. Given that CCAPS depression scores can be an indicator of global functioning, it was hypothesized that this pilot study would demonstrate significant decreases in clients’ depression scores. Interestingly, clients in this study did not demonstrate elevated depression scores when compared to the cut score for college populations. In fact, their depression scores were all within one standard deviation of the mean. Additionally, their other CCAPS scores (e.g., hostility and general anxiety) were within one standard deviation of the mean as well. It is possible that scale 8 elevations in clients with intrusive and histrionic styles may not be accompanied by elevated depression or anxiety scores. Thus, if a clinician is looking for these clients’ CCAPS scores to be elevated, she/he may miss out on the client’s distress. The IIP may be more sensitive at detecting the interpersonal distress that clients with intrusive and histrionic styles experience.

Reliable change index scores (Jacobsen & Truax, 1991) were calculated to

measure clinically significant change among all clients when compared to their treatment group. The indexes were used in this study to assess change on a more individual level for each client. Results indicated that more than half of the clients in this study experienced a significant improvement on their scale 8 scores, as well as their total interpersonal distress scores. Interestingly, the two clients whose total distress scores increased after FBGT demonstrated no significant changes on their scale 8 scores. This may suggest that these clients struggled to achieve their target goal of reducing their scale 8 symptoms, which could have contributed to an increase in their overall interpersonal distress. In a group therapy setting, clients can more easily compare their progress or lack of progress to their peers, which may create more distress if progress is not being made.

As was previously mentioned, the clients in this study were primarily white, heterosexual, able-bodied women. Therefore, the elevated 8 profile that is mentioned in this study may conflict with clients from different backgrounds, and cultural sensitivity should be used when interpreting results. For example, some cultures may view being very open, sharing information quickly, and reaching out to show physical affection as positive qualities, whereas another culture may experience these same qualities as overwhelming or intrusive. Thus, clinicians should carefully consider a client's values and world views when interpreting results and setting goals with clients for group therapy since interpersonal styles are intricately related to cultural backgrounds and contextual variables (Teyber & Holmes-McClure, 2011).

In conclusion, the results of this study underscore that clients with Scale 8 elevations generally improved after engaging in Focused Brief Group Therapy, as was evidenced by a statistically significant decrease in their scale 8 and total interpersonal

distress scores. Even with the more conservative Bonferroni correction, scale 8 improvements were still significant. In addition, both Scale 8 and Total Interpersonal Distress scores demonstrated large effect sizes. Overall, clients who engaged in Focused Brief Group Therapy demonstrated significant improvements on their scale 8 scores, which is indicative that group therapy can be an effective modality for this population. For clinicians who have conducted a group with scale 8 clients, it may seem as if these clients may need to be excluded because they can significantly disrupt the group and seem unlikely to benefit (from) the group. However, this pilot study indicates that these clients have the potential to benefit from group therapy with inoculation and pre-group preparation.

### **Future Research Directions**

Based on the detailed discussion above, the following are suggestions for future research directions. First, given the outlier in the study, which raised the question of multiple scale elevations and significant total interpersonal distress future, research should include larger samples in which t-score ranges are more closely examined. For example, are there optimal t-score ranges (e.g.,  $t = 65$  to  $75$ ) that make clients most amenable to positive group experiences? These questions reflect Yalom and Leszcz's (2005) discussion on distress level and determining when it is so high that it actually impedes group success.

Second, future research should replicate studies that further explore the impact of pre-group preparation and inoculation for clients with scale 8 elevations. In doing so, it may help build further support for the utility of inoculating and preparing a subset of clients who often struggle in group settings, as well as further clarify the inoculation

process. For example, what is helpful to provide clients with in group screenings? How much pre-group preparation is needed?

Third, future research should aim to link diagnostic information with clients who demonstrate scale 8 profiles to achieve greater specificity in that problem area. In other words, how are they initially in distress (e.g., depression, anxiety, substance use)? In light of the results, future research should collect diagnostic information for clients with scale 8 elevations to identify which instruments can more provide sensitivity to change for this population. Further, future research should examine the efficacy of group therapy alone and group therapy combined with individual therapy or psychiatry to optimize treatment.

Given that interpersonal behaviors and norms are intricately related to clients' cultural backgrounds, future research should investigate scale 8 elevations in a more diverse sample of students to compare outcome and patterns. Future research should include clients from various backgrounds, including but not limited to race, ethnicity, age, gender, disability status, sexual orientation, geographic region, spirituality, and SES.

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