RELATING THEORY — CLINICAL AND FORENSIC APPLICATIONS

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Relating Theory – Clinical and Forensic Applications

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palgrave
macmillan

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ISBN 978-1-137-50458-6 ISBN 978-1-137-50459-3 (eBook)
DOI 10.1057/978-1-137-50459-3

Library of Congress Control Number: 2016938054

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Foreword

Back in the 1980s John Birtchnell and I worked together in the then MRC Social Psychiatry Unit at the Institute of Psychiatry in London. Social psychiatry had been an exciting and even innovative area to be involved in from the 1960s onwards, but then the great tsunami of neuroscience and neuro-everything swept through, wiping out anything that stood in its way. However, the things that are good are resilient enough to withstand even a neuroscience tsunami and there are many of the questions and issues that formed the bedrock of the social approaches to mental health back then that have survived and even resurfaced in modern consideration.

One of the outstanding areas that must continue to engage anybody involved in mental health concerns issues of the social context in which those mental health problems occur. Timothy Leary, who became the bad boy of psychology because of his drug studies in the 1960s, had earlier proposed an interpersonal circumplex model of human relating, but Leary's distractions led many to forget his more important earlier work. Birtchnell took the circumplex model and redesigned it to consider Upper and Lower ways of relating in addition to Distant and Close. He developed the Person's Relating to Others Questionnaire as a novel method of assessing a person's interpersonal style and this measure has now travelled through the generations and emerged both in new and shorter forms, in addition to having been applied in a variety of different

client groups and cross-cultural populations. As a measure of Birtchnell's innovativeness with the approach, therapeutic interventions have since been developed based on the person's relating to others style.

This volume is a fitting testament to Birtchnell's lasting contribution to the formulation and assessment of close relationships in illness and in health. The volume demonstrates how the issues around social relationships will always be important in our understanding of health and well-being, whatever other area might have become temporarily fashionable in the meantime.

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Preface

Relating is a central feature of human behaviour. In thinking about this John Birtchnell attempted to define its principal components and develop instruments to measure an individual's relating style. Since the publication of his book *How Humans Relate: A New Interpersonal Theory* in 1993, a number of clinicians and researchers have taken an interest in Relating Theory (Birtchnell 1993/1996), used the measures that are based upon it, or made modifications of existing measures for specific purposes. Another two books were published by 2003 on the topic of Relating Theory and this theory has now been adopted and applied by a number of academics, researchers, and clinicians in diverse settings. In 2012 John Birtchnell was delighted and honoured to host a half day conference at the Institute of Psychiatry, London, bringing together speakers from several countries who had in common the application of his theory and instruments. It was during this fertile exchange of ideas and perspectives that the seeds of the idea to produce a book capturing the breadth of the possible applications of Relating Theory were first planted. This is that book.

Some of the chapters have been written by John Birtchnell and his co-editors, who have done much work on Relating Theory, but several others have been written by other scholars who have used and worked with the theory. This would seem to be highly appropriate since the main objective of the book is to reveal the usefulness of the theory in a range

of diverse settings. Indeed, the book brings together the recent research developments on Relating Theory from a variety of cultures and contexts. In addition, it covers a wide variety of research involving both quantitative and qualitative methods. The contributors are eminent therapists and/or academics in their field and through their writings demonstrate their expertise in various topics such as the application of Relating Theory to couple therapy, and the treatment of patients with schizophrenia and of offenders with intellectual disabilities and personality disorder in secure hospitals, as well as many others.

The book is divided into four parts which are interwoven and inextricable: the first part introduces Relating Theory, the second part the instruments developed from the theory and the third and fourth parts the application of the theory and measures to two areas of interest – clinical and forensic psychology, respectively. Initially it was considered appropriate to locate the chapters concerning the measures in either the clinical or forensic section depending on the research area in which they were developed but then we decided that it would be more appropriate to include the instruments together in one section before presenting their application to real-life clinical and forensic contexts. This decision was made because, firstly all of the measures can and have been applied in either a clinical or forensic context or in various contexts, and secondly, they comprise the means to conduct research and so, in a way, the development of a measure actually constitutes the application of the theory. It is hoped that researchers and academics will be inspired to apply the measures in other areas too and/or to modify them to make them suitable for their research purposes.

Specifically, Part I of the book includes an introductory chapter to Relating Theory (Chap. 1) and the comparison of the fundamental theoretical structure of relating theory, that is the interpersonal octagon, with Leary's well known interpersonal circle (Chap. 2). Part II presents the measures of relating and interrelating developed from Relating Theory, including the first measure of negative relating (Chap. 3), and an evaluation of its psychometric viability (Chap. 4). Following this, two measures of interrelating are presented (Chaps. 5 and 6) before describing a new measure of interrelating between young adults and their parents (Chap. 7). Chapter 8 reports a measure designed to assess parental

relating retrospectively from the child's perspective and Chapter 9 presents two measures for assessing observers' perceptions of other people's relating – a checklist and an interview. Following this, a modification of the Person's Relating to Others Questionnaire (PROQ) for use in the workplace is outlined (Chap. 10). Part II of the book ends with Chapter 11 which describes the development and related research of a new measure based on positive psychology.

Part III of the book refers to the applications of Relating Theory to Clinical Psychology. Six chapters are included: Relating Therapy is first introduced (Chap. 12) and a presentation of how psychotherapy can improve relating follows (Chap. 13). The use of an interrelating measure in romantic couple/relationship therapy is presented in Chapter 14, and Chapter 15 provides a fascinating account of how relating theory can be applied to clinical work with schizophrenic patients. Chapter 16 introduces how relating theory can be applied to highlight relational patterns in group therapy, and finally, Chapter 17 outlines empirical and research findings on how psychotherapy can improve interrelating.

The final part of the book (Part IV) reports the applications of Relating Theory to Forensic Psychology. Six chapters are included, all of which present findings from empirical research. Chapter 18 introduces the relating tendencies of offenders convicted of different crimes, and Chapter 19 reveals that negative interpersonal relating is associated with risk taking behaviour and alcohol use in young adults. Following this, two chapters present the associations of negative relating with psychopathic personality traits (Chap. 20) and sadistic behaviours (Chap. 21). In Chapter 22 a new oral version of the PROQ for use with prisoners with a low level of intellectual ability and personality disorder is described. The final chapter of Part IV (Chap. 23) discusses how offenders demonstrate improvements in relating following treatment in a therapeutic community prison. The book concludes with the ultimate chapter, Chapter 24, written by the Editors, which posits further directions for research on relating theory and practice.

We believe that the book, despite its possible omissions, covers a wide range of topics on interpersonal relating. For this reason, it should be of interest to clinicians/practitioners, academics, and both undergraduate and postgraduate students in the fields of psychology, clinical psychology,

forensic/criminal psychology, psychiatry, psychotherapy, counselling, art therapy, and mental health.

Despite the undoubted proliferation of Leary's interpersonal circle and associated measures, Relating Theory seems to have expanded in recent years and has established its own place in the interpersonal literature. We hope that this book will enrich the relevant literature, and encourage the application of Relating Theory to other areas both in research and applied settings.

Finally, we are especially indebted to the authors who contributed their research and clinical expertise to this volume, without whom, this work would not have been possible. We would also like to express our gratitude to Nicola Jones, Publisher for Psychology at Palgrave Macmillan and Eleanor Christie, our Editorial Assistant, who helped us patiently through the process of producing this volume. Last but not least, we would like to thank our partners and family for their support in completing this endeavour.

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John Birtchnell trained in medicine at the University of Edinburgh and worked as a Consultant Psychiatrist at the Maudsley Hospital, London. He is a Fellow of the Royal College of Psychiatrists (FRCPsych), a Fellow of the British Psychological Society (FBPsS), Psychotherapist (Dip Psychotherapy, University of Aberdeen), and an Honorary Member of the British Association of Art Therapists. For over 20 years he was Scientific Officer of the Medical Research Council, working with Dr Peter Sainsbury in Graylingwell Hospital, Chichester, and subsequently under Professor John Wing at the Institute of Psychiatry, King's College London. He has published extensively in the psychiatric literature including three previous books on relating theory, and was editor of the

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Marion Brown is a group analyst with more than 30 years' experience of working in the National Health Service (NHS), UK as a Consultant Psychotherapist, Group Analyst and Clinical Manager of a large psychological service within a Mental Health Setting, Head of Psychotherapy for a county-wide psychotherapy service and has managed an eating disorder service. She was one of the originators and clinical directors of a three-county personality disorder service. Marion has extensive experience of supervising and lecturing both within and outside of the NHS and was Head of Training for a Counselling Organisation. Marion is now working as a part-time freelance consultant, is a National Supervisor for a country-wide psychological prison service (PIPE) and is currently Chair of the Institute of Group Analysis.

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Lydia de Haan obtained her Bachelor degree in Biology with a focus on genetics and behaviour and minor in neuropsychology, and her MSc in Cognitive Neuroscience from Utrecht University, the Netherlands. During her studies she has gained experience with gene, animal, and human research. Her PhD research developed a new instrument that assesses risk-taking behaviour in adolescents and young adults. Her research interests are neuroscience, behaviour, personality, methodology, psychometrics, clinimetrics, translational research, and valorisation of research.

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Joannis Nestoros is Professor of Clinical Psychology at the University of Crete and since 2005 the Scientific Director of Synchronal Amphiaraia, an institution devoted to integrating ancient and modern psychotherapeutic approaches with the neurosciences and with Greek philosophy and culture. He completed his Residency in Psychiatry and PhD in Neurophysiology at McGill University, Montreal, Canada. He was the first Chairman of the first Department of Psychology in Greece in Crete and the Director of Postgraduate Training in Clinical Psychology at the University of Crete. He has authored many peer-reviewed journal articles and book chapters, as well as books including a textbook on psychotherapy in English (co-edited with P. J. Hawkins) which has been translated into Chinese, Russian, and Uzbek. He specialises in the treatment of schizophrenia.

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Theodora Seliniotaki graduated from the Psychology Department at the University of Crete and has been recently accepted onto the postgraduate programme entitled 'Stress and Health Promotion' at the Medical School of the National and Kapodistrian University of Athens. Her undergraduate thesis, entitled 'The Neuroscientific Substrate of Psychotherapy', was supervised by Professor Joannis Nestoros and was presented at the 15th Panhellenic Conference of Psychological Research at the University of Cyprus in May 2015. She has published a scientific article in the refereed *Hellenic Journal of Nuclear Medicine* on pharmacotherapy research concerning Alzheimer's disease. Her research interests concern the neurophysiology of the human brain and the changes produced by mental states, psychiatric disorders, psychotherapy, and pharmacotherapy.

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Anastasia Vergoti graduated from the Department of Psychology at the University of Crete, having Professor Joannis Nestoros as her supervisor. Her thesis was entitled 'Schizophrenia and psychotherapy' and its short version was accepted for publication as an article in the refereed Greek scientific journal *Tetradia Psychiatrikis*. She is carrying out her practicum at Attica Psychiatric Hospital working with psychotic (mostly schizophrenic) patients. Moreover she is in training for Integrative Psychotherapy in the programme offered by the Greek Institution Synchronal Amphiaraia. At the 15th Panhellenic Conference of Psychological Research at the University of Cyprus in May 2015 she presented a paper on the content analysis of a psychotherapeutic session with a patient suffering from schizoaffective disorder. She is interested in the forensic aspects of schizophrenia.

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Part I

Introduction to Relating Theory

1

What Is Relating Theory?

John Birtchnell

Introduction

My relating theory, previously called spatial theory, began to take shape in the late 1980s. At that time I had conversations with both the established attachment theorist John Bowlby and the researcher John Wing. John Bowlby had proposed the dimension of attachment versus detachment and John Wing had proposed the dimension of dependence versus independence. Bowlby was opposed to Wing's concept of dependence, but I could see the value of both these classificatory systems. However, I preferred to compress the terminology of relating behaviour even further into the simple terms of 'close versus distant' (on the horizontal axis) and 'upper versus lower' (on the vertical axis). This had the effect of organising a person's relating behaviour within a spatial framework so that the concept of people relating across space became central to my conceptualisation of how people relate to others and are related to by others, and this system began to be recognised by others in the 1990s. In 1991,

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_1

Professor Russell Gardner wrote, 'Dr Birtchnell's spatial schema has considerable potential for analysing data on interpersonal relationships' and in 1993 Professor Aaron Beck wrote an endorsement for the cover of my book *How Humans Relate*: *A New Interpersonal Theory* (Praeger) which stated 'I am convinced that John Birtchnell is on to something important in terms of his vertical and horizontal axes.' A number of other distinguished academics such as Professor Paul Gilbert also commended my theory in the foreword of the aforementioned book, and others (Trent 1994; Reichelt 1994) provided excellent reviews of it.

It was Maurice Lorr (personal communication 1987) who first brought to my attention the resemblance of my relating theory to interpersonal theory, a theory which he himself had helped to develop (Lorr and McNair 1963), and I have since sought to explain the similarities and differences between my theory and interpersonal theory (Birtchnell 1990, 1994, 2014; Birtchnell and Shine 2000; see also Chap. 2 of this volume).

I am not the only person to think in terms of the horizontal and the vertical axes. Hartup (1989) observed that vertical relationships emerge during the first year of life and provide protection by the parent for the infant. Horizontal relationships are essentially child–child relationships and are evident only in rudimentary form until about the third year of life. Thereafter they are increasingly common.

Relating theory is fully described in my three books on this topic: *How Humans Relate*: *A New Interpersonal Theory*, *Relating in Psychotherapy*: *The Application of a New Theory and The Two of Me*: *The Relational Outer Me and the Emotional Inner Me* (Birtchnell 1993/1996, 1999/2002, 2003, respectively). The present chapter is an updated summary of the theory. Because it is preoccupied with the interactions that occur between people across space, and because it is constructed around the vertical and the horizontal axes which intersect each other, it is sometimes referred to as spatial theory. However involved people may become with each other, each person will always remain a separate individual. We sometimes use terms such as 'I feel close to you' or 'you feel distant from me' or 'I look up to you' or 'You look down upon me', suggesting that, at some level, people quite often actually do experience relating in spatial terms. An important point to be made at this juncture is that each of the two axes serves

a separate set of functions: the horizontal one is concerned with degrees of involvement or separation and the poles are called Closeness (becoming close to others) and Distance (moving further away from others), respectively. The vertical one is concerned with whether the person relates from an upper position (a position of dominance) downwards or from a lower position (of submission) upwards and the poles are called Upperness and Lowerness, respectively. It is quite possible to straddle both the vertical and the horizontal dimensions, which is the basis of the four intermediate positions of upper close, lower close, upper distant, and lower distant. Since relating covers the broad range of attitudes, postures, behaviours, and interactions which occur between people, the main objective of relating theory is the simplification, definition, classification, and quantification of the processes that are involved in the relating process, by breaking them down into the four spatial components and the four intermediate positions noted above. Together, these components are referred to as the eight 'states of relatedness', which are represented by the spatial structure that is called the *Interpersonal Octagon* (Birtchnell 1994).

Whilst animals can and sometimes do relate to each other (Shapiro 2010), it can be argued that humans relate to an even greater extent and in more complex ways. Animals sometimes relate to humans and sometimes humans relate to animals. Certain people relate in certain ways under certain circumstances. Lovers, friends, neighbours, members of the same family, and colleagues at work are inclined to be close. People who enjoy their own company or work in isolation are inclined to be distant. Leaders, managers, organisers, helpers, doctors, nurses, teachers, and parents are inclined to be upper. Children, pupils, patients, employees, and people seeking advice or help are inclined to be lower. Ideally people should be capable of relating in the appropriate manner according to the task that is in hand. There can also be times when a person can feel close, distant, upper, or lower in relation to the same person. Furthermore, a person may not like certain aspects of a particular person that he/she may otherwise feel close to. Relating does not necessarily take place in the here and now; we have internal images of people to whom we can or do relate. Internally a person can be aware of having a particular relationship with a certain other person or with certain other people. Humans also relate

to God. Longing to meet with someone or dreading meeting someone are features of relating. We can even relate to the people who feature in our dreams.

A person who is capable of being either close or distant, or upper or lower, as and when it seems appropriate to be so, is referred to as being versatile; though being versatile does not necessarily mean consistently relating positively since all forms of relating are necessary for one to function as a confident and competent human being. Relating Theory is also concerned with the distinction that should be drawn between the directive, active form of relating (i.e. relating to another person), and the receptive, passive form of relating (i.e. being related to by another person – see 'Being related to' and 'Interrelating' below). All of this applies to each one of the eight relating positions of the Interpersonal Octagon in either positive or negative forms (see next section).

Positive and Negative Relating

An important feature of Relating Theory is that there are desirable and undesirable forms of each of the eight positions of the octagon. Thus, the theory distinguishes between the more pleasurable, friendly, constructive, and advantageous features of each form of relating – which are called positive – and the more unfriendly, less than pleasurable, more disadvantageous, and more destructive forms, which are called negative (i.e. selfish, clumsy, and offensive relating). The difference between positive and negative versions of each form of relating are a central feature of this book since most relating theorists do not pay sufficient attention to defining the difference between positive relating and negative relating. Positive relating is that which does not harm, disturb, or upset the person being related to. The positive relater pays attention to the possible effect that his/her relating might be having upon the person being related to and may modify what he/she says or how he/she says it in order not to be offensive. There are of course disturbing things that one person may have to say to another, such as 'You have a serious illness', although there are sensitive and insensitive ways of saying such things. An important aspect of Relating Theory, however, is that all states of relatedness are

advantageous ways of relating under certain circumstances. For instance, seemingly 'negative' distant relating offers the relater the opportunity to be distant from others and appreciate privacy, whereas seemingly 'negative' lower relating offers the relater the opportunity to be guided, advised, protected, and cared for (see next section).

Classes of Positive and Negative Relating

Positive closeness is pleasurable involvement with another person, such that both partners experience it as something they both want and enjoy. Negative closeness is the anxious clinging of one person to another for fear that the relationship will break up, or the imposing of closeness upon another person who does not particularly want it. Positive distance is enjoying one's own company and negative distance is feeling ignored or rejected by others. Positive upperness is leading, teaching, helping, or caring for another person and negative upperness is dominating, suppressing, threatening, or imposing one's will upon another person. There are also positive and negative versions of the four intermediate positions of upper close, lower close, upper distant, and lower distant, which have been described in detail elsewhere (Birtchnell 1993/1996). Therefore, there is a positive octagon that is made up of all of the positive positions of each octant and a negative octagon that is made up of all the negative positions of each octant (see Fig. 1.1). The positive forms are all secure and constructive and the negative forms are all insecure and destructive.

Negative relating refers to relating incompetence. Since people need to relate in order to attain desirable states of relatedness, even if they cannot relate competently to attain them they will relate incompetently to do so. The three main forms of negative relating are called Avoidant, Insecure, and Desperate. In avoidant relating, the person is so frightened of a particular state of relatedness that he/she clings desperately to the opposite state. Thus a person who is frightened of closeness clings to distance. Insecure relating means that the person tries to attain or maintain a particular state of relatedness but is constantly afraid that he/she is going to lose it. Thus an insecurely upper person is constantly trying to put other people down so as not to be dislodged from his/her position of

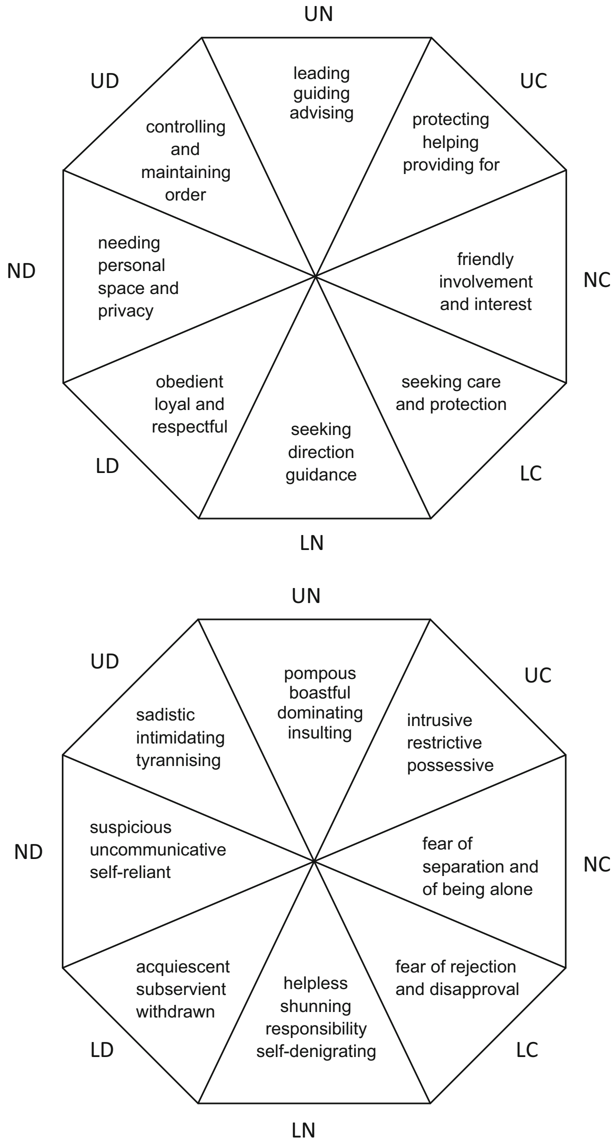

Fig. 1.1 The interpersonal octagon. *Note*: Positive (*upper diagram*) and negative (*lower diagram*) forms of relating. The pairs of initial letters are abbreviations for the full names of the octants given in the text. *Source*: Birtchnell (1994). Reproduced with permission from SAGE Publications

upperness. Desperate relating means that the person will do anything to attain or maintain a particular state of relatedness, irrespective of what it does to the other person. Thus a desperately close relater will impose his/her closeness upon another even if it is not welcome. A desperately lower person will plead and beg and feign helplessness in order to get others to relate downwards to him/her. The measures of relating (see Chaps. 3–10 of this volume) are predominantly measures of negative relating.

Since the main objective of Relating Theory is to provide a theoretical framework within which a person's relating behaviour can be defined and classified, this can be of particular value in assessing and defining the deficiencies and charting the progress of patients receiving various forms of psychotherapy. A measure of a person's acknowledged negative relating tendencies towards people in general for each of the eight positions of the octagon is called the Person's Relating to Others Questionnaire (the PROQ; Birtchnell et al. 1992; Birtchnell and Evans 2004; Birtchnell et al. 2013), which are fully described later in this volume (see Chaps. 3 and 4). It is scored by computer software and the scores can be represented both numerically and graphically.

The Outer Me and the Inner Me

Relating is a natural process which, once learned, happens quite spontaneously and without thinking, by way of the 'inner me' (Birtchnell 2003); though it can also be more carefully and deliberately thought out, by way of the 'outer me'. These are roughly the same as what in psychoanalytic terms have been called the conscious mind and the unconscious mind (e.g. Fonagy and Target 2003; Freud 1915; Sandler et al. 1999). The *outer me* is that which has to be deliberately thought out and consciously planned and executed, and the *inner me*, which while at an earlier stage would have had to have been consciously and deliberately thought out and planned, happens quite spontaneously and automatically, without the intervention of any deliberate thought or action. The same would appear to be the case with relating. Although we sometimes do consciously think out how, in any given situation, we should relate (by way of the outer me), the greater part of our relating behaviour would

appear to happen quite automatically and spontaneously (by way of the inner me). Of course it is always possible for us to notice that, in certain situations, we are not relating as effectively as we ought to be. Under such circumstances it is possible for us to consciously intervene (by way of the outer me) and modify our relating behaviour, either alone or, more probably, with the assistance of a therapist.

I have concluded (Birtchnell 2003) that the 'inner me' would need to be capable of conceptualising each state of relatedness, knowing what it feels like, wanting it, and wanting more of it. It should also be capable of recognising whether it has been attained or lost so that it can evoke the appropriate emotional responses of pleasure when it has been attained and displeasure when it has been lost.

Learning How to Relate

It is important to remember that people are not born with the ability to relate in any one of the eight positions. Whilst I believe that we are born with innate dispositions to the four states of relatedness, we need, during the course of maturation, to develop competence in attaining and maintaining each of them and this has to be acquired during the early years of life. Attachment theory posits that the way a mother interacts with her baby in the first year of life is strongly related to how the child behaves later on (Costello 2013; Lahey et al. 2008).

Interestingly, parents do not consciously train their children to relate in any one of the eight positions of the octagon. The children somehow simply pick up the various forms of relating behaviour, perhaps by watching, copying, or identifying with others. Certainly this is what Bandura's (1977) social learning theory would advocate. This may happen quite automatically and they may not be aware that it is happening. On the other hand, consistent with the behaviourist perspective, in particular operant conditioning (e.g. Skinner 1938), if they have had unpleasant experiences of a particular relating position then they may be inclined to avoid it in the future.

Before people are able to relate confidently in any particular position they need to have had good experiences of that position. In his book *Attachment*, Bowlby (1969) described how the mother needs to be

encouraging, supportive, and welcoming of the child before it feels confident enough to enter into a close relationship. Main et al. (1985) cited Ainsworth's 'Strange Situation' (Ainsworth et al. 1978) for determining the extent to which an attachment between a young child and its mother has taken place. In this experiment the child was left with a stranger, then left on his/her own and finally reintroduced to its mother. Ideally the child would approach his/her mother with pleasure (i.e. securely attached), but a minority of children have been observed in this experiment to turn away from their mother (i.e. avoidant insecurely attached children) or being ambivalent upon their mother's return (i.e. resistant insecurely attached or 'ambivalent' children). Adults too need to have had good experiences of closeness, distance, upperness, and lowerness before they feel comfortable in any one of these positions.

Being Related To

Just as we constantly relate to people, we are being constantly related to (by others) even though we do not always know that we are being related to. For example, a celebrity is unaware of the feelings that all kinds of other people have towards him/her. All that applies to relating applies also to being related to. It can apply as much to what happens in an instant as to what happens over a lifetime. It can apply as much to internalised people as to people in the real world. People can be profoundly affected by the way that certain others relate to them. Relating and being related to are combined in the process of interrelating (see below), and the Couple's Relating to Each Other Questionnaire (CREOQ) (see below), which measures interrelating, has separate measures of relating and being related to.

Interrelating

Beyond the issue of relating is the issue of interrelating. Whereas relating is a characteristic of a person, interrelating is a characteristic of a pair of people (or sometimes a number of people). Interrelating can be brief (as when a person makes a purchase in a shop) or can be extended over

a period of time (as in a long-term relationship). When two people are in a relationship each person relates to the other and is also related to by the other. Ideally each person should relate positively towards the other and be related to positively by the other, but it is not uncommon for one or both persons sometimes to relate positively and sometimes to relate negatively. There are relationships in which both persons are consistently close or in which both persons are inclined to be distant, and there are some in which one person is mainly close and the other is mainly distant. There are relationships in which one person is consistently upper and the other is consistently lower, as between teachers and pupils or parents and children; and there are relationships in which one person is sometimes upper and sometimes lower, or one is upper in some respects and the other is upper in other respects. One person may be consistently more distant or closer than the other would wish them to be, or more upper or more lower than the other would wish them to be.

Relationships can survive somewhat precariously when one person relates negatively and the other has to adjust to that person's negative relating, but this would impose strains upon the relationship. A questionnaire-based measure of each partner's negative relating towards the other and also his/her perception of the other's negative relating towards him/her is called the CREOQ (Birtchnell et al. 2006) which will be fully described later in this volume (see Chap. 5).

The CREOQ is scored by computer software and the scores are represented both numerically and graphically. Relating Therapy (Birtchnell 2001, 2014, see Chap. 12 of this volume) is directed towards identifying the patient's negative forms of relating, exploring how these may have come about and how they are being maintained, and helping the patient to acquire the ability to relate positively in any one of the eight positions (Birtchnell 1999/2002).

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2

Comparing Birtchnell's Interpersonal Octagon with Leary's Interpersonal Circle

John Birtchnell

Introduction

An Alternative to the Interpersonal Circle

LaForge et al. (1985) recall that the development of the interpersonal circle, or circumplex to which it is widely referred, began in the late 1940s at Berkeley, University of California, although the first published account of it was not until 1951 (Freedman et al. 1951). As I explain in Birtchnell (2014a), the interpersonal circle was made up of 16 segments arranged around a horizontal love–hate axis and a vertical dominate–submit axis, and an account of it was published by Leary (1957).

Although Leary's (1957) interpersonal circle predates my own Interpersonal Octagon I had been unaware of it when I first constructed my octagon. This has provided me with the opportunity to compare the two theoretical structures. In some respects there is a close correspondence

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_2

between them, which I have found reassuring, but there are also a number of important differences.

The interpersonal circle originated from an extensive search for terms which describe interpersonal behaviour which were subsequently organised into a 16-segment circle. In contrast, the octagon arose out of consideration of the nature of dependence (Birtchnell and Shine 2000). Birtchnell's (1987) belief that dependence had both a closeness-seeking component and a relating upward component led to the idea that closeness-seeking vs distance-seeking and relating upwards vs relating downwards represented the two fundamental axes of interpersonal relating.

The names for the axes of the octagon were selected so as to be general, generic, and neutral, whereas the names for the axes of the circle do not have these characteristics (Birtchnell and Shine 2000). For example, Love and Hate, or Dominate and Submit are anything but neutral (love would be considered to be preferable to hate for example), and are not broad enough to encompass an entire range of behaviours. The four principal relating objectives posited by Relating Theory (Birtchnell 1993/1996) exist on two intersecting axes (closeness vs distance and upperness vs lowerness), and the Interpersonal Octagon (Birtchnell 1994) is formed by inserting intermediate positions between these four main positions. Each octant has a two-word name, the first word referring to the vertical axis and the second referring to the horizontal axis. For the four polar positions, the word 'neutral' is inserted where the word for the other axis would be. Thus, moving in a clockwise direction around the octagon, the names and their abbreviations of the octants are: upper neutral (UN), upper close (UC), neutral close (NC), lower close (LC), lower neutral (LN), lower distant (LD), neutral distant (ND), and upper distant (UD).

Different authors since Leary (1957) have given different names to each segment of the interpersonal circle. Some have used pairs of words and others have used pairs of letters for defining each position. A particularly elegant sequence of terms is that of Wiggins (1979). His horizontal axis extended from Cold-Hearted (DE) to the left, to Warm-Agreeable (LM) to the right, and his vertical axis extended from Assured-Dominant (PA) at the top to Unassured-Submissive (HI) at the bottom. Bakan (1966) introduced the terms 'agency' and 'communion'. Horowitz

et al. (2006) considered that agency corresponded with the vertical (*y*) Dominate–Submit axis and communion corresponded with the horizontal (*x*) Ignore–Love axis. They used the vertical Agentic axis to refer to one person's influencing another and the horizontal, Communal axis, to refer to the interconnection between any two people. I would consider my own terms close, distant, upper, and lower to be preferable because they each refer to a person's spatial position in relation to others and there is both a positive form and a negative form for each position which are described in more detail later (see also Chap. 1 of this volume).

Initially Leary's circle was made up of 16 segments (Leary 1957), but later, pairs of neighbouring segments were combined in order to create eight segments. Similarly Wiggins (1979) reduced the 16 segments of his circumplex to 8. Paddock and Nowicki (1986) claimed that when an analysis goes beyond four axes (with eight poles) the internal consistencies of the scales drop to unacceptable levels. This reduction of the number of segments has made it easier for me to compare Leary's circle with my own octagon, since both structures now have eight segments, though the content and the naming of the segments are different; hence the need for this chapter.

Avoidance of Interpersonal Anxiety or Attainment of States of Relatedness?

Leary (1957) wrote: 'All the social, emotional, interpersonal activities of an individual can be understood as attempts to avoid anxiety or to establish and maintain self-esteem' (p. 59). The motivation proposed for the attainment of the positions of the octagon in Relating Theory is quite different. It does not concern a need to avoid interpersonal anxiety; rather it is a move towards the attainment of certain forms of relating. I believe that it is 'unduly pessimistic to consider all human interpersonal behaviour to be a flight from something rather than a drive towards something' (Birtchnell 2014a, p. 64). There are, however, positive (socially acceptable) ways and negative (socially unacceptable) ways of doing so. During their years of development a person comes to acquire the social skills that are needed in order for him/her to attain any one of

the eight relating objectives. A person who is capable of attaining every one of these is referred to as versatile. This is the ideal (see Chap. 1 of this volume).

Personality Traits Versus States of Relatedness

Because Leary's (1957) book was entitled *Interpersonal Theory of Personality*, it may be assumed that the circle's primary concern is with personality; as some of the terms Leary used (e.g. Love and Hate) are not personality characteristics this seems incongruent.

A term often used by circle theorists is 'preferred interpersonal style'; so personality must refer to that part of the circle which a person prefers to be in and personality disorder would be an extreme version of this (Birtchnell and Shine 2000). Because Relating Theory argues that the ideal is competence in relating in every position of the octagon (i.e. attainment of all 'states of relatedness', or the capability for a person to relate to another from any spatial position of the octagon; see Chap. 1 for a more detailed discussion) preference is not an issue. The primary concern of the octagon is relating, and personality disorder can be conceptualised as a particular form of negative relating extending over a period of years.

Positive Versus Negative Relating

The difference between positive (advantageous) relating and negative (disadvantageous) relating is a central feature of my classificatory system (Birtchnell 1993/1996). As described in more detail in Chap. 1, my approach is first to define the four main positions of relating in space, namely being close, being distant, being upper, and being lower, then to introduce the intermediate positions of UC, LC, UD and LD, thus creating the Interpersonal Octagon (Birtchnell 1994). The important point to make here is that each one of the eight positions of the octagon can have either positive qualities or negative qualities, hence my creation of a separate, positive octagon and a separate negative octagon to reflect desirable and undesirable states of relatedness, respectively (see Fig. 1.1; see also the

'One Circle versus Two Octagons' section below). This differs from Leary (1957) who included both negative and positive qualities within his single interpersonal circle. A strength of the octagonal model is that whatever position in space a person is relating from, he/she can still be relating either positively or negatively. The ideal is that a person should be competent in each of the eight positions, so no position should be considered preferable to any other. If there were a measure of positive relating, the universally good relater would obtain maximum points for each position. Similarly, if there were a measure of negative relating, the universally bad relater would obtain maximum points for each position (Birtchnell and Shine 2000).

Extreme Versus Incompetent Relating

For the interpersonal circle the distinction between adaptive and maladaptive behaviour is distinguished by how extreme and rigid it is (Birtchnell and Shine 2000), with maladaptive behaviour being considered more extreme and rigid than adaptive behaviour. For the octagon however, that which is called positive relating reflects competence in attaining relating objectives, and that which is called negative relating reflects incompetence. Negative relating can be defined under three headings: Avoidant, Insecure, and Desperate (Birtchnell 1993/1996). A person who is totally incompetent at relating will *avoid* a particular form of relating, adopting only the opposite form (e.g. an incompetently close person will stay distant), whereas a partially competent relater will either attempt to relate in a particular way but do so apprehensively (e.g. he/she will try to get close but he/she is insecure and fear rejection), or by desperately imposing that form of relating upon another with little concern for what the other feels (e.g. forcing closeness when clearly it is not wanted).

It is confusing for Leary (1957) to use the term 'psychiatric extremes' when they do not correspond directly to psychiatric diagnoses. My own term of 'negative relating', whilst disadvantageous to the individual, is not itself a psychiatric condition in a categorical sense since it is not the case that a person is a 'negative relater' or a 'non-negative' relater. My view is therefore that relating is a dimensional construct. This argument is supported by the fact that diagnostic categories of mental disorders

rarely capture most individuals and that the 'not-otherwise-specified' diagnoses of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 1980, 1994, 2000) are remarkably popular (Widiger and Samuel 2005). Relating Theory therefore provides a different theoretical approach to the interpersonal circle.

Although negative relating is not a psychiatric condition, it is conceded that certain professional psychotherapists are skilled in helping their patients to reduce their negative forms of relating and enabling them to replace them with more positive forms, and this is the basis of that which I have called Relating Therapy (Birtchnell 1999/2002, 2014b, see Chap. 12). The term 'negative relating' simply implies that it is a rather clumsy and inconsiderate way of relating to others. Almost everyone, at some time or another, slips into a negative form of relating, but this does not necessarily imply that the person who does so requires treatment. However, it would appear to be advantageous for a person to relate positively.

One Circle Versus Two Octagons

Leary (1957) proposed only one interpersonal circle with some of the positions being described as positive (i.e. desirable), and some being described as negative (i.e. undesirable). The left side of Leary's circle concerns negative (i.e. unfriendly) behaviour and the right side concerns positive (i.e. friendly) behaviour. The top side concerns dominating behaviour and the bottom side concerns submissive behaviour. Leary has argued that for every segment of his circle there has to be a gradient from adaptive adjustment that is located at the centre of the circle to that which he has called the psychiatric extremes (i.e. negative qualities) that are located at the periphery (e.g. managerial personality through to autocratic personality). I believe that positive and negative relating are qualitatively different, whereas Leary believes that the extreme form of any relating tendency is what I would call negative relating. This justifies the separate positive and negative octagons. For example, someone who obtains the maximum possible score (i.e. 15) on the UD scale of the Interpersonal Octagon (i.e. being sadistic, intimidating, or tyrannising), is very sadistic, whereas someone who obtains a score of 0 is not sadistic at all, but this does not necessarily mean that the latter person relates

in a *positively* UD way (i.e. controlling and maintaining order, see Fig. 1.1). The positive UD relater could be 'not at all' to 'very much so'. Since the positive and negative forms of UD represent qualitatively different constructs, positive UD would need to be measured separately. Referring back to Leary's managerial–autocratic dimension there should have been a gradation from being not managerial at all to very managerial just as there should have been a gradation from not being autocratic at all to being very autocratic. Thus, having two separate octagons allows the conceptualisation and illustration of relating tendencies and their gradation in a wider interpersonal space than Leary's single circle.

Bipolarity

Leary's circle has been closely aligned with the establishment of a bipolar relationship between the poles of the axes, that is, if a person has a high score on a scale from one pole of an axis then they should have a low score on a scale from the opposite pole. However, the octagon is not concerned with a bipolar relationship between the poles. As Broughton and Paulhus (1984) point out, having a capability (or lacking a capability) from one side of the circle does not preclude that person from having a capability (or lacking a capability) from the opposite side. This is important for octagonal theory which posits that relating positively (being competent) from a position on one side of the octagon does not preclude a person from relating positively from a position on the opposite side and in fact it is desirable to be able to relate from all positions of the octagon if one is to be a well-adjusted person with a complete range of relating capabilities (Birtchnell 2014a). For example, a person might relate positively from the upper (e.g. being leading) or close position (e.g. being involved) and at the same relate positively from the opposite positions of lowerness (e.g. seeking directions) or distance (e.g. enjoying privacy) of the octagon.

The Circumplex

Where Leary's circle is concerned with the mathematical model that has been called the circumplex, the octagon is not. The circumplex is not a psychological concept; it is a statistical one. It was first described by

Guttman (1954) for defining the interrelationship between variables that are located within a two-dimensional domain. Plutchik and Conte (1997) published an entire book on the circumplex, although it was not developed specifically for classifying the two axes of the interpersonal circle. The most widely used circle-based measure is the circumplex version of the Inventory of Interpersonal Problems (Alden et al. 1990) which generates high positive correlations between its scales and a large, first general factor, but these imperfections have had to be corrected by the statistical procedure that is called ipsatisation (Cattell 1944). This involves subtracting the person's mean score from every item and in some forms it may require access to population means.

The 'Outer Me' and the 'Inner Me'

Leary does not appear to have drawn a distinction between that which I have called the 'outer me' and that which I have called the 'inner me' (Birtchnell 2003, see Chap. 1).This is an important distinction between interpersonal behaviours which are deliberate and intended (outer me) and those which are habitual and spontaneous (inner me).

Summary and Conclusions

This chapter has presented a comparison of Birtchnell's Relating Theory (1993/1996) with Leary's (1957) Interpersonal Theory and their associated structures, the *Interpersonal Octagon* and the *Interpersonal Circle*, respectively. Both systems are represented by two intersecting axes: a horizontal one extending from close involvement to distant separation and a vertical one extending from upper control to lower submission. In both systems intermediate axes are inserted between the two main ones. Leary has argued that the interpersonal activities of an individual can be seen as attempts to avoid interpersonal anxiety, whereas Birtchnell argues that relating is concerned with seeking a set of relating objectives. Where the circle is concerned with personality traits, the octagon is concerned with what are called states of relatedness. The circle is concerned with extreme relating whereas the octagon is concerned with competent/incompetent relating. Leary has argued that for each segment of the circle there should be a gradient from

adaptive adjustment at the centre of the circle to what he has called the psychiatric extremes at the periphery. Birtchnell advocates a separate gradient for positive and negative relating; that is, an individual might display very negative upperness (controlling and dominating) but also positive upperness (leadership and protectiveness). Whereas Leary created one interpersonal circle, Birtchnell created two octagons, one comprising the positive features of human relating across the eight positions of the octagon and the other comprising the negative features across the same positions. Whilst the circle has been closely aligned with the establishment of a bipolar relationship between the poles of the axes and with the mathematical model that is called the circumplex, the octagon has not. Finally, Leary has not drawn a distinction between an 'outer me' and an 'inner me' as Birtchnell has.

The interpersonal circle is nearly 50 years old and therefore well established. However, although it has a considerable body of literature and is widely accepted this should not mean that it is beyond criticism or modification. Relating Theory and its associated theoretical structure, the Interpersonal Octagon, are much more recent. In a sense it is an advantage that it has arisen quite independently, since coming at the problem from a different angle has provided new insights which ultimately should provide a useful alternative.

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Part II

Measures Based on Relating Theory

3

The Person's Relating to Others Questionnaire (PROQ)

Argyroula Kalaitzaki and John Birtchnell

Introduction

The Importance of Relating to Others

The greatest quality of a human being is the ability to build relationships. Building relationships of any type, whether it is between spouses/partners, family members, co-workers, or friends, is the most challenging and the most worthwhile experience humans have. Relationships are rewarding for a number of reasons, not least of which are one's personal growth and development.

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_3

The importance of developing relationships with others was initially proposed by the attachment theorist John Bowlby who devoted extensive research to the concept of attachment, describing it as a 'lasting psychological connectedness between human beings' (Bowlby 1969, p. 194). He suggested that every person is biologically preprogrammed to form attachments with others. The most important relationship for a person is the one he/she forms with one main attachment figure (usually the mother). Birtchnell's (1990, 1993/1996, 1994) Relating Theory rests on a similar premise. The tendency to relate to others is considered to be innate, so people are born with the capacity to do so (Birtchnell 1993/1996). Bowlby's (1969) attachment theory also suggests that if, during the critical first two years of life, the bond between an infant and its parent is disrupted, there may be irreversible long-term consequences. Bowlby further proposed that a person's future interactions with others are influenced by the internal working models of self and others that were formed with the primary caregiver early in life (Bowlby 1969). Birtchnell (1993/1996) also proposed that the learning of relating skills is a long-term process, beginning at birth and extending through the whole of a person's life. If a person has experiences of negative relating in any of what are called the eight states of relatedness (see Chap. 1 of this volume) he/she may not practise and improve his/her relating skills through the remainder of his/her interactions with others.

According to Relating Theory (Birtchnell 1993/1996), a truly competent and successful person in relating is someone who has developed the capacity to relate to others with positive ways in any state of relatedness and this relating is rewarding for all. Of course, people sometimes encounter difficulties in relating positively to a particular person or to a specific moment or situation for a variety of reasons. No two persons are alike or have the same relating needs. A person may feel comfortable in relating to a particular other from a state of closeness, though it is not uncommon that there could be times for that person to feel estranged from a particular other and to want to distance him/herself from him/her. A person may also feel comfortable relating from a state of upperness (e.g. providing for, looking after, and making the decisions) with a particular other, though there could be times that the person would derive pleasure from being provided for/looked after, or be guided by

the very same other person. If the particular other does not go along with the person's need, relating difficulties may arise in their relationship. A variety of mental health problems including personality disorders can also lead to difficulty in relating to others (American Psychiatric Association 2013; Birtchnell and Shine 2000). A full account of Relating Theory can be found in Chap. 1 of this volume.

In sum, relating is perhaps the most prominent quality of a human being. No one can be understood in separation from his social environment as the ancient Greek philosopher Aristotle (*Politika*, *c*.328 BC) once stated: 'Man is by nature a social animal.' Learning to relate positively to others is a central feature of one's life and so addressing any relating deficiencies is essential for having a fulfilling and satisfying life.

Measures of Interpersonal Difficulties

Despite the importance of recognising and measuring any interpersonal limitations in one's life, there is a lack of brief, well-validated, readily interpretable measures of interpersonal deficiencies that can be easily applied in clinical settings. The 127 items of the Inventory of Interpersonal Problems (IIP; Horowitz et al. 1988) measure a range of interpersonal problems potentially reported by psychotherapy patients. The original IIP resulted in more than ten variants, which favour either Leary's (1957) circumplex model of personality (e.g. the IIP-C; Alden et al. 1990; Horowitz et al. 2000) or a factor-analytic approach (e.g. the IIP-32; Barkham et al. 1996). The short 32-item version of the IIP (Barkham et al. 1996) was created to ease administration in clinical settings. Evidence of its eight-factor structure has been demonstrated in samples of individuals with anxiety, depression, and eating disorders (McEvoy et al. 2013).

Critiques of the IIP have been published elsewhere (Birtchnell 2014). In 1992, Birtchnell published the PROQ (Birtchnell et al. 1992). This measure stems from Relating Theory (Birtchnell 1993/1996) and bears many advantages over the traditional interpersonal measures (for a detailed account see Birtchnell 1999, 2014). Unlike other measures, the PROQ is theory-driven and its factorial structure conforms to the underlying theory (Birtchnell 2014). The PROQ is comparable with

the IIP-32 in that they both share an eight-factor structure. The PROQ is also comparable with the IIP-C in that there is a relative overlap between what these instruments measure (i.e. maladaptive relating). This was confirmed by the positive correlations found between a number of IIP-C and scales of the recently developed shortened version of the PROQ (PROQ3; Birtchnell et al. 2013), such as the correlation between the PROQ3 upper neutral (UN) scale and the IIP-C domineering/controlling (PA) scale.

The PROQ and Its Variants

The PROQ is a self-administered measure designed specifically to measure a person's general negative relating tendencies to others in each of the eight positions of the Interpersonal Octagon (for a full account of the theory see Chap. 1). There are four versions of it. The original PROQ (Birtchnell et al. 1992) is a 96-item measure. The second version of the PROQ, the PROQ2 (Birtchnell 2001; Birtchnell and Evans 2000, 2004), has the same structure as the original PROQ, but a number of items have been replaced or rephrased and the response options have been modified. This latter version has been most widely used and so it will be briefly described here.

The items of the PROQ2 are randomly distributed across 8 scales (with 12 items each) and their names correspond to the 8 positions of the Interpersonal Octagon. The scales, presented in the sequence that they are allocated in the octagon, are called upper neutral (UN), upper close (UC), neutral close (NC), lower close (LC), lower neutral (LN), lower distant (LD), and upper distant (UD). Ten items per scale describe features of negative relating. These negative items are summed and contribute to the total score. Two more items, which describe positive or desirable relating tendencies, have been included in each scale so as to offer the respondent the opportunity to say something good about him/herself and smooth out the negative tone of the questionnaire. The positive items normally remain unscored.

Since many of the characteristics of negative relating are considered to be undesirable, care has been taken to avoid including the more flagrant

statements, such as *I am a bully* that a person completing the questionnaire might have been reluctant to admit to. Typical items with high loadings for each scale are: Upper Neutral (UN): *I can be very critical of other people*. Upper Close (UC): *I can't say 'No' when it comes to helping other people*. Neutral Close (NC): *I have a tendency to cling to people*. Lower Close (LC): *I don't like to argue with people in case they end up disliking me*. Lower Neutral (LN): *I feel lost when there is no one to turn to for advice*. Lower Distant (LD): *I find it hard to stand up to people*. Neutral Distant (ND): *I do not let people get too close to me*. Upper Distant (UD): *Getting my own way is very important to me*. The person is invited to reply to the items in a four-point scale ('Nearly always true', 'Quite often true', 'Sometimes true', and 'Rarely true'); these are scored as 3, 2, 1, and 0, respectively. The maximum score for each scale is 30 (3×10 negative items) and 240 for the whole questionnaire (3×80 negative items). A computer program presents scores both numerically and graphically.

The PROQ2a was the first attempt of a shorter version of half the items of its predecessor, the PROQ2. The highest 48 loading items were selected from the extracted factors of an explanatory factor analysis (EFA). A further modification of the UC and LD scale items resulted in the revision that is called the PROQ3 (Birtchnell et al. 2013). This latter derivative is presently the most widely used measure developed from Relating Theory.

In the PROQ3, five negative items and one positive item were included. Typical negative items for each of its scales are: Upper Neutral (UN): *I like to be the one in control*; *It annoys me when people will not do what I expect of them*. Upper Close (UC): *I try to keep people for myself*; *I keep a firm hold on someone who is close to me*. Neutral Close (NC): *I have a tendency to cling to people*; *I cannot bear to be left on my own*. Lower Close (LC): *I can never be sure that people approve of me*; *I have a dread of being rejected*. Lower Neutral (LN): *I prefer other people to take the lead*; *I appreciate it when others tell me what to do*. Lower Distant (LD): *When I am put under pressure I withdraw*; *when people try to intimidate me I retreat*. Neutral Distant (ND): *I do not let people get too close to me*; *I tend to keep my feelings to myself*. Upper Distant (UD): *I can be quite ruthless when I need to be*; *I tend to get back at people who offend me*. The scoring procedure is the same (i.e. there are four item responses, only the negative items are scored,

and a computer program can be used), but the maximum scale score is 15 (3 × 5 negative items) and 120 for the entire questionnaire (3 × 40 negative items). All versions of the PROQ and the scoring program are available from www.johnbirtchnell.co.uk.

Psychometric Data on the PROQ and Its Variants

Adequate psychometric properties have been shown for both the PROQ (Birtchnell 1993/1996; Birtchnell et al. 1992) and the PROQ2 (Birtchnell 1999; Birtchnell and Shine 2000). The PROQ2 has been translated into Greek (the so-called PROQ2-GR; Kalaitzaki and Nestoros 2002/2012) with good psychometric properties (Kalaitzaki and Nestoros 2003), which were shown to be comparable to those provided for the English version (Birtchnell and Evans 2004).

The PROQ3 has been translated into Greek, Irish, and Dutch, and the psychometric properties of the English version and its three translations have been published (Birtchnell et al. 2013). The PROQ3 has been shown to have satisfactory psychometric properties and to be fairly consistent across the four national samples (Birtchnell et al. 2013). Its factorial structure conformed to the underlying theory and some high inter-scale correlations between neighbouring scales were found. Also the Cronbach alpha coefficients were consistently acceptable across the samples (Birtchnell et al. 2013). It has also demonstrated convergent and discriminant validity. In the study by Kalaitzaki and Birtchnell (2014), the PROQ3 was positively correlated with the participants' self-reports of Internet addiction. The PROQ3 has been translated into Italian (Leoni unpublished) and used in a clinical setting of 67 patients (54 % males; mean age 41.9, SD = 14.1) who were depressed (14.9 %), psychotic or bipolar (47.8 %), or who had a personality disorder (35.8 %). Only preliminary results are available so far. The Cronbach alpha coefficient for the whole questionnaire was 0.85 and for the 8 scales ranged from 0.66 (LN) to 0.73 (UN), with the exception of the low LD scale (0.46). EFA, accounting for 62.55 % of the variance, yielded eight factors corresponding to the octant scales; LD was again shown to be a weak scale. Future work is therefore needed to address the potential drawbacks and validate the Italian version of the instrument further.

The Usefulness of the PROQ3 in Clinical Practice

From its inception the PROQ and its variants have been repeatedly used in measuring the relating difficulties in diverse populations. The PROQ2 has been successfully used in studies to discriminate between non-patients and psychotherapy patients (e.g. Birtchnell and Evans 2004; Birtchnell et al. 2013). Certain scales of the measure have shown high correlations with specific personality disorders (Birtchnell and Shine 2000) and with aggressive behaviour in dating relationships, such as the perpetration of assault, injury, and sexual coercion (Kalaitzaki et al. 2010). In the latter study, the PROQ2 has also been shown to differentiate between the perpetrators and victims of aggression from those who were neither aggressors nor victims of aggression by their dating partners. As also anticipated, the perpetrators were shown to relate negatively from an upper position (e.g. dominance, restriction, intimidation, degradation).

The shortened version of the PROQ, the PROQ3, has recently replaced the longer version of the PROQ2. In a Greek study, Kalaitzaki et al. (2014) examined whether a two-month period of individual psychotherapy led to improvements in 60 patients' and their partners' negative relating to others (and also in their interrelating). Positive changes were expected to occur in the partners' negative relating due to their close involvement with the patients. The results showed that the therapy, which had not specifically addressed issues of relating (or interrelating), was successful in ameliorating some of the patients' relating deficiencies, compared to a sample of non-patients. However, consistent with other findings (e.g. Zeitner 2003), the therapy proved to be catastrophic for the partners, in that it resulted in deterioration of some of their relating to others and of their interrelating with the patients. It is unfortunate though that so far no other translations of the PROQ3 have been systematically applied in clinical or therapeutic settings. Therefore, no results are as yet available for its efficacy in tracking relating changes in other cultural settings.

A recent advancement of the PROQ3 is the attempt to validate the measure for use through the Internet. Kalaitzaki et al. (2015) have compared the Internet-administered format of the PROQ3 with the standard-written version across four national samples (British, Irish, Dutch, and Greek). It was found that the Internet-administered format was fairly

equivalent in terms of its measurement and structural qualities compared to the standard-written version across the four nations. An important finding was the confirmation of a consistent eight-factor underlying structure and an octagonal higher-order factor, across nationality. It was concluded that the study findings were highly supportive of the general contention that the PROQ3 can be administered via the Internet in any of the four languages or cultures with maintained psychometric properties (Kalaitzaki et al. 2015). The implications of these findings are important since clinicians may choose the format that best fits their clients' specific needs. For example, those that implement e-therapy (i.e. online or Internet-supported therapeutic interventions) may readily apply the Internet-administered format of the PROQ3. To the authors' knowledge there is no such other measure for assessing a person's relating difficulties to others for use through the Internet. Research can be facilitated too. An extensive account of the benefits of data collection through the Internet, including cost- and time-effectiveness, ease of administration, and recruitment of large and diverse populations can be found in Reips (2000).

Concisely speaking, the two studies on the psychometric properties of the PROQ3 (Birtchnell et al. 2013; Kalaitzaki et al. 2015) have concluded that both formats of the PROQ3 (i.e. the standard-written and the Internet-administered, respectively), in either the English language or in the Greek, Dutch, and Irish translations, are sound instruments for measuring a person's general, negative relating tendencies. Hopefully, the use of the PROQ3 will continue to increase and other translations will emerge soon.

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4

The Psychometric Viability of the Person's Relating to Others Questionnaire (PROQ)

Sean Hammond

Introduction

When developing his Relating Theory, Birtchnell (1990, 1993/1996) identified two axes of relating. The first concerns the power dynamic in interpersonal relating, at one end of which is relating from a position of power/dominance while at the other end is relating from a position of weakness, termed upper and lower relating, respectively. The second axis distinguished between emotionally distant and close relating, and the extremes are termed distant and close, respectively.

The two axes may be conceptualised geometrically as two right-angled axes creating the four polar positions of upper, lower, close, and distant, represented at the North, South, East, and West points, respectively. The *Interpersonal Octagon* (Birtchnell 1994) is completed by identifying four intermediate regions between the four polar ones that blend the characteristics of the extremes (see Fig. 1.1). In order to test this model, Birtchnell developed the Person's Relating to Others Questionnaire

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_4

(PROQ; Birtchnell et al. 1992) and its later modifications (the PROQ2; Birtchnell and Evans 2004 and the PROQ3; Birtchnell et al. 2013).

The PROQ3 has been available for a number of years although it was only relatively recently introduced into the psychological literature (Birtchnell et al. 2009, 2013). It derived from its longer predecessor (the PROQ2; Birtchnell and Evans 2004). All versions have eight scales each representing a maladaptive region in the octagon. The PROQ has been used in both clinical (Birtchnell 2001; Birtchnell and Bourgherini 1999; Birtchnell et al. 1992) and research contexts (Birtchnell and Shine 2000; Kalaitzaki et al. 2010). The need for a shorter and easily accessible measure to explore maladaptive relating was recognised and the PROQ3 was developed.

The practice of developing a short form from a longer one is well established (Goldberg et al. 1997; Mooi et al. 2011; Rammstedt and John 2007), but for a psychometrically robust device, a number of compromises are required (McDonald 1999). Firstly, reducing the number of questions inevitably results in loss of information, one casualty of which is that scores lose reliability. The purpose of this chapter is to examine whether the compromises of the development of the PROQ3 were psychometrically justified. A reliability estimation followed by an appraisal of the eight-factor structure using a restricted factor analysis procedure will be examined. An attempt to show how well the octagon model fits with the current PROQ3 data will follow. Finally, aspects of concurrent validity, by examining the role of personality in relating to others, will be considered.

Reliability Generalisation

The reliability of a test is often referred to as if it is a property of the test but, strictly, it is the interaction between the test and the sample from which the data are derived. Rather than arguing that a test has a particular reliability we should stipulate that the reliability describes the test score which is itself subject to all moderating factors defined by the sample in question (e.g. respondents' sex or nationality). Although we use published reliability coefficients to bolster our confidence that the

test may be robust, the onus is upon researchers and test users to ascertain that this is justified with their own data. In an extreme case a score may appear very reliable for student respondents but extremely poor for general adult respondents.

Reliability generalisation (Vacha-Haase 1998) is a widely used technique for establishing the expected range and variability of reliability estimates for a given tool (e.g. Caruso 2000; Rouse 2007), and it was applied to a small sample of studies of the PROQ3 in order to examine the consistency of its reliability estimates. The generalisation reported here uses summary data from 16 sources drawn from 4 nationalities (British, Greek, Irish, and Dutch) using either the standard written version of the measure or an Internet-administered version (Birtchnell et al. 2013; Kalaitzaki et al. 2015). Categorising these data by sex, modality and nationality ($2 \times 2 \times 4$), there were 16 estimates of reliability for each of the 8 scales. After transforming the alpha coefficients using the Hakstian–Whalen method, a fixed effects model was utilised with an inverse variance weighting of each data set (Sanchez-Meca et al. 2013). The results are summarised in Table 4.1. The alpha coefficients were reasonably consistent across the studies. The homogeneity statistic, *Q*, is distributed as χ^2 with $n-1$ degrees of freedom and is designed to identify deviations from homogeneity. None of the scales had a statistically significant level of heterogeneity. The moderator effects (sex, nationality, modality) were

Table 4.1 Reliability generalisation summary based on Hakstian–Whalen transformation and a fixed effects model

Scale	Reliability Mean	Reliability SD	Homogeneity *Q* (ns)	Sex Effect	Nationality Effect	Modality Effect
UN	0.72	0.028	13.61	0.06	0.21	0.19
UC	0.73	0.102	18.15	0.13	0.14	0.29
NC	0.70	0.074	19.31	0.01	0.43	0.09
LC	0.76	0.082	24.04	0.24	0.06	0.11
LN	0.76	0.057	11.52	0.00	0.01	0.14
LD	0.63	0.078	12.12	0.04	0.05	0.00
ND	0.77	0.055	15.71	0.00	0.14	0.13
UD	0.67	0.077	21.11	0.00	0.15	0.04

Q is a homogeneity statistic distributed as χ^2. A significant value would indicate inconsistent estimates of reliability

estimated using standard OLS regression. There were few strong effects and it could be concluded that these reliability coefficients are likely to be fairly consistent across further studies irrespective of nationality, sex of respondents or modality of delivery.

Despite the relative consistency of reliability estimates, it is clear that some PROQ3 scale scores do not manifest strong reliability (e.g. LD); the reliability estimates tend to be found in the mid to low 0.70's. The overall picture, then, is of a psychometric measure that serves quite well as a short research tool but one or two scales probably lack the desired accuracy. There may be good explanations for this. First, the compromise of creating a short measure militates against strong internal consistencies and second, it should be remembered that these reliability coefficients are all lower bound estimates and that the 'true' reliability of the test score is likely to be somewhat higher (Guttman 1945). Nevertheless, these results do need to be taken at face value until more data are available and this is the aim of the following section.

Lower Bound Estimation of Reliability

A general rule of thumb states that reliability estimates less than 0.70 indicate questionable reliability, impairing the practical use of the measure in question (Nunnally 1968). Research tools have less rigorous requirements than those recommended for diagnostic purposes (around 0.90), but if psychology is to advance as a scientific discipline it is important that measurements have maximal reliability or findings will lack generalisability.

Typically, the reliability of multi-item self-report scales is estimated using Cronbach's alpha coefficient (Cronbach 1951). Before Cronbach's seminal paper, Guttman (1945) had already identified alpha as a lower bound estimate of reliability that he labelled λ_3. The idea of a lower bound estimate is that the researcher can say that a particular score has reliability no less than the value reported. The actual or 'true' reliability of a device is difficult to determine and is never exact. Other estimates of reliability have been proposed and some are even stronger lower bound estimates than alpha such as Armor's (1974) theta (θ) and McDonald's

(1999) omega (ω) which derived from weighted composite, principal components and factor analysis models, respectively (see McDonald 1999, Chap. 6; Sijtsma 2009a, b; Revelle and Zinbarg 2009). For the following analyses all three estimates were used to examine the reliabilities of the PROQ3 scales.

The remainder of this chapter describes a relatively detailed psychometric evaluation of the PROQ3 based upon an Irish sample and addresses issues and caveats often found in psychometric accounts of this kind of measure. The sample consisted of 3013 adult Irish respondents (1123 were male) who completed the Internet-administered PROQ3. Their age was skewed towards the younger range (median of 27 with a minimum of 18 and maximum of 77 years).

Table 4.2 shows the results of the first psychometric appraisal of the Irish data combining both males and females. The reliability estimates are reasonably high given the results of the generalisation analysis. As anticipated, ω gives a higher value than α, suggesting that it is a better lower bound estimate and that the actual reliabilities are in a higher range than α would suggest. Notably, whereas the LD scores manifest an α value of 0.68, the ω estimate, at 0.74, suggests a more acceptable reliability than α which brings us over the (arbitrary) standard of 0.70. Armor's θ is consistently marginally higher than alpha but not as high as ω.

Table 4.2 Descriptive statistics for PROQ3 scale scores based upon the total sample

Scale	Norms		Internal consistency			Difference	
	Mean	SD	Alpha	Omega	Theta	*t*	Sex
UN	11.83	3.40	0.73	0.77	0.73	2.38*	M
UC	9.54	4.07	0.86	0.87	0.86	2.77**	M
NC	10.16	3.99	0.80	0.83	0.81	2.27*	F
LC	12.35	4.10	0.80	0.83	0.80	4.98**	F
LN	9.97	3.92	0.86	0.87	0.86	1.81	F
LD	10.60	3.47	0.68	0.74	0.71	5.97**	F
ND	11.79	4.23	0.83	0.85	0.83	3.05**	M
UD	10.98	3.55	0.72	0.76	0.72	12.01**	M

M = Male, *F* = Female

*$p<0.05$; **$p<0.01$

Because the ordinal scoring for each item ranges from 1 to 4, the scores for each scale range between 5 and 20 (as there are five items per scale) and a mid-point of 12.5. The means are pretty low-central in that range and the standard deviations point to scores that have a reasonable degree of spread. For all scales the sexes differ in terms of maladaptive relating apart from LN; males tended to have higher scores on the upper scales and females on the lower scales.

Scale Integrity

The fact that the PROQ3 scale scores manifest acceptable reliability estimates is encouraging but it does not necessarily imply that the scales are discrete entities. It can often occur with multi-scale measures that the larger item pool may be highly homogeneous and this may imply a strong superordinate domain, such as maladaptive relating. It is possible then that each scale is simply a measure of maladaptive relating, since items have been randomly sampled from this general relating domain, and owes its reliability to the high internal consistency of the larger item pool. In order to evaluate the separate meaning of each scale, an investigation of the construct validity of the item pool is required. Typically, this is achieved by using factor analysis in which the relations between the items are used to identify discrete underlying factors.

Eight underlying factors were expected and the items expected to represent each factor were specified. A restricted (confirmatory) factor analysis was conducted in which the 40 items were constrained to conform to the a-priori 8-factor model. Fitting such models is often problematic because the coefficients most often used are either sample size dependent or heuristic estimates. A least squares multiple-group factor analysis (Harman 1976) was used which lends itself well to a simple fitting index proposed by Fleming (1985). This has the advantage of allowing the model fit to be gauged for each item and each factor separately as well as providing a general model fit parameter. Fleming's index is essentially a signal to noise ratio (ranging between 0 and 1) and may be interpreted in the same way as a reliability coefficient (a higher value indicating better fit). An additional advantage of this method is that a very large number of competing models can be tested alongside the theoretical target model; 10,000 models were

randomly generated and the fit was estimated for each. The target fit was then compared with the randomly generated models. Experience suggests that the distribution of random fit indices is essentially normal although there is no statistical guarantee of this. As a rough guide, a standardised deviation of the target fit from the mean random fit provides a method for judging whether the target model has been confirmed (Curtin and Hammond 2012). The results of the Oblique solution are not presented here due to space limitations but are available on request.

The overall fit index was very good (0.96). The items were ordered so that the first five were items from the UN scale, the next five were from the UC scale and so on. The factors reflected the scale structure extremely well and all items loaded on their expected factor. All items had fit indices well above 0.80, whereas the weakest was item 48 of the LD scale (0.71). The factor fit indices were excellent and all exceeded 0.90. This means that the eight-factor Octagon model fits the data extremely well and the eight scales are indeed discrete entities. An analysis of 10,000 randomly generated 8-factor models to preclude the possibility that another model better fits the data is summarised in Table 4.3. The standardised residual of the expected model fit to the norms generated from the random models is estimated at 9.7566 which is very highly statistically significant.

Octagon or Circumplex

Consistent with the Interpersonal Octagon (Birtchnell 1993/1996, 2014) and with a circumplex model (Blackburn and Renwick 1996; Hofsess and Tracey 2005) the factor correlation matrix (available on

Table 4.3 Summary of randomly generated models compared with the expected model

Expected model fit = 0.9614	
Randomly generated models	
Mean fit	0.7409
SD of fit	0.0226
Minimum fit	0.6801
Maximum fit	0.9614
Model deviation from random (*z*)	9.7566 ($p < 0.001$)

request) indicated a circumferential structure; the coefficients decrease in size from the diagonal and then start to increase. Psychometrically speaking, the arrangement of eight scales around two orthogonal axes describes both models equally well (Gurtman 1992). However, the circumplex model leans towards a conceptualisation where the vectors representing the eight dimensions should be of standard or equal length which serves to position the extreme ends upon the circumference of a circle around the joint vector origin (McCrae and Costa 1989). There is also an expectation of equidistance between these traits (Bezembinder and Jeurissen 2003). These constraints do not apply to the Interpersonal Octagon as such, although they can be applied and they would certainly provide an aesthetically pleasing representation but this may be at the cost of good fit to the data. The Interpersonal Octagon simply dictates the two-dimensional order of the scales, without specifying their equidistant positioning around a circumferential space. Also, there is no psychological reason to expect that in such an ordinal model, the size and shape of the regions representing each scale may vary but their order may not.

In this section, the examination of the validity of the PROQ3 is presented. The ordinal structure of the 8 scales was explored by use of a multidimensional scaling analysis of the 40 items of the scales. A 'confirmatory' analysis was carried out by placing constraints on the distances between items (Borg and Lingoes 1980). The plot in Fig. 4.1 presents the items in blocks of five, numbered successively. Thus, items 1–5 define the UN scale, while 6–10 represent UC and so on. The stress measure for this analysis was 0.132 for the constrained analysis and 0.106 when the constraints were not applied. These may be construed as misfit indices (smaller values indicate better fit). It is clear that there was not appreciably more stress when the data were squeezed into the model structure by applying constraints.

This analysis indicates that the eight regions representing the eight styles of maladaptive relating are revealed in much the same order as specified by the Interpersonal Octagon. The inversion of Birtchnell's representation of the octagon is purely due to the arbitrary orientation of the plot and holds no substantive significance (e.g. the upper scales occupy the south-eastern areas of the plot). Noteworthy is the positioning of the UN items (1–5) and UD items (36–40). Although they emerged as

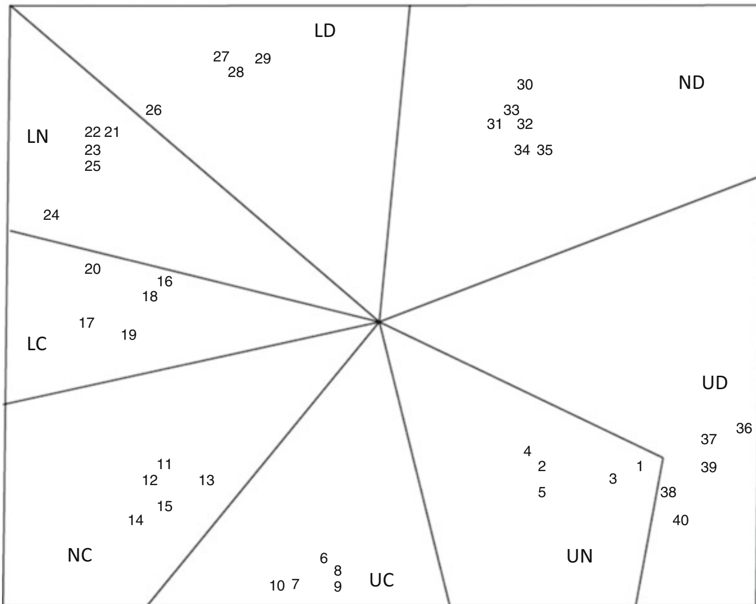

Fig. 4.1 Constrained MDS analysis of the 40 items of the PROQ3.
Note: The *lines* represent the regional separation of the items into eight sectors corresponding to the Interpersonal Octagon

discrete clusters their juxtaposition clearly indicates a close integration, which suggests a weaker separation between the UN and UD scales than would normally be expected according to theory.

Concurrent Validity

The psychometric evaluation of the PROQ3 was completed by considering the relationship between maladaptive relating and normal personality structure. Birtchnell (1997) discussed the association between personality and relating, although most of the relevant research concerns personality disorders (Birtchnell and Bourgherini 1999; Birtchnell and Shine 2000), depression (Birtchnell et al. 1992) or abuse (Kalaitzaki et al. 2010). The sample consisted of 492 Irish adults who completed the PROQ3 and the International Personality Item Pool (IPIP; Goldberg et al. 2006), a measure of the 'big

five' personality traits (Extraversion, Anxiety, Agreeableness, Conscientious, and Openness to Experience). In order to see how these traits correspond to undesirable relating styles, the eight PROQ3 scale scores and the five IPIP scores were subjected to a canonical correlation analysis (Knapp 1978). This is a multivariate procedure in which the joint variance of the PROQ3 and IPIP scales is partitioned in such a way as to provide canonical functions that depict the variety of ways that the two variable sets interact (see Table 4.4). The first four functions account for statistically significant amounts of variance although the fourth function (with a $p > 0.01$) may be considered rather borderline.

The standardised function weights for each scale score are presented in Table 4.5. Function 1 contains PROQ3 loadings from the Lower scales

Table 4.4 Canonical correlation extraction statistics

Function	Eigen value	R^2	Wilk's λ	χ^2	df	*p*
1	0.39	0.63	0.38	297.71	40	0.000
2	0.24	0.49	0.62	144.78	28	0.000
3	0.11	0.34	0.82	58.63	18	0.000
4	0.06	0.24	0.93	21.92	10	0.015
5	0.01	0.10	0.99	3.22	4	0.523

Table 4.5 PROQ3 and IPIP canonical analysis: item–function correlations

Scale	1	2	3	4
UN	0.03	0.35	**0.65**	−0.08
UC	0.24	**0.50**	**0.42**	0.31
NC	0.12	**0.69**	0.25	0.34
LC	**0.42**	**0.79**	−0.25	0.08
LN	**0.43**	0.09	−0.24	**0.74**
LD	**0.43**	0.38	−0.28	−0.09
ND	**0.85**	−0.14	0.27	−0.36
UD	−0.23	0.29	**0.47**	−0.36
EXTRA	**−0.96**	0.16	0.11	−0.14
AGREE	**−0.45**	0.14	**−0.61**	−0.11
CONSC	−0.04	−0.05	**0.52**	−0.17
STABL	**−0.40**	**−0.85**	−0.04	−0.27
OPEN	−0.19	0.32	−0.19	**−0.90**

Weights greater than 0.4 are highlighted
EXTRA extraversion, *AGREE* agreeableness, *CONSC* conscientiousness, *STABL* stability, *OPEN* openness to experience

indicating relating from a position of weakness. The personality scale loadings indicate a profile of Introvert, Disagreeable, and Anxious (i.e. low levels of Stability) characteristics. This is congruent with the lower part of the vertical octagon axis. For function 2, the PROQ3 loadings are dominated by the Closeness end of the horizontal axis and this is juxtaposed with high levels of anxiety. For function 3 the PROQ3 loadings are predominantly from the upper area of the vertical axis and the personality profile best describing this function is disagreeableness and conscientiousness. Function four is less readily interpreted but is principally defined by Openness which, because this is a strong negative loading, implies that the function should be interpreted as closed-mindedness coupled with characteristics derived from the LN scale such as helplessness and self-denigration.

These canonical functions provide a good validation for the octagon model, particularly the first three which clearly discriminate the upper–lower and distant–close axes. Bearing in mind that the PROQ3 measures maladaptive relating, it is no surprise that disagreeableness and anxiety emerge as salient on two of the four functions. It seems that people who score highly on the lower or upper regions are likely to be disagreeable but those on the lower end are also likely to be highly introverted and anxious, while those on the upper level are more likely to score highly on conscientiousness or, in its maladaptive form, overcontrol. People who manifest maladaptive relating in the closeness region of the horizontal axis are likely to be highly anxious. This interpretation conforms with a stereotypical image of maladaptive relating and dependent personality traits (see Bowlby 1988). The degree to which these results may be helpful in treatment formulation is not clear but they do suggest that patients presenting with different personality profiles may manifest predictably different maladaptive relating problems. Each canonical function may be interpreted as representing a particular composite of problematic relating. Thus function 1 presents a profile of a lower style of relating problems, while function 2 represents deficiencies in closeness and function 3 pertains to upper dominated problems. The canonical analysis presented provides ample evidence of concurrent validity and maps the octagon factors into personality space quite convincingly.

Conclusions

The PROQ3 is a shorter version of the PROQ2 and as such it must make some psychometric compromises. This chapter examined the degree to which such compromises have been justified. The conclusions drawn are that the PROQ3 manifests good psychometric properties and may be recommended for research. Cronbach's alpha for estimating reliability underestimates the true levels of reliability and so users must be cautious of overconfidence in interpreting individual profiles. Indeed, if used clinically or as a diagnostic tool, practitioners might be advised to use the longer PROQ2. That said, the PROQ3 offers a reliable profile that might aid in therapeutic formulation and will most certainly prove useful in a research context.

The PROQ3 reflects the prespecified eight-factor structure of the Interpersonal Octagon. The examination of the ordinal arrangement of these factors suggests that caution must be exercised because a clear separation between the UN and UD items may be difficult. However, this might be of little import since the PROQ3 as a whole has a lot to recommend it and the upper–lower and distant–close axes are well represented by the measure. The PROQ3 can therefore be considered a useful research tool that remains faithful to its founding theory.

Note: The software to perform the analyses reported in this chapter was written by the author and is available upon request.

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5

The Couple's Relating to Each Other Questionnaire (CREOQ): A Measure of Negative Interrelating

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Introduction

The Evolvement of the CREOQ

The Couple's Relating to Each Other Questionnaire (CREOQ; Birtchnell et al. 2006) is made up of a set of four questionnaires for measuring negative forms of interrelating within couples. These are based upon the theoretical structure called the Interpersonal Octagon, which was developed from Birtchnell's (1993/1996, 1999/2002) Relating Theory. For a detailed description of the theory and a comparison with Leary's traditional theory, the reader may refer to the relevant chapters within

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_5

this volume (Chaps. 1 and 2, respectively). The CREOQ actually evolved from the Person's Relating to Others Questionnaire (PROQ2; Birtchnell and Evans 2004; Kalaitzaki and Nestoros 2003). However, whereas the PROQ2 measures a person's negative relating tendencies towards others in general, the CREOQ measures how individuals in an intimate relationship relate to each other. Therefore, the four questionnaires comprise one self-assessment (i.e. a person's assessment of his/her own negative relating towards his/her partner) and one partner assessment (i.e. a person's assessment of his/her partner's relating towards him/her) for each partner.

These are called MS (man's self-assessment of his relating to his partner), WS (woman's self-assessment of her relating to her partner), MP (man's assessment of his partner's relating to him) and WP (woman's assessment of her partner's relating to her). The items of the self-assessments (i.e. MS and WS) are identical apart from the use of the appropriate gender word (as for the partner assessments, i.e. MP and WP). The appropriate gender words can be substituted for use with homosexual couples, and the researcher or clinician may choose to administer only the self-assessment questionnaires.

The CREOQ has a structure similar to the PROQ2. Thus, as with the PROQ2, the CREOQ is a multidimensional scale; each of the four questionnaires has 96 items contributing to eight scales which correspond to the eight octants of the Octagon (Birtchnell 1993/1996). The octagon is constructed around a horizontal axis concerned with seeking closeness or distance and a vertical axis concerned with relating in an upper or in a lower way. The scales lying at the end of the two axes are called Neutral Close (NC), Neutral Distant (ND), Upper Neutral (UN), and Lower Neutral (LN), respectively. Combining these four poles, four additional scales are created, situated at the end of two secondary, intersecting axes, lying in between the principal ones: Upper Close (UC), Lower Close (LC), Upper Distant (UD), and Lower Distant (LD). Eighty items (ten items per scale) contribute to the total 'negative relating' score and scale scores. Another set of 16 items (two items per scale) measures the positive qualities of relating and have been added mainly to reduce the negative tone of the questionnaires and to offer respondents the opportunity to say something good about themselves and their partners. However, these are not normally scored.

The questionnaires are scored by computer (similar to the PROQ2), producing a graphical representation of the four octagons. Figure 5.1 is a diagram of the mean interrelating scores of 61 Greek couples admitted to an in vitro fertilisation (IVF) cycle (Mavrogiannaki et al. 2015). For each octagon the sequence of scores corresponds to the eight octant positions (UN, UC, NC, LC, LN, LD, ND, UD) and the extent of the shaded areas of octants represents the size of the score; the more the shading the higher the score in the particular octant, namely, the extent of the person's interrelating difficulties. It can be seen that couples interrelate negatively to each other and there are differences in the self-ratings and other-ratings between the partners.

Good psychometric properties have been reported for the CREOQ for the English, Dutch (Birtchnell et al. 2006), and Greek versions (Kalaitzaki et al. 2009). Since its development, many studies have used the CREOQ for assessing couples' interrelating difficulties. Studies have consistently confirmed that the mean CREOQ scores of couples seeking therapy are significantly higher than those of non-therapy couples (Birtchnell et al. 2006; Gordon 2005). They have also been significantly higher for the parents of psychotherapy outpatients than for the parents of non-patients (Kalaitzaki et al. 2009). Patients' individual therapy has been shown to ameliorate the negative interrelating between them and their partners (Kalaitzaki et al. 2014) and between the patients' parents (Kalaitzaki et al. 2010).

Comparison with Similar Measures

Over the years, several instruments have been developed to assess couples' distress and relationship problems (for a detailed review see Corcoran and Fischer's compendium 2013). Existing widely used instruments assess either the quality of the marital relationship in general or certain aspects of the relationship, such as marital conflict (e.g. the Conflict Tactics Scale, by Straus 1979, the Kansas Marital Conflict Scale, by Eggeman et al. 1985) or marital satisfaction (e.g. the Marital Adjustment Test by Locke and Wallace 1959). However, some of these are too short (e.g. the three-item Kansas Marital Satisfaction Scale by Schumm et al. 1983, the six-item Quality of Marriage Index by Norton 1983, and

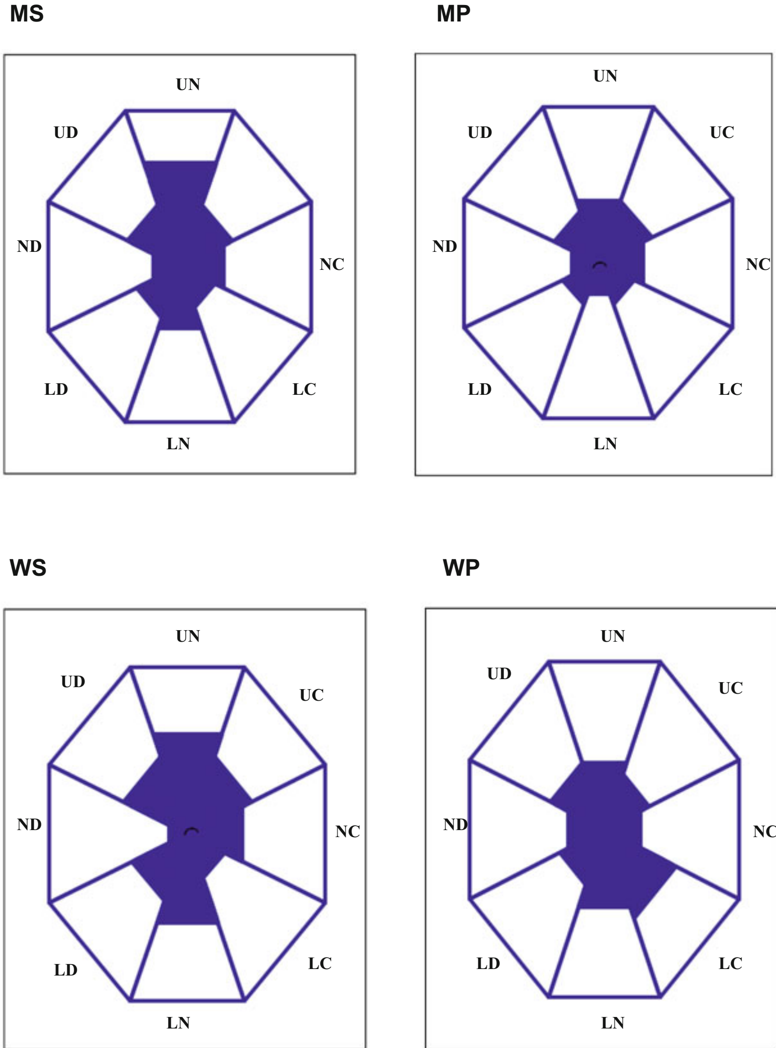

Fig. 5.1 Mean CREOQ3 scores of couples undergoing an in vitro fertilisation (IVF) cycle. *MS* man's self-assessment, *MP* man's partner-assessment, *WS* woman's self-assessment, *WP* woman's partner-assessment, *UN* Upper Neutral, *UC* Upper Close, *NC* Neutral Close, *LC* Lower Close, *LN* Lower Neutral, *LD* Lower Distant, *ND* Neutral Distant, *UD* Upper Distant

the seven-item Relationship Assessment Scale by Hendrick 1988). There are many instruments concerned solely with aspects of couples' intimacy (e.g. the Relationship Closeness Inventory by Berscheid et al. 1989, the Communication patterns Questionnaire–Short Form by Christensen and Heavey 1990, and the Relationship Issues Questionnaire by Christensen and Sullaway 1984). Also, a number of instruments specifically measure attachment styles in adult romantic relationships (e.g. Adult Attachment Questionnaire by Hazan and Shaver's (1990), the Multi-item Measure of Adult Romantic Attachments by Brennan and Shaver 1995, the Relationships Questionnaire by Bartholomew and Horowitz 1991, and the Experiences in Close Relationships–Revised by Fraley et al. 2000).

There are a few multidimensional instruments, such as the Perceived Relationship Quality Components (PRQC) Inventory (Fletcher et al. 2000), which includes five subscales (i.e. relationship satisfaction, commitment, intimacy, trust, passion, and love), the Marital Satisfaction Inventory–Revised (Snyder 1981), with 13 subscales (e.g. affective communication, time together, dissatisfaction with children, conflict over child rearing, sexual dissatisfaction), and the Network of Relationship Inventory (NRI; Furman and Buhrmester 1985) with 10 three-item subscales. However, most of them are quite lengthy (e.g. the Marital Satisfaction Inventory–Revised by Snyder has 150 items) or too short (e.g. the Dyadic Adjustment Scale by Spanier 1976, with 32 items allocated across four scales and its revised version of 14 items allocated across three scales by Busby et al. 1995).

Although potential measures have been developed for many constructs besides marital satisfaction and communication, psychometric evidence for these measures is particularly lacking. Many of them have been largely developed based on generally quite limited statistical analyses, such as face validity analysis which is not a sufficient method for ensuring that they are conceptually equivalent across diverse samples (Bronte-Tinkew et al. 2003). The psychometric properties of the measures need to be tested for different groups (e.g. across cultures), especially with advanced statistical procedures. Implicitly, there is also a lack of theoretically driven and empirically sound instruments (Murray 2007). Despite the compendium of instruments used in existing studies, there is no evidence that the field has developed a single measure or measures as the most appropriate for assessing relating in couples (Bronte-Tinkew et al. 2003).

There are only a few instruments that closely resemble the CREOQ (Birtchnell et al. 2006). Although the Dyadic Perspective-Taking Scale (Long and Andrews 1990) includes self-rating and partner-rating scales, it measures only empathic ability. Saffrey et al. (2003) devised a self-report and a partner-report version of the Inventory of Interpersonal Problems–Circumplex (IIP-C; Alden et al. 1990), which like the CREOQ, has eight scales based upon an octagonal theoretical structure. The Interpersonal Checklist, created by Paddock and Nowicki (1986), included eight, 16-item scales. The Family Adaptability and Cohesion Evaluation Scales, Couples Version (FACES III; Olson et al. 1983) is completed by both partners, but it includes 'we' items. The Ryle/Scott-Heyes Marital Patterns Questionnaire (Scott-Heyes 1982), like the CREOQ, has both a self-rating and a partner-rating version, is completed by both partners, and measures both horizontal and vertical interpersonal aspects of the relationship. However, it is essentially a measure of only positive characteristics on the horizontal axis (i.e. affection) and only negative characteristics on the vertical one (dominance).

The CREOQ was devised to address some of the drawbacks that the previously developed instruments had. It therefore has many advantages over the aforementioned instruments. It is a theoretically based, empirically tested, and multidimensional set of questionnaires. It is completed by both partners and enables each partner to rate his/her relating to the other and his/her view of the other's relating to him/her. Thus, a comparison between one's self-assessment and the other's partner assessment can advance comprehension of relating difficulties. In short, there is no measure like the CREOQ which (1) is theoretically based, (2) is multidimensional, consisting of eight scales, (3) has a longer (96 items) and a shorter version (48 items), both of which have good psychometric properties (Birtchnell et al. 2006; Kalaitzaki et al. 2009, 2014), (4) measures both close/distant and upper/lower features of relating, (5) distinguishes between positive and negative relating, (6) provides a self-rating and a partner-rating measure for each partner (i.e. measures how each person believes that the self relates to the other and how the other relates to the self), and (7) it is empirically tested in varied cultural contexts (Kalaitzaki et al. 2009, 2010, 2014).

Clinical Usefulness of the CREOQ

The CREOQ is intended for use in couple therapy (Birtchnell 2001; see Chap. 14 of this volume). The couple therapist who is familiar with Relating Theory (Birtchnell 1993/1996, 1999/2002) can administer the questionnaires to disclose what is happening within the relationship. His/her clinical judgement may or may not correspond with what the questionnaires reveal. Also a respondent's perception of how he/she relates to the partner and how the partner relates to him/her may or may not correspond with the partner's ratings. For instance, in Fig. 5.1, the women rate their interrelating to their husbands (WS) quite negatively, particularly on the upper scales (UN, UC, and UD) and also on the LN scale. The husbands seem not to agree at all. They rather view their wives (MP) as relating less negatively than their wives view themselves on nearly all the scales. The husbands rate their interrelating to their wives (MS) as negatively upper (UN), whereas their wives rates their husbands' relating to them (WP) as negatively lower close (LC). In general, both partners share negative interrelating (MS and WS), which, as expected, is particularly evident in women (WS). Men do not seem to recognise their wives' negative interrelating (MP), but wives do (WP). In non-clinical samples it is quite likely that what one partner divulges about him/herself corresponds closely with what the other partner divulges about him/her. On the other hand, disagreement between interspousal ratings is quite likely to occur in cases of dysfunctional marriages. In such cases, the US as a Couple Questionnaire (US; Birtchnell and Spicer, unpublished) may provide useful information about the overall quality of the marriage and validate the partners' ratings. A short description of the US can be found in the next section and a full account of it in Chap. 6 of this volume.

A couple's discrepancies in their perceptions of their interrelating may provide quite valuable information to the therapist and form the starting point for therapy (Kalaitzaki and Nestoros 2006). Within the context of individual therapy, inviting the partner to complete the questionnaires offers the therapist the chance to understand his/her view of the patient's changes during the course of therapy. In the study by Kalaitzaki et al. (2014) the partners of the patients undergoing individual therapy rated

the patients as improving on a broader range of scales than the patients rated themselves. Besides, the partners' self-ratings (i.e. the assessment of their relating to the patients) revealed to the therapist that they themselves demonstrated some degree of deterioration both in their relating with other people in general and in their interrelating with their partners. As this was not anticipated, it could have been overlooked if not revealed by the questionnaires.

Frequently monitoring potential changes in interrelating and offering couples feedback may have positive impact on the outcome of therapy (e.g. Knaup et al. 2009). Disclosing improvements or deterioration in interrelating, the couple is likely to be more motivated to engage in therapy and the therapist may modify his/her strategies and techniques to address the interrelating difficulties that need particular attention (Kalaitzaki and Nestoros 2006).

Recent Advancements and Modifications of the CREOQ

An adjunct to the CREOQ has recently been developed (Birtchnell and Spicer, unpublished), as it was deemed necessary for the clinician to rate not only the interrelating within the couple from each partner's perspective, but also the relationship as a whole. Thus, the US questionnaire allows each partner to rate how he/she views their between relationship. The 'US' refers to the 'us as a couple', and the wording of the items is 'we' rather than 'I' (like the self-rating version of the CREOQ) or 'he'/'she' (like the partner-rating version of the CREOQ). It has been translated into various languages (e.g. Greek and Dutch) and its psychometric properties in Dutch community and therapy couples can be found in Chap. 6 of this volume.

Over the years the CREOQ has undergone a number of modifications. After all, the developer, Birtchnell (1999/2002), has suggested that modifying the wording of the CREOQ can make it applicable to any dyadic relationship. Lucy Daniels has modified the CREOQ to measure the interrelating between job-sharers (see Chap. 10) and Deidre Gordon has modified it to measure the relationships of couples attending couple

therapy (see Chap. 14). Recently, a shortened version of the CREOQ has emerged, the so-called CREOQ3 (Kalaitzaki et al. 2014). In its name, the number '3' has been assigned in order to make it comparable with the PROQ3 (the shorter measure of general, negative relating to others). There never was a CREOQ2. It is half the length of the original 96-item CREOQ (Birtchnell 2001; Birtchnell et al. 2006) and is available from http://www.johnbirtchnell.co.uk. Since its inception, it has been applied in many studies.

The psychometric properties of the shortened version (i.e. the CREOQ3), like those of the longer version (i.e. the CREOQ), have been shown to be adequate. Kalaitzaki et al. (2014) have reported good psychometric properties for the Greek translation of the CREOQ3, as pertains to internal consistency (as assessed by Cronbach's alpha) and discriminant validity (as assessed by the mean inter-scale correlations) in samples of patients, non-patients, and their partners. Unfortunately, the CREOQ3 has not yet been used in its English form.

Research Findings

Kalaitzaki et al. (2014) used the CREOQ3 to examine whether 2 months of individual psychotherapy improved 60 Greek patients' relating to others and interrelating with their partners compared to a sample of 48 non-patients and their partners, over a comparable time span. It was shown that the CREOQ3 was sensitive to record changes in patients' and their partners' interrelating scores through the course of patients' therapy. More specifically, it was shown that the patients' reportedly negative interrelating with their partners, who had not been involved in therapy, improved significantly after only 2 months of patients' therapy, particularly as the couple's relationship may not have been the focus of therapy.

A brief report of unpublished CREOQ3 data follows. Kalaitzaki and Kateri (unpublished data) conducted a study to assess whether the self-construal of 200 Greek couples is predominantly individualistic or collectivistic (i.e. the image of self as separate from others vs the image of self as connected with others, respectively, as defined by Singelis and Sharkley 1995) and whether it correlates with their marital satisfaction.

It was hypothesised that couples in which both partners have collectivistic self-construal would have a higher level of marital satisfaction compared to couples that have individualistic self-construal. In addition, partners that have the same self-construal (e.g. both individualistic) would have a higher level of marital satisfaction than couples who have different self-construal (e.g. one partner has individualistic self-construal and the other collectivistic self-construal). Preliminary results showed that, as anticipated, couples in which both partners had collectivistic self-construal had a higher level of marital satisfaction (as lower scores correspond to lower level of relationship difficulty), as assessed with the US questionnaire ($M = 2.3$) than couples in which both partners had individualistic self-construal ($M = 4.5$; $t_{(195)} = -3.411$, $p < 0.001$). Unexpectedly, couples with the same level of individualistic self-construal (i.e. both high or low) had higher CREOQ3 scores ($M = 46.7$), that is more negative interrelating, than couples with different levels of individualistic self-construal (i.e. one high and the other low) ($M = 42.8$; $t_{(194)} = 2.049$, $p = 0.042$).

Mavrogiannaki et al. (2015) conducted a study to assess the marital quality of 61 infertile Greek couples admitted to an in vitro fertilisation (IVF) unit of a general hospital and whether it impacts upon (along with other factors) the successful outcome of IVF. Results showed that 50.8 % of the women achieved pregnancy. A stepwise logistic regression was conducted with pregnancy as the dependent variable and a number of independent variables, such as age, known infertility cause, infertility stress, coping mechanisms, personality type, locus of control, marital quality, resilience, life satisfaction, positive and negative feelings, and well-being (i.e. positive relations, self-acceptance, autonomy, personal growth, environmental mastery, and purpose in life). The model was statistically significant (Omnibus chi-square = 27.324, $df = 5$, $p < 0.001$) and it explained 40.9–54.7 % of the variance in the dependent variable. Overall, 84.6 % of the predictions were correct. It was shown that purpose in life and the negative feelings (e.g. discontent, sorrow) impacted positively on the outcome of IVF (i.e. achieving pregnancy), whereas autonomy, personal growth, and stress impacted negatively on the outcome (i.e. pregnancy failed). It is likely that negative feelings concerning childlessness may motivate infertile women to conform to the medical recommendations and to the procedures required in an IVF cycle, whereas autonomy–inde-

pendence and interest in personal growth interfere and hamper the process and therefore, the outcome.

The development of an Internet-administered version of the CREOQ3 and the study of its psychometric properties when administered via the Internet are the authors' future plans. The PROQ3 has already been administered through the Internet and the measurement and structural equivalence of its Internet-administered format were compared with those of the standard-written one across four national samples (English, Greek, Dutch, and Irish) in a study conducted by Kalaitzaki et al. (2015). It was found that the two formats were psychometrically equivalent across modality and nationality. There is no reason to doubt that the CREOQ3 will also maintain its psychometric properties when administered via the Internet, but this must be established. A difficulty faced with the Internet version of the CREOQ3 would be that both partners need to complete the questionnaire and in some cases, although invited by the respondent, the partner might be forgetful or even reluctant to complete it. The study of the psychometric properties of the CREOQ3 in varied cultural groups would be desirable. It is indeed a pity that currently the psychometric properties of the shortened version have only been tested in Greek samples.

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6

The Us as a Couple Questionnaire (US): A Unidimensional Measure of Couple Satisfaction

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Introduction

Relationship quality and satisfaction are two of the most widely investigated areas of relationship research (Boesch et al. 2007; Karney and Bradbury 1995; Rosen-Grandon et al. 2004) which tend to stem from two different approaches: the unidimensional and multidimensional approach (Kluwer 2001).

Crosby (1991) considers relationship quality a unidimensional concept and defines it as 'the global evaluation of marriage, i.e. the evaluation placed on the relationship as a whole by the marital partners' (p. 3). Others consider it as a multidimensional higher-order construct. For instance, the Perceived Relationship Quality Components (PRQC) Inventory (Fletcher et al. 2000) discriminates five subscales: relationship satisfaction, commitment, intimacy, trust, passion, and love.

The PRQC inventory conceptualises relationship satisfaction as part of relationship quality as it is by others (e.g. Hassebrauck and Aron

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_6

2001; Hendrick et al. 1998). A commonly used definition of relationship satisfaction is 'positivity of affect or attraction to one's relationship' (Rusbult 1983, p. 102). Additional measures that assess relationship satisfaction are: the Marital Satisfaction Inventory (Snyder 1979); the Relationship Assessment Scale (Birnbaum 2007; Hendrick et al. 1998); the Relationship Satisfaction Scale (Heyman et al. 1994; Troy et al. 2006); the Revised Dyadic Adjustment Scale (Busby et al. 1995), and the RELATionship Evaluation (Busby et al. 2001; Larson et al. 2007). Some measures are quite lengthy and measure various dimensions, like the 280-item Marital Satisfaction Inventory (Snyder 1979) or the 271-item RELATionship Evaluation (Busby et al. 2001) which measures the influence of individual, family, and cultural contexts on relationship satisfaction.

Most questionnaires have been developed according to a classical test model, which assigns a measure on a scale as the sum of the responses to each item on that scale (Crocker and Algina 1986; Nunnally and Bernstein 1994). The Rasch model (Robin et al. 1999) is another approach which constructs a hypothetical unidimensional line along which items and persons are located according to their difficulty and ability to measure underlying concepts. This provides a scale on which the items are placed hierarchically: the simplest items will be answered by all respondents, and the more difficult items only by those who are best informed about the concept. This is in contrast to most questionnaires, for which items of a subscale are related but not hierarchically. So in these questionnaires it is not clear from a subscale score which items are summed. Fit statistics such as R1 and Q2 (see Suarez-Falcon and Glas 2003 for further explanation of the Rasch statistics) indicate how well different items describe the group of respondents and how well individual respondents fit the group (Wright and Masters 1982; Wright and Stone 1979).

A practical advantage of Rasch homogeneous, unidimensional questionnaires is their use in clinical settings. When a couple with relationship problems is in therapy, it can be useful to gauge their general evaluation of the relationship from the start. For a good relationship partners do not have to think the same things, but if they are not good friends any more one can wonder whether the relationship is still worth it. On a Rasch homogeneous scale a decrease of the scale score over time indicates that

more difficult aspects of the concept measured have been solved. In other words: the higher the score, the worse the relationship. But it is not just the score that makes Rasch analysis interesting for testing the psychometric quality of questionnaires. The sequence revealed by the analysis makes interpretation easier and is appealing for a clinician. If for instance an item halfway through the questionnaire is positive then lower items will also be positive.

Unidimensional measures of relationship satisfaction measure the relationship in general (Hendrick et al. 1998; Norton 1983) and the results are usually unambiguous (Fincham and Linfield 1997), meaning that the most difficult issues are solved. These instruments usually consist of just a few (less than ten) items, with questions like 'In general, how satisfied are you with your relationship?' For example, the Interactional Problem Solving Questionnaire (Lange 1983) contains only four questions on general satisfaction.

The Us as a Couple Questionnaire (US; Birtchnell 1999) is a brief, single-scale 20-item measure which assesses how well each partner considers the two partners get on together. The US shows similarities with the Family Adaptability and Cohesion Evaluation Scales (FACES III; Olson 1986) and Marital Stability and Cohesion Evaluation Scales (MACES III, Olson 2000) which are used predominantly with couples. The FACES III is a 20-item self-report questionnaire that measures the amount of cohesion and adaptation within a relationship according to the partners. It is administered twice per participant: once in terms of the way one currently experiences the relationship, and once in terms of the way this relationship would ideally be. The difference between these two measures provides an indication of the family or couple satisfaction: the less the difference, the more satisfied the partners are (Olson 2000). Unlike the FACES III, the US evaluates the relationship on one dimension by asking how satisfied each partner is with his/her relationship. Compared to the FACES III, the US has a narrower focus and the items are constructed from a 'we' perspective (e.g. 'We found ourselves avoiding each other' and 'There is a lot of give and take in our relationship').

Before the development of the US, Birtchnell developed the Couples Relating to Each Other Questionnaire (CREOQ; Birtchnell et al. 2006)

which measures negative forms of interrelating within couples and consists of a set of four questionnaires of 48 items each. The US was developed as an additional, less complex instrument that could provide a global indication of how a partner judges the aspect of getting on together in his/her relationship. The US may assist couples in clarifying perceptions and highlight areas of agreement and disagreement within the relationship. Further, it shows the individual's and the couples' strengths and challenges related to the quality of their relationship. The self-report nature of the US means that it can be easily administered in research and therapy settings. However, the US has not yet been validated psychometrically, particularly in terms of its unidimensionality, and this was the aim of the current study. Five hypotheses were tested: (1) the items of the US will fit the Rasch model; (2) the internal reliability of the US is sufficient; (3) the average total score of the US will be higher for 'addicted couples' than for 'non-addicted couples'; (4) there will be a significant negative correlation between the US and the Satisfaction subscale of the Interactional Problem Solving Questionnaire, and (5) there will be no significant correlation between the US and the Symptoms Checklist-90-Revised (SCL-90-R).

Method

Participants

Two groups participated in this study: 112 Dutch couples that reported no psychological or relationship problems (Group 1) and 50 couples, in which one of the partners had an alcohol or substance use disorder for which they were being treated in an addiction treatment centre (Group 2). All participants were heterosexual.

Group 1 was recruited from the general Dutch population via snowball sampling (Biernacki and Waldorf 1981). The third author asked acquaintances to invite their own acquaintances to participate in a study about the Dutch version of the US. Those willing to participate were asked to contact the researcher. To be eligible, no partner in a couple could be

suffering from any substance abuse or psychological disorder. The mean age of Group 1 was 33.1 years (SD = 12.8) and the mean duration of their relationship was 9.9 years (SD = 9.3).

Group 2 consisted of 50 couples, of which one of the partners was in treatment for alcohol or drug dependence (80 % alcohol, 2 % benzodiazepines, 2 % opioids, or 16 % more than one substance). They were recruited by therapists working at one of three addiction treatment centres in the Netherlands. Couples were included if the partner was not dependent on any psychoactive substances according to DSM-IV criteria. The patients were following a period of three-month inpatient treatment. The mean age of Group 2 was 45 years (SD = 8.5), the mean duration of the relationship was 19 years (SD = 10.6), and the mean duration of addiction problems was 11 years (SD = 8.3).

Measures

The Us as a Couple Questionnaire (US; Birtchnell 1999)

The US measures how each partner considers the two partners get on together. It has 20 items (Table 6.1), each with a possible response of 'true' or 'false'. Each even item answered with a 'true' response and each odd item answered with a 'false' response receives one point. The higher the total score, the less satisfied one is with his/her relationship. The minimum possible total score is 0 and the maximum is 20.

Interactional Problem Solving Questionnaire (IPSQ; Lange 1983)

The IPSQ contains four questions on global satisfaction about relationships. The higher the total score, the more satisfied one is with his/her relationship. This is contrary to the US, where a high score indicates difficulties in the relationship. The IPSQ has a good level of internal reliability (Cronbach's alpha = 0.81).

Table 6.1 The original English and translated Dutch items of the US and the Rasch order of the 17 items of the US-2

Original English items	Items translated in Dutch	Rasch order
1. We are good friends. ($F=1$)	1. We zijn goede vrienden.	17.
2. We find ourselves avoiding each other. ($T=1$)	2. We komen erachter dat we elkaar vermijden.	13.
3. We help each other out of difficulties.* ($F=1$)	3. We helpen elkaar uit de moeilijkheden.*	* Deleted from original US
4. We don't have very much in common. ($T=1$)	4. We hebben niet erg veel gemeenschappelijk.	5.
5. When we have a problem we sit down and sort it out together. ($F=1$)	5. Als we een probleem hebben, gaan we bij elkaar zitten en zoeken we het samen uit.	4.
6. We seem to be drifting apart. ($T=1$)	6. We lijken van elkaar te vervreemden.	8.
7. There is a lot of give and take in our relationship. ($F=1$)	7. Er is een goede balans tussen geven en nemen in onze relatie.	3.
8. We can't talk for long without starting to argue. ($T=1$)	8. We kunnen niet lang met elkaar praten zonder dat we gaan redetwisten.	6.
9. If we have a row it is quickly over and there are no hard feelings afterwards. ($F=1$)	9. Als we ruzie hebben is het snel over en zijn er geen verwijten achteraf.	2.
10. The fun has gone out of our relationship. ($T=1$)	10. De lol is er af in onze relatie.	14.
11. We are usually able to see each other's point of view. ($F=1$)	11. We zijn meestal in staat elkaars standpunt in te zien.	11.
12. We rub each other up the wrong way. ($T=1$)	12. We strijken elkaar meestal tegen de haren in.	12.
13. We are quite open with each other. ($F=1$)	13. We zijn behoorlijk open naar elkaar.	7.
14. We don't enjoy each other's company.* ($T=1$)	14. We genieten niet van elkaars gezelschap.*	*Deleted from original US
15. When we each want different things, we compromise.* ($F=1$)	15. Als we allebei iets anders willen, komen we tot overeenstemming.*	*Deleted from original US
16. We don't have much to say to each other. ($T=1$)	16. We hebben elkaar niet veel te zeggen.	10.

(*continued*)

Table 6.1 (continued)

Original English items	Items translated in Dutch	Rasch order
17. We often find ourselves thinking the same thing. ($F = 1$)	17. We komen erachter dat we hetzelfde denken.	1.
18. We are not good for each other. ($T = 1$)	18. We zijn niet goed voor elkaar.	15.
19. We are always pleased to see each other. ($F = 1$)	19. Het doet ons altijd plezier om elkaar te zien.	9.
20. We can't seem to agree about anything. ($T = 1$)	20. Het lijkt erop dat we het nergens over eens zijn.	16.

Note: All even items are scored with one point if true and all odd items are scored with one point if false

Symptoms Checklist-90-R (SCL-90-R; Arrindell and Ettema 1986)

The 90-item SCL-90-R measures physical and psychological complaints during the past week (somatisation, obsessive-compulsiveness, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism). The Dutch version of the SCL-90-R has good psychometric properties (Arrindell and Ettema 1986). It was administered to Group 1.

Dutch Translation of the US (Hunt et al. 1991)

Two Dutch researchers translated the English version of the US to Dutch independently. Another independent researcher, whose native language was English and whose second language was Dutch, translated the Dutch version of the questionnaire back into English. The original and back-translated versions were compared and differences were discussed. Eventually the Dutch version was established. Comments on the questionnaire were gathered from three therapists from the family therapy in addiction treatment centres. A pilot study on five patients showed that the questionnaire could be easily read and the questions were well understood.

Procedure

Couples in both groups provided informed consent and were administered the US and the Satisfaction subscale of the IPSQ. Group 1 also completed the SCL-90-R and questions about psychiatric and substance-related disorders. The partners were instructed not to view each other's responses. Scores were calculated by computer. The medical ethical board of the addiction treatment centres approved the procedure.

Data Analysis

The structure of the US was analysed in order to test whether the items fit a Rasch model and whether it could be regarded as unidimensional. In cases where the items did not fit, items were deleted using the Rasch Scaling Program (Robin et al. 1999). The internal consistency of the US was tested by computing the Cronbach alpha coefficient. The comparison of the US total score between the two groups was tested with an independent-samples *t*-test and the correlations between the US and the Satisfaction subscale of the IPSQ and between the US and the SCL-90-R were estimated using Pearson's correlation coefficient.

Results

Unidimensionality of the US

A Rasch analysis was conducted on the two combined groups described above which was divided into the scores of two gender groups. Table 6.2 shows that the Rasch model did not fit the US data for either group. After deleting the three items which contributed most to the significance of R1 and Q2, the tests for both gender groups became insignificant. This indicated that the remaining set of items was unidimensional. Thus, the Rasch model for the remaining 17 items fit the data for both males and females (see Table 6.2). The deleted items were: 3: *We help each other out of difficulties*, 14: *We don't enjoy each other's company*, and 15: *When we*

Table 6.2 Results of the Rasch analysis for the original 20-item US and 17-item US-2

	R1 statistic	Df	*p* (R1)	Q2 statistic	Df	*p* (Q2)
Original version (20 items)						
Males	61.57	38	0.01	488.95	510	0.74
Females	49.79	38	0.10	663.61	510	0.00
US-2 (17 items)						
Males	44.60	32	0.07	288.62	357	1.00
Females	44.08	32	0.08	312.77	357	0.96

each want different things, we compromise. Items 3, 14 and 15 were therefore excluded from the subsequent analyses. This short version of the US is hereafter referred to as the US-2.

The sequence of US-2 items based on the Rasch analysis is listed in the last column of Table 6.1. The item '*We often find ourselves thinking the same thing*' (item 17) was the one that most couples disagreed on. The item '*We are good friends*', was the one that most couples agreed on, that is the majority of couples reported that they were good friends. Furthermore, the results of the Rasch analysis indicated that the US-2 is unidimensional. This can be interpreted as follows. If a partner agrees on the statement '*We seem to be drifting apart*' (item 6, sequence order 8) then it is highly probable that he/she will also agree on the item '*We don't have very much in common*' (item 4, sequence order 5) and that he/she will disagree on the item '*There is a lot of give and take in our relationship*' (item 7, sequence order 3).

Internal Consistency

The internal consistency of the 17 items of the US-2 was very good for both males and females (Cronbach's alpha = 0.79 and 0.81, respectively).

Discriminant Validity

It was expected that the US mean scores would differ for the two groups. The means and standard deviations for Groups 1 and 2 were 1.44 (1.79) and 4.71 (3.71), respectively and the difference between the two groups

was statistically significant ($t = -8.45$; $p < 0.001$; 95 % CI [−4.04, −2.50]. Therefore, the Dutch version of the US clearly discriminates community control couples from couples in treatment for an addiction.

Construct Validity

Correlations between the US-2, the Satisfaction subscale of the IPSQ and the total score of the SCL-90-R are presented in Table 6.3. As predicted, there was a statistically significant negative correlation between the US-2 and the Satisfaction subscale for both groups. The correlations between the US-2 and the SCL-90-R were all weak and non-significant.

Discussion

The findings of this study indicate that the revised version of the US (the US-2) which consists of 17 of the original 20 items fit well with the Rasch model, meaning that the scale is unidimensional. This yielded substantial support for the construct validity of the US-2. Due to the scale's unidimensionality, the sum of all items assesses the level of relationship satisfaction. Because the items are hierarchically ordered from a high level of satisfaction (low score on the US-2) to a low level (high score on the US-2), a decrease of the score is easily interpreted. It also means that if two individuals have the same total score, they have answered the same questions positively. One of the advantages of a measure fitting the

Table 6.3 Correlations between the US-2 and Satisfaction subscale of the IPSQ and between the US-2 and SCL-90-R for males and females

	US-2 – IPSQ		US-2 – SCL-90-R	
Group	Male	Female	Male	Female
1	−0.516**	−0.708**	0.084	0.171
2	−0.577**	−0.608**	×	×

Group 1 = community-based population ($n = 112$)
Group 2 = couples with one addicted partner ($n = 50$)
* $p < 0.05$; ** $p < 0.01$; × No correlation calculated because the SCL-90 was only administered to sample 1

Rasch model is that one group is well comparable with another group. Furthermore, the Cronbach alphas ranged from 0.79 to 0.88, showing that the US-2 has good reliability.

Couples in which a partner had an addiction (Group 2) scored significantly higher on the US-2 than the community group (Group 1). As expected, the addiction problem of one partner had a negative effect on the quality of his/her relationship; in our study couples in which a partner had an addiction had a lower mean score of 4.2 (identical for both males and females) than couples seeking therapy in Birtchnell and Spicer's unpublished study (8.8 for males and 10.5 for females), which indicates that addicted couples tended to report less relationship satisfaction than non-addicted couples. It should be noted, however, that the mean total score of the therapy couples in Birtchnell and Spicer's study (US: 20 items) was three points higher than the mean total score of the addicted couples (US-2: 17 items).

The current results indicate that the US-2 has a good level of convergent validity. As predicted, the US-2 was negatively related to the Satisfaction subscale of the IPSQ which suggests that the US-2 is a valid instrument for assessing aspects of satisfaction in relationships. The findings also indicated an acceptable level of divergent validity since all correlation coefficients between the US-2 and the SCL-90-R were weak and non-significant.

Our study has several limitations. Firstly, it was conducted in the Netherlands involving couples in which one partner was being treated for a substance-related disorder and so there may be different results in populations in which one partner has a different mental disorder. In addition, because of the rather small samples it was not possible to take into account potential confounding couple-related variables such as length of the relationship and the presence of children in the household.

Overall, the results indicated that the US-2 is a unidimensional instrument fitting the Rasch model with good internal consistency, validity, and reliability. It is a short self-report measure which is straightforward to complete and does not require much training for the professionals (e.g. therapists) to administer it. This makes the US-2 a relatively inexpensive research and treatment evaluation instrument. The US-2 is designed to be used as a global measure of how both partners consider they get on

together; for different aspects of relationship difficulties, such as communication or sexuality, other questionnaires are required. Because both partners complete the US-2, the evaluation of the relationship is more objective than if only one person were to judge his/her relationship. We expect the US-2 to measure change in a relationship, but this has only be assessed in a pilot study (DeJong et al. 2008). The relationship of the US-2 with the concepts 'relationship quality' and 'relationship satisfaction' is also not yet clear and so this would be a fruitful area for future research.

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7

The Family Members Interrelating Questionnaire (FMIQ): A Measure of Interrelating Between Young Adults and Their Parents

Argyroula Kalaitzaki

Introduction

The present chapter reports the development of the Family Members' Interrelating Questionnaire (FMIQ; Kalaitzaki et al. 1999, 2002/2012, 2009, 2010) for the assessment of the interrelating between young adults and their parents. Initially, it intended to measure interrelating within the families of the persons exhibiting schizophrenic symptoms (Kalaitzaki and Nestoros 2002), and for this, it was used in the author's theses (Kalaitzaki 2000, 2005). It has also been administered to neurotic and non-patient samples, the results of which are reported in this chapter.

Rationale for the Development of a New Instrument for Assessing Family Relationships

In reviewing the relevant literature one could locate a multitude of diverse instruments which assess familial relationships. Interestingly, most of these

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_7

instruments have been developed without a sound underlying theoretical framework. This of course may facilitate the use of these instruments by researchers and practitioners from different theoretical perspectives, but it inevitably results in sparse contributions, which may inhibit the advancement of the field (Touliatos et al. 2001). Other instruments, such as the Experiences in Close Relationships-Revised Scale (ECR-R; Fraley et al. 2000) are theory driven, but they assess certain concepts derived from specific theories that not all researchers and practitioners are willing to embrace.

A prominent drawback is that the majority of the instruments are based exclusively on self-reports. However, the multiple perspective approach is considered advantageous over the single perspective approach, as it requires self-report data to be collected from multiple sources (Cullerton-Sen and Crick 2005; Klonsky et al. 2002). People with relating deficiencies might be unable to perceive their own and others' relating difficulties objectively. Collecting data from other family members could provide a more valid and accurate description of the target person's relating deficiencies, whose self-reports might be limited to what he/she is able or willing to perceive, and thus biased and misleading (Klonsky et al. 2002). Relatively few instruments, such as the Sibling Relationship Inventory (Stocker and McHale 1992), allow for multiple members to provide their perceptions of the quality of family and sibling relationships.

Self-assessments – even from multiple sources – are also likely to be affected either by people's (overly) positive or negative views of themselves or by people's tendency to present themselves in a positive or negative way (Leising et al. 2010; Vazire 2010). Undoubtedly, there is benefit in complementing self-reports with observational ones. Incorporating an observational approach into a single family instrument could be made by asking each family member to assess the other members' relating behaviour. Connelly and Ones (2010) have recognised the advantages of using other-assessments to complement self-assessments. This approach would allow the comparison of one's own self-assessed relating with the other members' other-assessed relating. The lack of agreement between raters might need to be taken into careful consideration. However, research has shown that the level of self–other agreement is dependent upon the level of familiarity between the target and the respondent (Kurtz and Sherker 2003).

Provided that independent assessments of the targets' relating are missing, this approach would reinforce the validity of the measured concept.

In sum, inspecting the various instruments derived from the literature review, it became clear to the author that none of them accommodated all of the required advantages. Many instruments focus on family functioning (and not on family relationships) either through self-assessment (e.g. the Family Assessment Measure, Skinner et al. 2000; the Family Environment Scale 3rd Edition, Moos and Moos 1994) or through an observational approach (e.g. the Iowa Family Interaction Rating Scales, Melby and Conger 2001; the Family Adaptability and Cohesion Evaluation Scale IV, Olson and Gorall 2006). Those that specifically measure family relationships are confined to a certain aspect of the dyadic assessment, such as the child's report of his/her parents (e.g. the Revised Child Report of Parental Behavior Inventory, Schludermann and Schludermann 1988), and not the inverse assessment or they are not theoretically driven and do not include both a self- and other-assessment.

Getting Acquainted with the Theory and with the First Relating Instrument

Having considered the reviewed instruments insufficient for measuring dysfunctional familial interrelating comprehensively, the author came across the second version of the Person's Relating to Others Questionnaire (PROQ2; Birtchnell et al. 1992). This is a questionnaire for the assessment of a person's general, negative relating tendencies towards other persons, which is based on Relating Theory (Birtchnell 1993/1996). The confluence of Relating Theory with seemingly opposite theories, such as the traditional interpersonal circle theories (e.g. Leary's in 1957), has been accounted for in Birtchnell (2014) (see also Chap. 2 of this volume). The theory is described in detail elsewhere (see Chap. 1 of this volume) and so only a brief account will be made here. Relating Theory proposes that people's relating behaviours can be classified across a close/distant and an upper/lower axis. Introducing intermediate positions between the four main ones creates eight positions, which can be graphically represented by the *Interpersonal Octagon* (Birtchnell 1993/1996).

The author considered that Relating Theory is a coherent, rational, and sound theoretical framework for the understanding, interpretation, and measurement of one's relating tendencies (J. Birtchnell, personal communication, 1998).

The Couple's Relating to Each Other Questionnaire (CREOQ; Birtchnell et al. 2006) is the earliest developed interrelating measure, from which the FMIQ was developed. The CREOQ concerns the assessment of negative interrelating between two married or cohabiting partners (Birtchnell 2001; Birtchnell et al. 2006). At this point, the distinction between relating and interrelating should be made. Relating concerns a person's attitude and behaviour towards other people or one particular person, whereas interrelating concerns both relating to and being related to by the other(s) (Birtchnell 1993/1996). Positive and negative forms of relating/interrelating should be also defined. Positive relating/interrelating refers to relating/interrelating confidently, effectively, respectfully, considerately, and inoffensively in each one of the eight positions of the octagon. Negative relating is a tendency to relate in a destructive, anxious, self-centred, inconsiderate, clumsy, or awkward way (Birtchnell 1993/1996; Kalaitzaki et al. 2014) and reflects one's incompetency to establish and maintain mutually satisfying relationships with others. More specifically, the CREOQ assesses the way each partner of a dyad relates to the other, and the way each partner perceives that the other relates to him/her (Birtchnell 1993/1996, 1994). This necessitates a self-rating questionnaire and an other-rating questionnaire for each partner (four questionnaires overall). The author considered this an ideal instrument for the assessment of dyadic relationships. It needed to be modified, however, in order to be applicable to the assessment of familial relationships (i.e. the interrelating between young adults and their parents).

The Development of the FMIQ

As mentioned earlier, the Family Members' Interrelating Questionnaire (FMIQ) is a derivative of the CREOQ and concerns interrelating within families (Kalaitzaki et al. 2009). Similar to the CREOQ, it specifically measures the interrelating between two specified members (in this case family members). Thus, a *self-rating questionnaire* assesses the way that

each family member relates to the other and *an other-rating questionnaire* assesses the way that each family member perceives how the other relates to him/her. The items of the FMIQ were derived from the CREOQ. The phrasing of a few items were modified (less than 10 for the self-rating and less than 15 for the other-rating questionnaires) to account for the relating differences between the parents and the children (Kalaitzaki et al. 2009). The number of items (96 overall), the item structure, and the scoring instructions are identical to the CREOQ. It therefore consists of 8 scales of 12 items each (ten of which are summed to produce the total score) which measure negative interrelating corresponding to the eight positions of the Interpersonal Octagon. In order to render the questionnaire more acceptable and relieve its negative tone, 16 of the 96 items are positive unscored (two items for each scale). The other-rating questionnaires describe more negative behaviours compared to the self-rating questionnaires.

Since four questionnaires are required to evaluate the interrelating between two specified persons for a family of three (father, mother, and adult child) assessments of three two-person relationships need to be made (father–mother, father–child, mother–child). For a four-member family, five two-person relationships need to be evaluated (father–mother, father–child1, father–child2, mother–child1, mother–child2). Because the CREOQ assesses the father–mother relating, 8 and 16 questionnaires (four for each family member) are required, respectively. The names of the questionnaires were selected in terms of who was making the assessment and who was being assessed. Thus, the initials Fa, Mo, So, and Da stand for father, mother, son, and daughter, respectively. When the syllabus 'Se' (short for self) is included in the naming of a questionnaire, it indicates that the respondent assesses his/her own relating to the other. When it is not, it concerns the respondent's assessment of the other person. For example, the questionnaires with which the father evaluates his own relating toward his son and his daughter are called FaSeSo and FaSeDa, respectively. Those with which the father assesses his son's and his daughter's relating towards himself are called FaSo and FaDa, respectively. For the assessment of the father/son interrelating the FaSeSo and FaSo are to be completed by the father and the SoSeFa and the SoFa are to be completed by the son. The whole set of 16 questionnaires (the names and their abbreviations) is presented in Table 7.1. For a three-member family,

Table 7.1 The sixteen FMIQ questionnaires for the assessment of a four-member family

Assessor	Person being assessed	Self-rating questionnaires	Other-rating questionnaires
Father	Daughter	FaSeDa: *Father's assessment of his relating to his daughter*	FaDa: *Father's assessment of his daughter's relating to him*
	Son	FaSeSo: *Father's assessment of his relating to his son*	FaSo: *Father's assessment of his son's relating to him*
Mother	Daughter	MoSeDa: *Mother's assessment of her relating to her daughter*	MoDa: *Mother's assessment of her daughter's relating to her*
	Son	MoSeSo: *Mother's assessment of her relating to her son*	*Mother's assessment of her son's relating to her*
Daughter	Father	DaSeFa: *Daughter's assessment of her relating to her father*	DaFa: *Daughter's assessment of her father's relating to him*
	Mother	DaSeMo: *Daughter's assessment of her relating to her mother*	DaMo: *Daughter's assessment of her mother's relating to her*
Son	Father	SoSeFa: *Son's assessment of his relating to his father*	SoFa: *Son's assessment of his father's relating to him*
	Mother	SoSeMo: *Son's assessment of his relating to his mother*	SoMo: *Son's assessment of his mothers relating to him*

the appropriate questionnaires in terms of child's gender are selected and administered, appropriately. The questionnaires for the assessment of the interrelating between siblings are in their initial phase of development and their psychometric properties have yet to be examined.

The factor structure and psychometric properties (internal reliability, inter-rater reliability, test–retest reliability, and inter-scale correlations) of the Greek translation of the FMIQ are acceptable (Kalaitzaki 2000, 2005; Kalaitzaki et al. 2009, 2010). In all studies, principal component analyses consistently extracted four factors both for the self-rating and for the other-rating questionnaires, resembling the four main poles of the Interpersonal Octagon. The mean Cronbach alphas were in general

acceptable both for the sample of non-patients and the sample of psychotherapy patients (either psychotic or neurotic). The correlations between the self-ratings of one family member (e.g. parent) and the other-ratings of the other family member (e.g. child) were also acceptable.

The Scoring and Graphic Representation of FMIQ Scores

Since the FMIQ items are very similar to those of the CREOQ, the same computer software is used for the scoring. It produces a list and a graphical representation of the scores within a single diagram (see next section). The FMIQ allows the scoring and representation of the way the parents relate toward their child(ren) and the way the child(ren) relate toward their parents. It also enables the depiction of each member's self-rating and other-rating scores across the eight relating behaviours represented by the Interpersonal Octagon. To the author's knowledge, no other instrument combines all these different aspects of assessment in one instrument.

One who is familiar with the theory can compare the extent of the shaded area of the octagons between a pair of relaters. The greater the extent of the shaded area in each octant of an octagon, the higher the level of negative interrelating in that particular area. At a glance one could determine who relates to, or who is related to, more negatively than the others. Furthermore, detailed information can be gathered, by comparing (1) either the self- or the other-rating octagons between two specified persons (e.g. FaSeSo-SoSeFa or FaSo-SoFa) and/or (2) the self- and other-rating octagons of two specified persons (e.g. FaSeSo-SoFa or SoSeFa-FaSo) (Kalaitzaki and Nestoros 2002). In rating the other person, different sources of biases, such as the assimilation effect (i.e. one's tendency to perceive others similarly) or the assumed similarity (i.e. one's tendency to perceive others as similar to the self) (Kenny 1994) could be deterred through the comparison of the self- and other-ratings between two persons.

Figure 7.1 shows a typical printout of the FMIQ interrelating within a family including a mother (M), a father (F), a patient (C1), and a well

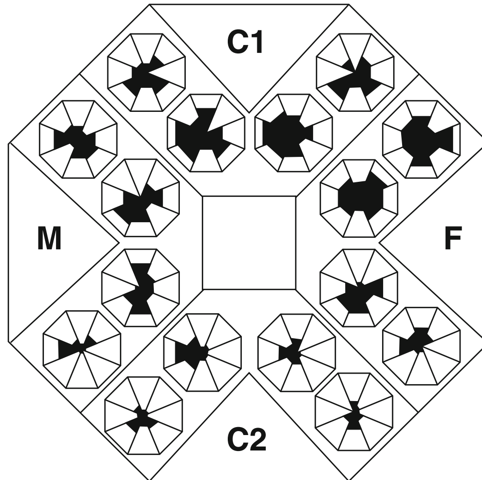

Fig. 7.1 The FMIQ interrelating scores of a four-member family. The *C1*, *C2*, *F*, and *M* stand for the patient (adult child), his healthy sibling, the father, and the mother, respectively

sibling C2). The octagons are arranged in four sets of four, each of which forms an angle around the specified person. In each angle, the two inner octagons depict the respondent's self-relating to the person that the octagon faces, whereas the two outer octagons depict the same respondent's perception of how these persons relate to him/her. The interrelating scores between the patient and his parents are very high (see the four octagons around C1 and the two upper octagons around M and F). This is not the case for the healthy sibling (see the four octagons around C2 and the two lower octagons around M and F). It is noteworthy that the patient's relating to his parents (two inner octagons around C1) is more marked than the parents' relating to him (two inner octagons around M and F) and also from their views of the patient's relating to them (two outer octagons around M and F). On the other hand, the patient's view of his parents' relating to him (two outer octagons around C1) is more marked than the parents' self-assessed relating to the patient (two inner octagons around M and F). The patient's predominant interrelating deficiencies concern his negative upper and distant relating toward his parents (i.e. being

dominating, boasting, exploitative, avoidant, and rejecting). The father exhibits the same interrelating deficiencies in his relating with his son, whereas the mother relates predominantly negatively from the positions of lowerness and closeness (i.e. feeling helpless, being submissive, and concurrently intrusive, possessive, and clinging). In sum, the father/son interrelating is highly quarrelsome, whereas the mother is presumably intimidated by her son's upper relating, whereas at the same time she desperately tries to cling to him.

Figure 7.2 depicts a three-member family, in which the parents undergo therapy for marital problems and the adult child is a non-patient. The lower four octagons concern the adult child, whereas the four to the left concern the father, and the four to the right concern the mother. The inner octagons concern the respondent's relating to the person that the

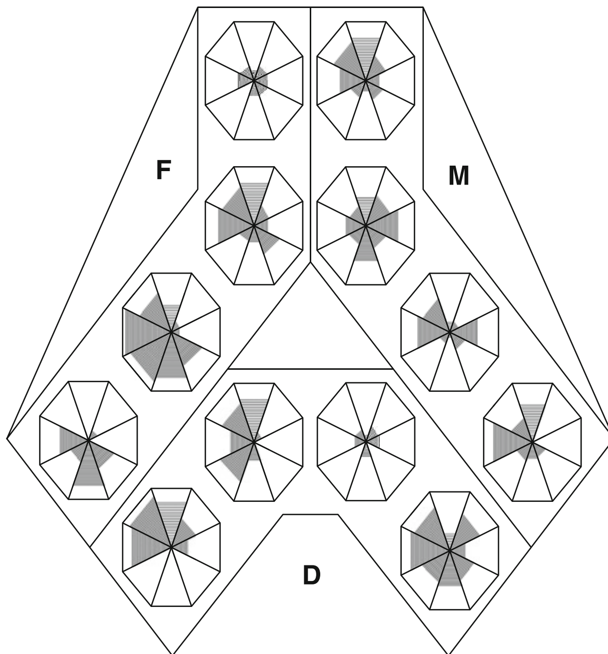

Fig. 7.2 The FMIQ interrelating scores of a three-member family. The *C*, *F*, and *M* stand for the patient (adult child), the father, and the mother, respectively

octagon faces, whereas the two outer octagons concern the respondent's perception of the others' relating. The parents (particularly the father) registered high levels of negative interrelating between each other and extremely high levels of negative interrelating with their daughter, and this concerned both their relating towards her and their daughter's relating towards them. The daughter assessed her relating towards her parents less negatively than what her parents experience and perceived her parents' relating towards her extremely negatively. The parents (particularly the father) rated themselves as negatively lower and distant towards their daughter, but the daughter reported that she experiences them predominantly as negatively upper and distant towards her.

Research Applications of the FMIQ

To date the FMIQ has only been used in two Greek studies. Kalaitzaki et al. (2009) compared the interrelating within the families of 84 psychotic outpatients receiving psychotherapy and 80 non-patients. A healthy sibling of both the non-patients and the patients also completed the FMIQ. The parents completed the CREOQ. The results showed that the parents of the patients rated themselves significantly more distant towards each other than the parents of the non-patients. The reported interrelating between the patients and their parents was markedly more negative than that between the non-patients and their parents. In the families of the patients, the patients/parents' interrelating was also significantly worse than that between the healthy siblings and their parents. These findings also provide preliminary evidence for the discriminant validity of the FMIQ.

A second study (Kalaitzaki et al. 2010) examined changes in negative interrelating between the patients and their parents over the course of patients' individual therapy. The interrelating between 115 psychotic psychotherapy outpatients and their parents was significantly more negative than that between 56 neurotic patients and their parents. In this study the patient's therapy appeared to have some beneficial effects upon the interrelating between all family members, even those that had not themselves been involved in the therapy. Over the course of therapy the negative interrelating scores between the patients and their parents, between

the patients' siblings and their parents, and also between the parents themselves significantly decreased.

In line with the development of a shorter version of the CREOQ, a shortened version of half the items has been developed for the FMIQ (Kalaitzaki and Birtchnell 2008; Kalaitzaki, submitted). It is half the length of the original 96-item version. The item structure and scoring instructions are identical to the original version, but six items are now allocated to each octant scale, five of which are negative and scored. It is scored by computer and the scores can be represented both numerically and graphically. This has been used in a study conducted in Greece, as part of the International Parenting Study (IPS). In this study (Kalaitzaki, submitted) the potential transmission of the family-of-origin violence (e.g. experiencing punitive discipline and/or witnessing mutual interparental violence) in adults' dating relationships was examined in 973 Greek college students. The results showed that exposing a child to mutual interparental violence in early life both directly predicted later mutual dating violence and indirectly through the negative relating to mother (among other variables, such as violence approval, depression, etc.). The psychometric properties of the shortened version demand further examination. Should psychometric equivalence between the two versions be proved, it would be possible to increase the use of the shorter version in practice or apply it interchangeably with the longer one.

Familiarising family members with the theory and the graphic representations of the FMIQ scores could make it possible for the therapist to disclose the interrelating inadequacies to the family members (Kalaitzaki and Nestoros 2006). There is extended literature on the positive impact that the patients' feedback may have on the therapy outcome, though it concerns their symptoms (e.g. Knaup et al. 2009). It is in the author's future plans to examine the presumed positive impact of providing feedback to the therapist and/or the clients regarding the family's interrelating deficiencies.

Further research on the psychometric properties of the FMIQ is required. Advanced statistical procedures which test the eight-factor underlying structure and the octagonal higher order of the FMIQ are necessary. These have been evaluated for both the paper-and-pencil and the Internet-administered format of the shortened Person's Relating to

Others Questionnaire (PROQ3), which is a measure of negative relating to others (Birtchnell et al. 2013; Kalaitzaki et al. 2015).

A shortcoming of the study conducted by Kalaitzaki et al. (2010) was that since the therapy had not been specifically focused on ameliorating dysfunctional family interrelating, it was not possible to conclude what caused the improvements to the family members' interrelating that were not involved in therapy. A study in which the therapy is focused specifically on reducing interrelating deficiencies within the family would have been of great value. Different therapeutic modalities (e.g. systemic family therapy or CBT) might benefit from the use of the FMIQ in clinical practice. Applying the FMIQ to families with other clinical conditions (e.g. anorexia nervosa patients) could also be a worthwhile endeavour.

Acknowledgements We would like to acknowledge the contribution of Bill Birtchnell for designing the software used for the scoring and graphic representation of the FMIQ scores.

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8

Parental Relating: A New Conceptualisation of Parenting Styles and the Development of the Adult Recollection of Parental Relating Questionnaire (ARPRQ)

Cristina Harnagea

Introduction

Dimensions of Parenting

Efforts to understand the essence of parental interactions with children have resulted in conceptual frameworks which are based, almost invariably, on two main components: *support*, which is defined as a combination of affective, nurturant, and companionate behaviours, and *control*, which is defined as a range of regulatory and disciplinary behaviours (Barber et al. 2005). The control dimension has been further differentiated into *behavioural* and *psychological* (Barber 1996; Barber et al. 1994; Cummings et al. 2000). Similar concepts have been proposed by Symonds

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_8

(1939) (*acceptance/rejection* and *dominance/submission*), Baldwin (1948) (*control*, *democracy*, and *activity*), Sears et al. (1957) (*warmth* and *permissiveness*), Becker (1964) (*love versus hostility*, *restrictiveness versus permissiveness* and *anxious emotional involvement versus calm detachment*), Schaefer (1965) (*acceptance versus rejection*, *psychological control versus psychological autonomy* and *firm control versus lax control*) and Rollins and Thomas (1979) (*support* and *control*). The following section elaborates the characteristics of these three dimensions.

Parental Control

Behavioural control consists of parental behaviours characterised by the communication of a set of rules, enforcement of the rules, monitoring and supervision of children's activities, and the use of discipline techniques that emphasise the consequences of children's actions on others (Barber 1996; Maccoby and Martin 1983). Other terms are parental supervision (Kurdek and Fine 1994), parental monitoring (Brown et al. 1993), demandingness (Baumrind 1991; Maccoby and Martin 1983), family management (Patterson and Stouthamer-Loeber 1984), and structure (Grolnick 2003).

Research studies consistently evidence that close supervision, strict enforcement of family rules, and recognition of children's views are associated with desirable outcomes (Denham et al. 1991; Maccoby and Martin 1983), such as fewer behavioural problems, particularly delinquency, and affiliation with deviant peers (Maccoby and Martin 1983; Patterson and Stouthamer-Loeber 1984). Although low levels or inconsistent patterns of behavioural control may result in an increased risk of developing psychological problems, such as aggression, delinquency, or impulsivity (Barber 1996; Baumrind 1971), higher levels of parental control do not necessarily result in higher levels of compliance and desirable outcomes. For example, the use of power-assertive disciplinary techniques (e.g. threats, excessive use of commands, deprivation, and physical force) predicts an even wider range of maladjustment issues (Cummings et al. 2000). By comparison, induction techniques that emphasise the painful consequences of the child's behaviour toward others have been reported to result in greater competence, empathy, and pro-social behaviour (Hoffman and Saltzstein 1967).

Psychological Control

This consists of approaches that inhibit or intrude upon the psychological development of the child through exploitation and manipulation of the parent–child bond (e.g. withdrawal of love and induction of guilt, criticism, and expressions of negative affect, such as disappointment and shame, and excessive control, such as possessiveness and protectiveness; Barber 1996). Psychological control is associated with feelings of guilt, increased self-responsibility, inability to express aggression (Becker 1964), dependency (Baumrind 1978), social withdrawal (Baumrind and Black 1967), inability to make conscious choices (Baumrind 1978), low ego strength (Hauser et al. 1984), low self-esteem, passivity, inhibited and over-controlled conduct (Barber 1996), depressed affect and inhibition of the development of psychological autonomy (i.e. a clear sense of identity and appraisal of the self as competent, Barber et al. 1994), and healthy awareness and perception of self (Barber 1996). Parental control has also been associated with internalised and externalised problem behaviour and peer associations (e.g. Brown et al. 1993; Galambos et al. 2003; Soenens et al. 2005; Walker-Barnes and Mason 2001).

Parental Support

Parental support include expressions of warmth, acceptance, positive emotional tone, and sensitivity to children's psychological states, and responsiveness to their psychosocial needs (Cummings et al. 2000). Parental acceptance and responsiveness have been found to predict positive development outcomes, including self-regulation (Stayton et al. 1971), prosocial behaviour and sociability (Clarke-Stewart 1973), self-esteem and constructive play (Alessandri 1992), cognitive development, creativity, conformity, internal locus of control, moral behaviour, and social competence (Maccoby and Martin 1983; Rollins and Thomas 1979). In contrast, lack of responsiveness has been associated with maladaptive consequences, including attention deficit disorder (Jacobvitz and Sroufe 1987), aggression (Egeland et al. 1993a) and social withdrawal (Egeland et al. 1993b).

Studies investigating parental support and behavioural control revealed that they are related to higher levels of psychosocial functioning and

lower levels of maladaptation (e.g. Beyers et al. 2003; Brody et al. 2002), whereas high levels of these predict risk of association with deviant peers (Goldstein et al. 2005). Parental support and harsh or inconsistent parenting are linked to internalising and externalising symptoms (Melby et al. 1993). Numerous other studies have assessed all three dimensions (i.e. support, behavioural control, and psychological control). Highlighting the limitations of these studies, Barber et al. (2005) suggested that the key processes underlying parental influence may not emerge by studying the constructs of support and control, but by investigating the associations between these constructs.

Rationale for the Development of a New Measure

The rationale for the development of the Adult Recollection of Parental Relating Questionnaire (ARPRQ) stems from the advantages of investigating perceived parenting from an interpersonal perspective, for which a measure does not yet exist. The two dimensions of parenting, support and control, are remarkably similar to the definitions of proximity and power proposed by Relating Theory (Birtchnell 1987, 1993/1996), presented in Chap. 1, and, to some extent, by interpersonal theory (Horowitz 2004; Leary 1957; Wiggins 1979). For this reason, parenting can be conceptualised using the two dimensions postulated by Relating Theory.

Deconstructing the Constructs: A New Conceptualisation of Parenting Styles

The fact that similar dimensions have been extracted from the study of adult interpersonal interactions as well as parental behaviour indicates that parenting can be viewed as any interpersonal interaction. Existing measures of parental behaviour appear to be based upon aggregates of other constructs and so one reason for choosing Birtchnell's (1987, 1993/1996) Relating Theory as a configuration for parental relating is the simplicity and purity of its constructs, and which would enable the establishment of clearer links between parenting, or perceived parenting, and child outcome. The inability to establish these links has been considered

the principal disadvantage of configurational models of parenting (Maccoby and Martin 1983; Darling and Steinberg 1993). Concepts such as acceptance, care, warmth, love, responsiveness, and support not only incorporate a range of constructs but also seem incompatible with an explanation from the evolutionary perspective. For example, envisaging a supportive animal parent may prove considerably more challenging.

The conceptualisation of parental relating as consisting of two main orthogonal axes of proximity and power (Birtchnell 1993/1996) would result in placing concepts such as *acceptance*, *warmth*, *care*, *and love* on the *close* extremity of the proximity axis. The concept of support, however, encompasses closeness as well as a degree of power due to its semantic connotation of *providing for*, *looking after*, and *helping*. Consequently, support would be placed on the positive *upper close* octant, which is thought to be the result of the combination of power and closeness (see upper diagram of Fig. 1.1 in chapter 1 of this volume (see also Birtchnell 1994)).

It appears that the positive upper close octant is, in fact, the essence of parenting and the precursor to the formation of attachment in the young (Bowlby 1977), which is any form of behaviour that results in a person attaining or retaining proximity to some preferred individual, who is perceived as stronger and/or wiser. Bowlby (1969, 1973) observed that at birth the infant is completely helpless and could not survive independently. This condition places the infant in a position of *lowerness* compared to the parent on the power axis, and a position of *closeness* towards the parent on the proximity axis. Consequently, Birtchnell (1987) argues that the relating position of the parent towards the young would be *positive upper close*.

Considering the manifestations of behavioural control (e.g. monitoring, supervision, disciplining, and enforcing rules) and psychological control (e.g. emotional manipulation, criticism, expressions of negative affect, and excessive control) in conjunction with the outcomes associated with each, it appears that, in broad terms, the literature is referring to 'good' and 'bad' control, or in marginally less judgemental terms, 'positive' and 'negative', which coincides with the distinction of Relating Theory between positive and negative forms of relating (Birtchnell 1993/1996). In light of Relating Theory, the characteristics of behavioural control could be conceptualised as the *positive upper* relating styles

(i.e. UD, UN, and UC), and psychological control as the *negative upper relating* (see examples of both in Fig. 1.1). Parental support, according to Relating Theory, can also manifest in negative forms, such as, for example, intrusiveness or possessiveness, which could be conceptualised as UC and NC (see Fig. 1.1).

Since it has been suggested that parenting is an essentially upper relating state, the proposal that it can also incorporate forms of lowerness may, justifiably, appear as a most intriguing contradiction. This apparent inconsistency can be explained using Birtchnell's (1993/1996) theory. As the child develops, the power differential between parent and child changes, in that the child becomes increasingly self-sufficient and starts progressing towards the upper positions. At the same time, the degree of proximity between parent and child changes, in that the child gradually becomes more independent, and the parent gradually allows the child to be so. Eventually, the child becomes as self-sufficient as the parent and can detach from the parent completely, although in humans this detachment is not as abrupt and final as in other animals (Bowlby 1977). In Relating Theory terms, this progression from secure base to independence is conceptualised as the necessity for the child to experience, and feel comfortable in, all relating states and, therefore, to become what Birtchnell (1993/1996) calls a 'versatile' relater.

In order to facilitate the development of versatility in the child, the parent also needs to be a versatile relater. More specifically, in order to facilitate the development of positive upperness in the child, the parent needs to show the ability to relate from a position of positive lowerness. This state of relating is likely to occur initially during pretend play and later it can progress to interactions in which the child is genuinely upper to the parent. However, the negative form of lowerness in the parent has already been identified in the literature as *role reversal*, and has been defined as the inappropriate expectations of a child to meet the parent's needs (Morris and Gould 1963). Role reversal has been found to compromise the development of autonomy and individuation in the toddler period (Jacobvitz et al. 1991), is associated with identity issues in adults (Fullinwider-Bush and Jacobvitz 1993) and predicts attention problems (Carlson et al. 1995; Jacobvitz and Sroufe 1987), externalising symptoms and social problems (Macfie et al. 1999), as well as depression, anxiety,

and low self-esteem (Jacobvitz and Bush 1996). To this end, the conceptualisation of parenting as a form of relating could reside within other models as 'parenting style' (Darling and Steinberg 1993), as the 'moderating influence on the relationship between parenting practices and developmental outcomes and through its influence on the child's openness to parental socialisation' (Darling and Steinberg 1993, p. 493).

The distinction between positive and negative forms of relating offers the potential to integrate the various dimensions and configurations of parenting discussed in the literature. The application of Relating Theory to parental behaviour would result in a conceptualisation of parental relating based on the eight relating states, and as such, the relating of parents towards children would consist of an upperness–lowerness and a closeness–distance axis.

The Development of the New Measure

A measure of parental relating has been developed by the author based on this new conceptualisation and is at present being refined. The Adult Recollection of Parental Relating Questionnaire (ARPRQ) retrospectively measures the degree of proximity and power exhibited by parents, as perceived by the child until the age of 12, after which it is assumed that children would commence puberty and parenting requirements would change.

The measurement of perceived rather than actual relating was of interest due to the significance of the interpretation of behaviour, rather than behaviour per se. Leising and Borkenau (2011) conclude that this may the case because the consequences of the behaviour largely depend on the interpretation by the perceiver. Indeed, as early as the first century, Epictetus (AD 55–135) thought that people are not affected by the events themselves but by their interpretation of them (Dancy and Sosa 1993). Consequently, the relationship between parenting styles and child outcome depends, to a large degree, upon the child's perception of the parent's behaviour.

As part of the 'family' of octagonal measures (see Chaps. 3–11), the questionnaire was required to abide by the rules and format of other existing octagonal measures, such as the Person's Relating to Others Questionnaire Version 2 (PROQ2; Birtchnell and Evans 2004), the shortened

Person's Relating to Others Questionnaire (PROQ3; Birtchnell et al. 2013), and the Couples' Relating to Each Other Questionnaire (CREOQ; Birtchnell et al. 2006). To this end, the aim was to construct a questionnaire containing 48 items, five negative and one positive for each relating state, measured on a Likert-type scale of four responses. So far, after the development of the questionnaire (i.e. definition of constructs and item generation), three main psychometric studies were conducted.

Study One

The aim of Study One was to test the internal consistency of the new measure and its concurrent validity. There were 117 participants (61.4 % females), aged over 18 years. Sixty-four per cent were university students and 36 % were adults from the general population. The ARPRQ and the Parental Bonding Instrument (PBI; Parker et al. 1979) were administered. The ARPRQ asks participants to rate their mother's parenting behaviour as they remembered her in their childhood (i.e. up to the age of 12). Each item is scored on a four-point Likert scale, ranging from 'nearly always true' to 'almost never true'. The PBI is a widely used tool for measuring parental bonding and/or behaviour. Because the ARPRQ scales measure negative relating, it was anticipated that they would be positively correlated with the Overprotection scale of the PBI and negatively with the Care scale of the PBI.

Results showed that three out of the eight scales (LN, LD and NC) failed to reach the required levels of reliability (i.e. Cronbach's alpha higher than 0.70), and three items (one from LD and two from LN) achieved low correlation coefficients with their respective scale. As anticipated, the ARPRQ correlated negatively with the Care scale and positively with the Overprotection scale of the PBI.

Study Two

The aim was to test the internal consistency of the revised ARPRQ and to cross-validate it against data obtained from interviews. It was conducted online using the scores of the ARPRQ for both the mother and the father of the participants. The revised version of the ARPRQ for mothers,

the ARPRQ-M, incorporated the changes considered necessary after Study One, such as rephrasing of items and introducing the five-point Likert scale format. The ARPRQ-F was used in its first version and was developed by adapting the phrasing of the items of the ARPRQ-M to reflect their reference to the male parent equivalent. A total of 104 participants (75 % females) aged over 18 were recruited via email using snowball sampling and completed the questionnaire online. Of these, eight agreed to take part in interviews (three males, mean age 32 and five females, mean age 34).

Results showed that all but the LD scale of the ARPRQ-M reached alpha values over 0.70. Semi-structured interviews were conducted in which respondents were invited to talk freely about their parents and clarify certain points, if necessary. A content analysis was conducted followed by a comparison of the identified themes with the scores obtained from the questionnaires.

For each relating state there was a pattern consisting of high values of interview scores accompanied by high values of ARPRQ scores, which suggested that there may be a positive correlation between the results of the two methods. Although this observation could not be reliably substantiated by statistical analysis due to the small sample size, the emerging pattern was a sufficient indicator for the validity of the ARPRQ.

Study Three

The aim was to test the internal reliability of the revised ARPRQ and to establish its factorial structure. A total of 601 participants (57.4 % males), aged over 18, were recruited online and were awarded shopping points for participation. They completed both the mother and father versions of the ARPRQ online. The ARPRQ incorporated the rephrasing of the items deemed responsible for the low reliability values obtained in Study Two. All scales had Cronbach's alpha values higher than 0.70. For the ARPRQ-M the most adequate solution was a principal component method with orthogonal rotation, in which four factors were requested, which were tentatively named distance (16 items), closeness (10 items), lowerness (10 items), and upperness (3 items). For the ARPRQ-F the most adequate solution also comprised four orthogonally rotated factors (distance: 13 items; lowerness: 11 items; closeness: 10 items, and upperness: 6 items).

The Future of the ARPRQ

In spite of these findings, the ARPRQ is still being refined, including investigation of its test–retest reliability, a confirmatory factor analysis, and tests of predictive validity. The application of the ARPRQ to the field of clinical psychology would require its adjustment and validation in order to reflect the features of particular clinical populations. Relating Theory's distinction between positive and negative relating can be applied to a model of parental relating and may be helpful in facilitating the investigation of specific links between parental relating and child outcomes. For example, it may enable the prediction of specific developmental outcomes at different stages and roles in life.

Ascertaining the prediction of a particular outcome as a reference criterion would grant the ARPRQ the empirical validation of a genuinely useful instrument. Possible reference criteria range from functional behaviour (e.g. relating to others in general, relating to one's child(ren), or partner, relating in other specific roles), to dysfunctional behaviour as encountered in individuals suffering from anxiety, depression, personality disorders, and other psychological issues. Personality disorders have already been mapped using both relating (Birtchnell and Shine 2000) and interpersonal theories (Horowitz 2004) and, therefore, links to the relating styles of parents would provide further understanding of the developmental aspect of these disorders, further evidence for the validity of their classifications, and an enhanced empirical basis for the therapeutic interventions used to address them. In conclusion, it is hoped that the ARPRQ will prove to be a useful and versatile instrument for a variety of research purposes and clinical applications.

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9

The Person's Relating Interview (PRI) and the Observation of Relating Behaviour (ORB): Observers' Perceptions of Other People's Interpersonal Relating

Argyroula Kalaitzaki, Michelle Newberry, and John Birtchnell

Introduction

Irrespective of what people say about themselves, it is sometimes necessary for an external observer to have a systematic method for recording and classifying the relating behaviour of others, particularly of psychiatric patients. For this reason two measures have been developed from the self-report Person's Relating to Others Questionnaire (PROQ;

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_9

Birtchnell et al. 1992; Birtchnell and Evans 2004; Birtchnell et al. 2013; see also Chap. 3 of this volume), called the Person's Relating Interview (PRI; Leoni and Birtchnell 1999a) and the Observation of Relating Behaviour (ORB; Leoni and Birtchnell 1999b).

The Person's Relating Interview (PRI)

Leoni and Birtchnell (1999a) developed a structured interview called the Person's Relating Interview (PRI) which measures negative relating tendencies, similar to those assessed by the self-report Person's Relating to Others Questionnaire Version 2 (PROQ2; Birtchnell and Evans 2004). In contrast to the PROQ2, however, the items of the PRI are presented one octant at a time and the interviewer explains the general theme to be covered before each set of items. For each octant the items are grouped into five separate scales (Secure, Extreme, Desperate, Insecure, and Avoidant), which together produce the acronym SEDIA. Each of these scales has five items so there are 25 questions per octant, creating a total of 200 questions. Although this may seem lengthy, with a cooperative individual, the interview can be completed within 45 minutes. The interviewer first assesses the person's tendencies to get close to or distant from others then assesses features of upperness (i.e. dominance) and finally features of lowerness (i.e. subservience). Each item carries a score of 0 (not present), 1 (slightly present) or 2 (markedly present) and the scores of each octant can be summed to produce a total score.

The *Secure* items specifically measure positive relating and enable the interviewer to determine whether the interviewee is competent (as opposed to incompetent) in each octant. This can be done much more effectively in an interview setting than by way of a questionnaire. A person who relates in an *extreme* way has a marked inclination to relate in a particular way, be it either positively or negatively. In a sense it is a concession to the thinking that lies behind the interpersonal circle (Kiesler 1996; Leary 1957) and the concept of a 'preferred' relating style. This *Extreme* category was incorporated into the PRI because it appears that sometimes, an individual who has a high negative score on a particular octant also has a high positive score on it. The remaining items refer to

the three standard negative relating scales, as defined by Relating Theory (see Chap. 1 of this volume).

Typical forms of relating incompetence can be grouped under three categories. *Desperate* relating refers to a person's attempt to attain, maintain, or regain a particular state of relatedness by any means and irrespective of another person's needs. For example, a desperately close relater will impose his/her closeness upon another person even if this is not welcomed, whereas a desperate upper relater will try to maintain his/her position disregarding other people's needs. *Insecure* relating refers to a person's fear of losing a particular state of relatedness. Thus, an insecurely distant relater is constantly trying to withdraw and distance other people so as not to be dislodged from the position of distance, whereas an insecure upper relater degrades and relegates other people so as to attain the position of upperness. *Avoidant* relating refers to a person's rigidly clinging to one state because of incompetence or fear of relating in the opposite one. For example, an avoidant relater who is frightened of lowerness holds on firmly to upperness, being oblivious to the positive features of lowerness, and a person who is incapable of relating in the position of closeness clings firmly to distance. The Desperate, Insecure, and Avoidant scores for each octant of the PRI can be summed to produce a total negative score, the maximum of which (30) is the same as the maximum negative score for each octant of the PROQ2. This permits a degree of comparison between the two measures.

The Observation of Relating Behaviour (ORB)

Leoni and Birtchnell (1999b) developed a relating checklist called the Observation of Relating Behaviour (ORB) with scales that are based on the octants of the Interpersonal *Octagon* (Birtchnell 1994) (please see Chaps. 1 and 2). The ORB measures the relating behaviour of another person by an external observer. Unlike the Observed Person's Relating to Others Questionnaire (OPROQ; Kalaitzaki et al. 2014), which is intended for use by people to rate the negative relating of others, such as members of a psychotherapy group, it represents the judgement of a professional observer or interviewer. Structurally, the ORB resembles the PRI in that it

includes the same five Secure, Extreme, Desperate, Insecure, and Avoidant (SEDIA) scales, but unlike the PRI, there is only one item for each category. Therefore, the ORB includes 40 items allocated across eight scales. The five items of each scale describe one of the five relating styles (i.e. Secure, Extreme, Desperate, Insecure, and Avoidant). These have been described for the PRI and so they will only be briefly referred to here.

Secure relating is positive relating, whereas *extreme* relating is relating markedly differently, whether positively or negatively. *Desperate* relating involves trying to attain or maintain a particular state of relatedness, *Insecure* relating is fear of losing a particular state of relatedness, and *Avoidant* relating is rigidly relating to one state because of incompetence in relating in the opposite one. As with the PRI, the observer is invited to assess whether the characteristic is not present, slightly present, or markedly present and the answers carry a score of 0, 1, or 2, respectively. Separate scores for each scale are extracted (e.g. 0–2 for Secure relating, 0–2 for Extreme relating), whereas the three negative scale scores (i.e. Desperate, Insecure, and Avoidant) can be summed to yield a total negative score of 0–6.

There are two ways of presenting the items of the ORB. In the first, the items of each scale are grouped together. Thus, the person is presented first with the Upper Neutral (UN) items, then with the Upper Close (UC) and so on. In the second way, all items are randomly distributed and the person is presented randomly with items from all scales. Preferably the second version should be used to avoid bias by the observer. There is also a Greek version of the ORB for assessing the relating behaviour of children, called the Children's Observation of Relating Behaviour (CHORB) developed by Kalaitzaki (2010a); this has been used in a study, which will be briefly presented below.

Research on the CHORB

Research evidence suggests the importance of positive and successful peer relationships in preschool years and childhood (Bovey and Strain 2003; Ladd 1999). The benefits include a sense of connection and security, high self-esteem and self-confidence, and easier adaptation to the

preschool setting (Dunn 2004; Ladd 2009). The absence of positive peer interactions is clearly linked to negative long-term consequences for children's development (e.g. withdrawal, loneliness, depression, and feelings of anxiety) and later social interactions, such as difficulties dealing with peers (Woodward and Fergusson 2000). It also predicts school dropout, educational underachievement, and psychological and behavioural problems later in life (Criss et al. 2002; Ladd 1999). Toddlers who are engaged in complex play with peers are more competent in dealing with other children in the preschool years and in middle childhood (Ladd and Troop-Gordon 2003). Attending a nursery provides preschool children with the opportunity to interact more frequently with peers. Giannouli et al. (2010) examined the psychometric properties of the modified relating measures for use with children in a Greek sample and compared the relating styles of children attending nursery with those not attending nursery.

The Children's Observation of Relating Behaviour (CHORB; Kalaitzaki 2010a), and a modified version of the OPROQ for use with children, called the Observation of the Child's Relating to Others Questionnaire Version 3 (OCROQ3; Kalaitzaki 2010b) were administered to both the parents and nursery staff of 331 preschool children aged 2–6 years, recruited from 22 nurseries in Crete, Greece. The relating tendencies of these children were compared to those of a control group of 100 children of the same age not attending a nursery. In the control group parents completed only the CHORB and the OCROQ3. The Dimensions of Personality for Children and Adolescents questionnaire (E-DIPROPE; Besevegis and Pavlopoulos 1998) was also administered to both the parents of the children (either attending or not attending nursery) and the nursery staff in order to assess the children's personality components based on the Big Five personality traits (Costa and McCrae 1989). There is one form for the children aged 2–4 years called the E-DIPROPE 3, with 106 items and another form for the children aged 5–7 years, called the E-DIPROPE 6 which has 92 items.

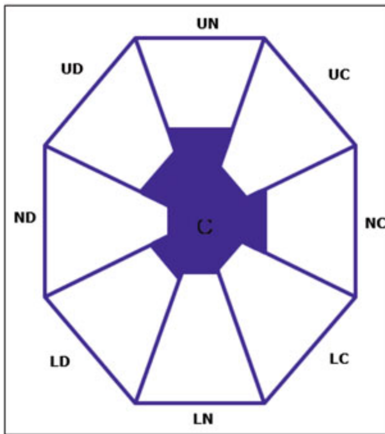
The CHORB and the OCROQ3 showed good internal consistency as assessed with Cronbach's alpha (0.80 and 0.86, respectively). The OCROQ3 scales' reliabilities were adequate, ranging from 0.67 to 0.85, whereas for the CHORB they were somewhat lower (ranging from

0.51 to 0.79). Interrater agreement between nursery staff and parents' CHORB assessments (as measured with Pearson's *r*) were moderate, as significant agreement ($p < 0.05$) was present in five out of the nine correlations (eight octant scales and the total score). The interrater agreement for the OCROQ3 was slightly lower (three out of nine correlations were significant). The inter-scale correlations for the CHORB and the OCROQ3 were relatively low or moderate, respectively, ranging from 0.40 to 0.64 for the parents and from 0.54 to 0.75 for the nursery staff. The scales' reliabilities for both forms of the E-DIPROPE were adequate, ranging from 0.75 to 0.85 for the parents and from 0.80 to 0.91 for the nursery staff.

A factor analysis of the OCROQ3 items yielded eight components which accounted for 58.2 % of the variance. Factors 1 and 2 were a bipolar split between lower neutral–lower distant (LN–LD) and upper distant–upper neutral (UD-UN) items, respectively. Factors 2 and 4 were predominantly upper close (UC) and neutral close (NC), respectively, and Factor 5 was mainly NC. Factor 6 contained two lower close (LC) items, whereas Factor 7 contained two NC and one LC item. Factor 8 contained only one item (LC). In sum, UC, NC, and LC octant scales were readily identified, whereas two factors contained a mixture of items from adjacent octants (e.g. LN–LD and UD–UN). A factor analysis of the CHORB items yielded seven components which accounted for 51.7 % of the variance. Overall the picture was less clear; neutral distance (ND) was clearly identified, whereas one factor was a mixture of UN–UC items and another one a mixture of LN–LD items. All other factors contained diffused items. Children were rated by both nursery staff and their parents as predominantly negatively upper neutral (UN) and neutral close (NC). Figure 9.1 presents the scores for the OCROQ3. It was not possible to produce a graphical depiction for the CHORB as there is presently no such software available.

In general, nursery staff rated the children with both the OCROQ3 and CHORB as more negative relaters than the parents on six out of the eight octant scales, although the difference was significant for only three of them. Using the CHORB, nursery staff rated the children as

(a) Parents



(b) Nursery staff

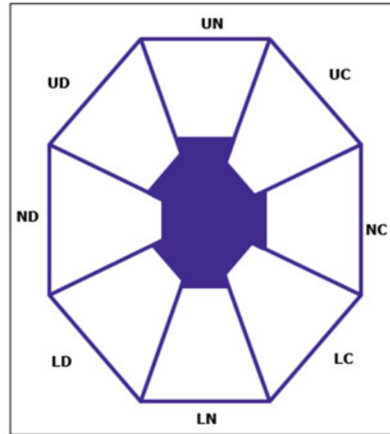


Fig. 9.1 OCROQ3 assessments of children by parents and nursery staff

significantly more negative relaters overall (with a total score of 29.3), as well as more negatively lower distant (LD: 4.0) and neutral distant (ND: 2.2) than the parents (27.9, 3.6 and 1.9, $t = -2.04$, $p < 0.05$; $t = -2.05$, $p < 0.05$; and $t = -2.27$, $p < 0.05$, respectively). The results were similar for the OCROQ3; nursery staff rated the children as significantly more negatively lower neutral (LN: 5.6) and neutral distant (ND: 4.2) than the parents (4.4 and 3.0, $t = -3.67$, $p < 0.001$ and $t = -4.35$, $p < 0.001$, respectively), whereas parents rated their children as significantly more negatively upper neutral than the nursery staff (UN: 7.7 vs 6.9, $t = 2.25$, $p < 0.05$).

One of the main aims of the study was to assess relating and personality differences between children attending nursery and those not attending nursery. Using the OCROQ3 the parents of the children not attending nursery rated their children as significantly more negatively upper close (UC: 5.6 vs 4.6, $t = 2.59$, $p < 0.01$), neutral distant (ND: 3.7 vs 3.0, $t = 2.14$, $p < 0.05$), and as more negative relaters overall (44.1 vs 40.5, $t = 2.06$, $p < 0.05$) than the parents of the children attending nursery. The CHORB scales also showed differences in favour of the

children attending nursery. The parents of the children not attending nursery (i.e. the control group) rated their children as significantly more Extreme, Desperate, and Avoidant relaters than the parents of the children attending nursery (5.8 vs 5.0, $t = 2.68$, $p < 0.01$; 4.5 vs 3.7, $t = 2.88$, $p < 0.01$; 4.9 vs 4.0. $t = 1.97$, $p < 0.05$).

Significant differences were also found for the personality characteristics of the children. For children aged 2–4 years, the parents rated the children attending nursery as significantly more extroverted (3.6 vs 3.2, $t = -7.32$, $p < 0.001$), mentally developed (3.7 vs 3.4, $t = -5.32$, $p < 0.001$), and scrupulous (3.3 vs 3.1, $t = -3.02$, $p = < 0.01$) and significantly less emotionally reactive (3.0 vs 3.2, $t = -3.02$, $p < 0.01$) and inhibited (2.9 vs 2.7, $t = 4.11$, $p < 0.001$) than the parents of the children not attending nursery. For children aged 5–7 years, significant differences were shown only for inhibition, with children attending nursery being rated as more inhibited than those not attending, as reported by parents (2.9 vs 2.7, $t = -3.03$, $p < 0.01$).

Inhibition, emotional reactivity, and intellectual development predicted 16.3 and 23.2 per cent of the variance in OCROQ3 for parents and nursery staff ($F = 15.463$, $p < 0.001$ and $F = 22.813$, $p < 0.001$, respectively). Inhibition and emotional reactivity predicted 16.1 and 25.5 % of the variance in CHORB for parents and teachers ($F = 29.439$, $p < 0.001$ and $F = 25.837$, $p < 0.001$, respectively). The same two variables accounted for 33.2 per cent of the variance in CHORB ($F = 25.623$, $p < 0.001$) for the control group. These two variables along with extroversion predicted 37.9 per cent of the variance in OCROQ3 ($F = 21.154$, $p < 0.001$). In sum, children described as inhibited and emotionally reactive were more likely to be assessed as negative relaters by both the parents and nursery staff using both measures.

Discussion

This chapter has presented the development of the PRI and ORB which are both measures of others' relating behaviour by an external observer. The PRI is an interview, whereas the ORB is a checklist completed by an external observer. An interview has the advantage over a questionnaire in that it enables the interviewer to ensure that the interviewee

fully understands what each of the items means, and although the questions are precisely scripted, both the interviewer and the interviewee are able to ask clarifying questions and even to seek examples. Whereas the PROQ2 and PRI rely upon an individual's willingness to reveal an accurate perception of his/her relating deficiencies, the ORB can provide an external assessment of a person's relating behaviour. However, this is only possible if the observer has an adequate understanding of Relating Theory (Birtchnell 1993/1996) on which the ORB is based.

As with other (inter)relating measures, such as the PROQ2 and OPROQ, both the PRI and ORB scores may comprise the starting point for a discussion to disclose relating difficulties to the respondent. If the observer is, for instance, a therapist and differences are divulged between how a patient perceives his/her relating to others and how the therapist observes him/her to be relating towards him/her (or towards others, according to the patients' narratives of various relating situations), the therapist may direct the therapy to reveal to the patient his/her relating deficiencies. The ORB can be used in group therapy since the discovery of discrepancies between group members' assessments may lead the therapist to discussions targeted at resolving the relating difficulties between the members.

In the current study two modified measures for use with children, the CHORB and the OCROQ3, were administered to both the parents and nursery staff of a sample of preschool children to assess their relating. The results showed that the nursery staff rated the children with both the OCROQ3 and ORB as more negative relaters than the parents. Although we do not know which ratings more accurately reflected the children's behaviour, one could argue that the staff would provide more objective ratings of the children's relating behaviour than the parents. On the other hand, for various reasons, children may exhibit more negative relating behaviour at the nursery compared to at home.

Using both the OCROQ3 and ORB the parents rated the children not attending nursery as significantly more negative relaters than the parents of the children attending nursery. The results confirm the findings of other studies that have shown the importance of peer relationships in preschool years (Bovey and Strain 2003; Ladd 1999) in making the children more skilful in social interactions (Ladd and Troop-Gordon 2003).

Significant differences were also found for the personality characteristics of the children attending and not attending nursery. Younger children attending nursery were rated as significantly more extroverted, mentally developed, and scrupulous, and significantly less emotionally reactive and inhibited than those not attending nursery, whereas older children attending nursery were rated as more inhibited than those not attending. It might be that older children have learned to control their behaviour more than younger children.

A significant finding was that the children described as inhibited and emotionally reactive were more likely to be assessed as negative relaters by both the parents and nursery staff using both measures. These results are in keeping with the symptoms of social and emotional disturbance exhibited by individuals with Reactive Attachment Disorder of Infancy or Early Childhood as specified in the DSM-V (American Psychiatric Association 2013). Although both types of Reactive Attachment Disorder (inhibited and disinhibited) include 'markedly disturbed and developmentally inappropriate social relatedness in most contexts', among other symptoms (American Psychiatric Association 2000, p. 127), the inhibited type is described as having a 'Consistent pattern of inhibited, emotionally withdrawn behaviour …' and 'persistent social and emotional disturbance – minimal responsiveness to others socially or emotionally, limited positive affect or episodes of unexplained irritability, sadness or fearfulness even during nonthreatening interactions' (p. 127).

It was also interesting that children who were described as highly extroverted or as having a high level of intellectual ability were more likely to be identified as negative relaters. It can be assumed that academically advanced or highly gifted children may be less socially competent and may have more problems in their peer relationships (Vialle et al. 2007) or may distance themselves from others (Kao 2011), whereas extroverted children may express more behavioural/emotional problems (Kuo et al. 2002; Zheng et al. 2014).

Research findings on the psychometric properties of the CHORB and the OCROQ3 suggest that further research is needed. Studies also need to validate these instruments in samples with various age ranges. No research has been conducted using the PRI to date and so future studies should aim to examine its psychometric properties and to establish norms using different samples.

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10

The Person's Relating to Others at Work Questionnaire (PROWQ): A Modified Version of the PROQ Applied to Job Sharing at Senior Levels in the Workplace

Lucy Daniels

Introduction

Relating Theory (Birtchnell 1993/1996) proposes that people strive to attain four states of relatedness known as closeness, distance, upperness, and lowerness, all of which are considered important and necessary for an individual to be competent and confident in their relationships with others. While capable and confident relating is positive, lesser forms of relating are referred to as negative. To help identify potentially negative forms of interrelating, Birtchnell has developed a number of measures, including the different versions of the Person's Relating to Others Questionnaire (PROQ; Birtchnell and Evans 2004; Birtchnell et al. 1992; Birtchnell et al. 2013), the Couples Relating to Each Other Questionnaire (CREOQ; Birtchnell et al. 2006), and the Us as a Couple

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_10

Questionnaire (US; Birtchnell 1999/2002). To illustrate an individual's responses, Birtchnell devised a spatial model which offers a very clear and accessible picture of where someone's strengths lie and areas where they may want to develop greater confidence and competency. This elegant model illustrates relating as occurring along two intersecting axes; a horizontal one, concerning a need for involvement with others (closeness) versus a need for separation (distance), and a vertical one, concerning a need to relate from above downwards (upperness) versus a need to relate from below upwards (lowerness) (Birtchnell1993/1996).

Research into Job Sharing

Job sharing is a way of working which usually involves two people voluntarily sharing the responsibilities of one full-time job (Walton 1990). A major literature review undertaken by Walton et al. (2011) revealed that job sharing has been part of the flexible working debate since the early 1980s. From that time onwards, job shares evolved and came to be regarded within the UK as a creative yet effective means of moving forward the equal opportunities agenda (Crampton and Mishra 2005). For example, an examination of how job-sharing arrangements worked in 48 public and private sector organisations in the UK (IRS Employment Trends 1998) found that job sharing could help promote equal opportunities, improve staff retention (most notably for maternity leave returners) and enhance flexibility (e.g. by improving sickness and holiday cover). Although in practice job-sharing arrangements commonly exist in secretarial/clerical and administrative work, higher-level occupations were also shared, with 21 organisations saying that they currently employed managers in job shares.

Whilst little academic literature existed at the time of Walton et al.'s (2011) literature review (e.g. Eick 2002; Thornicroft and Strathdee 1992), a number of studies by independent charitable organisations document case studies of job-sharing managers (e.g. New Ways to Work 2001; Working Families 2007). An article examining the advantages and disadvantages of job sharing (Incomes Data Services IDS 2006) profiled senior job sharers, and included partners in a solicitors firm and job-sharing

chief executives of a primary care trust. All found it a creative and sustainable way of working. Because there are so many variables involved it is difficult to prescribe what makes job share successful, but according to the senior job sharers interviewed there are a few prerequisites. The first and most obvious is the ability to collaborate. Job sharers cannot be competitive with one another as they have to operate as one person. The eight private sector senior job sharers interviewed by Working Families (2007) were all in challenging roles. Developing openness, trust, clarity, and communication were seen as key factors in the success of the partnerships, as was the absence of the need to be possessive about work done. A number of individual accounts of job shares make reference to the fact that job sharing can be a very different way of working which is collaborative and sharing. For example, Eick (2002) likens it 'to partners in a marriage'.

Most studies examined by Walton et al. pointed to the fact that the employer gets 'two heads for the price of one'. A job-sharing chief executive (Incomes Data Services IDS 2006) suggests that the more senior the job 'the more important it is that you choose each other so that you share the same core values and goals and have a common vision' (p. 9). The advantages of retaining two highly skilled and experienced individuals, who otherwise might resign, was repeatedly given as one of the main benefits of job sharing.

The Job Share Project

The *Job Share Project* was set up in 2011 to help bridge the gap in the relevant literature. The project explored the feasibility of job sharing in senior client-facing leadership roles, and identified best practice for job share design. The ultimate aim was to further understanding about what leads to successful job shares at senior levels, and to develop practical guidelines and toolkits for prospective job sharers and employers wishing to understand and implement job sharing at senior levels. The project was initiated by Sara Hill, CEO of Capability Jane Consulting, a flexible working consulting practice, and involved respondents from seven global organisations: Centrica, Deloitte, DHL, Freshfields, Herbert Smith,

KPMG, and Royal Bank of Scotland. The research was led by the author of this chapter and Pam Walton, a leading expert in job sharing and flexible working and author of *Job Sharing*: *A Practical Guide and Hours to Suit*: *Working Flexibly in Senior Roles*.

Both quantitative and qualitative data were collected. Job sharers or those working with job sharers were invited to complete an online survey which was promoted to individuals working for the participating employers and also through Capability Jane's network as a recruitment business. In all there were 303 responses, comprising 86 job sharers, 45 managers of job sharers, 63 people who work with job sharers, 53 people who know about job sharing and 55 people who would like to job share.

As a follow-up to the survey, 32 of the respondents (job sharers and managers of job sharers) were contacted and interviewed in depth via telephone. We were interested to learn more about both the pros and cons of job sharing, hence, the people selected for interview included not only those who were very positive about job sharing, but also those who expressed reservations about how well it had worked. A brief summary of the research findings from the Job Share Project is provided below and copies of the report can be obtained from http://www.thejobshareproject.com

Findings from the Job Share Project

While some of the job sharers worked in central and local government or in the health or education sectors, the majority (80 %) came from large private sector organisations. More than 80 % of all respondents held positions of responsibility (managers, team leaders, senior associates, directors and in one case a CEO). On average, people remained in their job share for 18 months to 2 years. One job share partnership (in the Civil Service) continued for far longer and enabled the same two job sharers to progress up through the organisation to the very top echelons of their department.

Significant advances in information and communications technology (ICT) in recent years have made it possible in some jobs to work

seamlessly from anywhere. But being available everywhere and at any time has led to work intensification for both full-time workers and their part-time counterparts. In contrast, provided workloads are manageable, the job sharers in the study said they enjoyed the benefits of stimulating full-time roles with the advantage of being able to 'switch off' when they know their counterpart is at the helm. Consistent with Walton et al. (2011), several respondents (both job sharers and their managers) made reference to the fact that the employer gets 'two heads for the price of one'. As one manager who was part of a job share remarked: 'It's good for our direct reports; as long as you are consistent in how you deal with them – If you act as one person. If you have different skill sets and personalities it is helpful and good for them to have two people they can try things out on – two heads are better than one.' As well as enhanced productivity, new ways of working more creatively helped to trigger wider cultural change and innovative process improvements: 'People liked it being a little bit different. We demonstrated performance and we achieved financial turnaround – also significant improvement in organisational functioning.'

Job sharing was used to extend hours of cover in sectors such as health, where there is often demand for longer hours to meet customer demand. For example, both job sharers could work three days per week to provide six day per week cover or share days to cater for early and late appointments. For businesses with a global reach, with the requirement of 24/7 operations, job sharing could enable two managers to provide the extended cover needed to work across time zones.

Practical Considerations and Attributes of Job Sharers

A lot can be learned from the achievements of the successful job sharers and managers in the study in terms of practical considerations when it comes to making a success of sharing a top role. Their responses suggest that job sharers need to be versatile and comfortable working closely with their partner but also capable of working independently. They will most likely need to work harder than their full-time counterparts at keeping on top of everything in order to provide a seamless service. This is to

avoid any potential criticism of what is still seen to be an 'atypical' way of working. Their work output also needs to reflect the culture in which they operate, meaning that if long hours and flexibility are the norm, they will need to be able to put in the extra hours where necessary, or risk alienating themselves from their colleagues. Job sharers may also need to put extra back-up plans in place when it comes to organising cover. For example, if they have caring responsibilities, either for children or adult dependants (or both) the cost of care can be prohibitive unless they are able to draw on informal family support networks.

While job sharing can pay dividends and help retain talent, feedback from managers was that it can also add a layer of complexity to how teams are organised. For this reason, respondents observed that many managers still shy away from having job sharers on their team. However, those managers who responded and who have invested time in making it work in terms of job design, people management, and client/colleague expectations, say that the benefits far outweigh the initial challenges. One of the managers in a very demanding corporate environment commented on two job-sharing reports:

> They were very effective at making it happen between them and at managing people in their team. They remained in post over five years. It was a very positive experience for me and for the people who worked for them. We are very precious here about management leadership capabilities. Jobs can be very draining—the job sharers divided out the performance reviews into two so they each had a number to do but had a contingency so that they covered for each other. It was totally seamless.

Successful job sharers and managers tend to have an optimistic approach to testing out new ways of working. They see the benefit of having two heads, and provided the relationship between the job sharers is good, think that job sharing can bring real added value to a role in terms of dynamism, creativity, perspective, and greater diversity. They are prepared to take a risk and work hard to make sure it pays off. They invest time at the start to develop a plan tailored to the needs of the role and to draw up an agreement that can be reviewed and tweaked along the way.

Positive and Negative Attributes of Job Sharers

In the report that followed the Job Share Project (*Job Sharing at Senior Levels*, Daniels 2011), the critical success factors for job sharing were highlighted as being: trust; having a good communications strategy; effective execution of handovers; having complementary skills; shared vision and values; and flexibility to make the job share work, and the following quote highlights these: 'It is so important that you get the right people with the same attitudes but with complementary skills and you can't have someone who is overly ambitious.'

Conversely, the whole arrangement is likely to be threatened for the following negative reasons: poor communication between job sharers; lack of trust; management attitude; competitiveness; or poor communication with other members of the team, as these quotes illustrate:

> People in a job share have to be proactive to make it work. Communication is the biggest issue and could be the biggest problem if not done well. … it is you and your partner's responsibility to pass on information to each other.
>
> In the long run the change to a new team has been the best thing as the people I job share with now—we split work evenly, I can shine in my own right, it feels like a proper share. I think probably because the two people I share with are more like me and we cover for each other rather than competing.

How Does Relating Theory Relate to Job Sharing?

Relating Theory (Birtchnell 1993/1996) proposes that people strive to attain four states of relatedness, known as closeness, distance, upperness, and lowerness. Birtchnell regards all four of these states to be important and necessary for an individual to be fully versatile and confident in his/her relationships with others. While capable and confident relating is positive, lesser forms of relating can prove negative. To help identify potentially negative forms of interrelating, Birtchnell has developed a number of measures, including the PROQ (Birtchnell et al. 1992), PROQ2 (Birtchnell and Evans 2004),

PROQ3 (Birtchnell et al. 2013), the CREOQ (Birtchnell et al. 2006), and the Us as a Couple Questionnaire (US; Birtchnell 1999/2002). To illustrate an individual's responses, Birtchnell (1993/1996) devised a spatial model which offers a very clear and accessible picture of where someone's strengths lie and areas where they may want to develop greater confidence and competency. The spatial model's elegant solution to the complexities of interpersonal relationships is to illustrate relating occurring along two intersecting axes, a horizontal one, concerning a need for involvement with others (closeness) versus a need for separation (distance), and a vertical one, concerning a need to relate from above downwards (upperness) versus a need to relate from below upwards (lowerness).

Relating Theory has proved its usefulness in clinical settings (see Chaps. 12–17 of this volume). In addition, it is potentially a very useful tool in the workplace, where new ways of working are leading to flatter, less hierarchical structures with greater flexibility around location and hours of work. So-called 'smarter' ways of working rely heavily on effective interpersonal relationships, including good communications and cooperation within teams. This is especially the case for teams working outside traditional standard full-time jobs in a fixed location. In this chapter we look specifically at the application of Relating Theory to job sharers and consider the distinction between positive and negative relating as applied to identifying good job share matches and making the arrangement work effectively.

Capabilities such as being able to work collaboratively (closeness) but independently (distance) as a job sharer or to assume a leadership role (upperness), whilst being willing to share accountability (lowerness) all have a resonance with Birtchnell's (1993/1996) Relating Theory and the four states of relatedness (i.e. closeness, distance, upperness, and lowerness). With a little imagination, it is not difficult to translate the forms of relating illustrated by Birtchnell's (1994) Interpersonal Octagon to how people relate in the workplace and its particular significance for job sharers. In addition, some of the questionnaires developed for use in clinical settings such as the PROQ2 (Birtchnell and Evans 2004), PROQ3 (Birtchnell et al. 2013), the CREOQ (Birtchnell et al. 2006), and the US (Birtchnell 1999/2002) could be adapted to the workplace. These would

help employees interested in job sharing to assess their readiness for such a collaborative role.

In the first instance, when initially thinking about job sharing or selecting job sharers, the PROQ2 (Birtchnell and Evans 2004; see Chap. 3 of this volume) could prove a useful tool. With only minor adjustments to the language to suit workplace use, a modified version of the PROQ2 can be created which can be referred to as the Person's Relating to Others at Work Questionnaire (PROWQ). At the time of writing, the PROWQ is still at an early stage of development and is not currently in circulation (however, a sample can be obtained from the author on request). The PROWQ could be used by individuals considering job sharing as a predictor for how well suited they might be to work with a colleague in this way. It would be especially pertinent in leadership roles, where senior job sharers must be willing to share accountability and cooperate, rather than compete with one another for the top slot.

Figure 10.1 shows how Birtchnell's (1994) Interpersonal Octagon (see Fig. 1.1) can be adapted to illustrate the positive and negative attributes of job sharers. Birtchnell (1993/1996) describes how a person who is not capable or confident of attaining a particular state of relatedness may do one of three things: avoid it altogether; attempt to attain it, but in an anxious and insecure manner; or strive to attain it by desperate, unscrupulous, or disrespectful means, and this lack of capability or confidence to attain a particular state of relatedness might also translate into the workplace. Being able to complete the PROWQ electronically and receive an immediate illustration of one's readiness to job share could be a useful tool to employers or would-be job sharers.

Once a good job share match has been identified and is in operation, another of Birtchnell's measures called the Us as a Couple Questionnaire (US; Birtchnell 1999/2002) could be adapted for use as part of an ongoing review process to ensure the arrangement continues to work well. The US is a brief, single-scale measure with which each partner rates the quality of their relationship with statements like: 'When we have a problem we sit down and sort it out together' or 'We often find ourselves thinking the same thing' or 'We can't seem to agree on anything'. A detailed description of the US can be found in Chap. 6 of this volume.

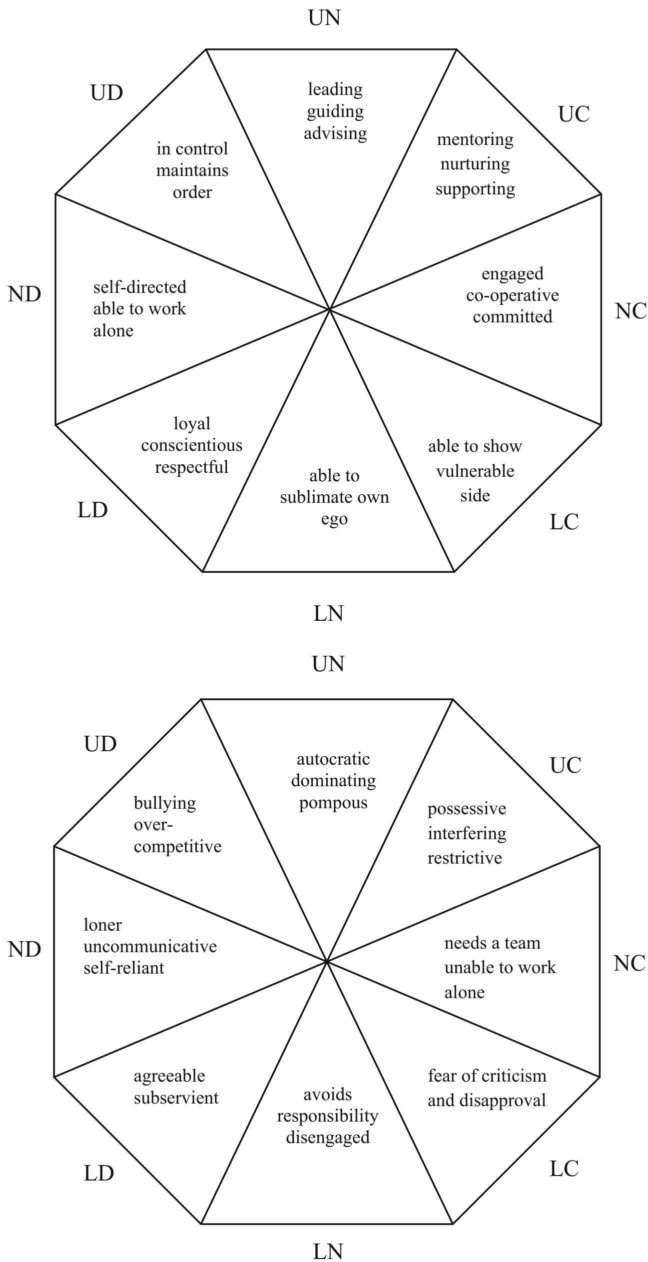

Fig. 10.1 Positive and negative attributes of job sharers based on the Interpersonal Octagon (Birtchnell 1994)

With minor modifications, a new questionnaire has been developed by the author of this chapter called the 'Us as a Job Share Questionnaire' (USJS), which uses 20 similar questions adapted to help reveal how well the job sharers communicate with each other, collaborate, trust, and are willing to compromise to make for a seamless arrangement. Like the PROWQ, it is still at the very early stages of development and requires piloting in order to develop it more fully. The potential benefit of being able to base both the PROWQ and USJS questionnaires on Birtchnell's existing and well-used questionnaires is that exactly the same system of scoring can be used, minimising the need for further costly development and maximising the benefits of Birtchnell's work to date with this new adaptation of his relating measures.

Sustaining a Job Share with the Help of Relating Theory

Ensuring that a job share arrangement continues to run smoothly is vital because workplaces undergo almost constant change in today's fast-paced world. Even over a relatively short period of time, cracks in how well the relationship works may appear. For example, work may become more pressurised due to mergers or changes in management structure or personal issues may begin impact on work. To help address the impact of change, successful job sharers must establish a plan right from the start – one that they can refer to and review from time to time (using the USJS questionnaire). Sharing good communications, being clear about how the role will be shared, and being aware of each other's strengths and weaknesses is the key to success.

Conclusions

In conclusion, Relating Theory has relevance for new work styles that demand competencies in closeness, distance, upperness, and lowerness. Furthermore, Birtchnell's Interpersonal Octagon and (inter)relating questionnaires provide a very practical blueprint which, with only minor

modifications, could be useful tools for job sharers. This chapter has discussed the potential for the PROWQ to be used to help individuals consider their readiness to job share, as well as the potential to use the USJS questionnaire as part of an ongoing review process for job sharers.

While it has not yet been possible at the time of writing to trial them in the workplace, the PROWQ and USJS have a lot of potential. Being able to predict who would make a good job sharer and finding job share partners is one of the biggest barriers to this model of flexible working. Yet, as research from the Job Share Project revealed, when job shares work well, the results can be measurably better.

Despite job sharing being around for some 40 years, it has not increased substantially, partly because of the difficulty in easily identifying suitable candidates who display the versatility required to work in a job share role. It is hoped that the application of Relating Theory and the tools developed by Birtchnell could make a difference.

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11

The Person's Positive Relating to Others Questionnaire (PPROQ): A New Relating Instrument Grounded in Positive Psychology

Argyroula Kalaitzaki and Sean Hammond

Introduction

Positive Psychology and Related Measures

The senior author has recently been interested in the positive aspects of human life, such as happiness, well-being, and flourishing. This is a new, fascinating, and rapidly developing field, called 'Positive Psychology', founded by Martin Seligman. Seligman and Csikszentmihalyi (2000) state that it is the 'scientific study of optimal human functioning [that] aims to discover and promote the factors that allow individuals and communities to thrive' (p. 5). Traditionally, mainstream psychology has been primarily concerned with measuring and effectively treating individuals' shortcomings and weaknesses in terms of abnormal behaviour and

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_11

mental illness. Positive Psychology intends to complement rather than replace traditional problem-focused psychology that has been dominant for many decades by increasing one's psychological well-being and promoting a purposeful, meaningful, fulfilling, and optimal/most functioning life (Seligman 2002).

Positive relationships have been incorporated into Seligman's (2011) 'PERMA' model (i.e. Positive emotion, Engagement, positive Relationships, Meaning, and Accomplishment/Achievement) as one of its elements. The acquisition of such relationships is necessary for promoting an individual's lasting well-being, happiness, and meaningful life (Seligman 2011). The design of a measure grounded in Positive Psychology to purposely assess an individual's positive, rather than negative, relating to others or interrelating within couples and families, would be of great interest. To the authors' knowledge no such measure which specifically focuses on positive relationships exists.

The Flourishing Scale (Diener et al. 2010) consists of eight items which describe aspects of human functioning, but only one item assesses positive relationships ('My social relationships are supportive and rewarding'). The Scales of Psychological Wellbeing (Ryff and Singer 1998), a 18-item inventory, include three statements which reflect positive relations with others ('Maintaining close relationships has been difficult and frustrating for me' – reverse scored; 'People would describe me as a giving person, willing to share my time with others'; 'I have not experienced many warm and trusting relationships with others' – reverse scored). There is also a three-item questionnaire called the Loneliness Scale (Hughes et al. 2004), that measures an individual's perceptions of social isolation; one might say that this construct resembles the distant scale of Relating Theory (Birtchnell 1993/1996; see Chap. 1 of this volume). However, it is limited in assessing only one relating feature.

The Development of the PPROQ

In an attempt to address the gap of the lack of an instrument specifically measuring positive relating, in 2014 the senior author conceived the idea of developing the Person's Positive Relating to Others Questionnaire

(PPROQ). The PPROQ was intended to be a theoretically grounded questionnaire, based on Relating Theory and on the already existing Person's Relating to Others Questionnaire (PROQ; Birtchnell et al. 1992), which is currently in its third version (PROQ3; Birtchnell et al. 2013; Kalaitzaki et al. 2015).

The clinical application of Relating Theory, in particular the PROQ which measures maladaptive relating, has led to the development of therapeutic interventions for relating deficits. However, Relating Theory also describes the positive features of human relating (i.e. competencies) across eight poles (i.e. upper neutral, upper close, neutral close, lower close, lower neutral, lower distant, neutral distant, and upper distant) which are represented on a theoretical structure called the Interpersonal Octagon (see Fig. 1.1). Therefore, using this relating model as a guide, positive relating competencies could be measured using statements describing features of positive relating to others.

The senior author and the developer of Relating Theory, John Birtchnell, started the process of designing the PPROQ by inventing items which corresponded to the relating features defined in each pole of the Interpersonal Octagon. This approach contributed to the process of establishing the content (or face) validity of the PPROQ. Eventually a pool of approximately 120 items (15 items for each scale) was generated. The majority of the items reflected positive relationships with other people, but a number of negative relating items were also created and were included in the questionnaire to serve against social desirability bias. For example, for neutral close (NC), which is defined as 'friendly involvement and interest', example items of positive relating were: 'I allow others to become close to me' and 'I am able to take part in a close relationship', whereas example items of negative relating were: 'I have a tendency to cling to people' and 'I cannot bear to be left on my own'. A high scorer on the positive NC scale finds it pleasant to be involved with others, whereas a low scorer on this same scale finds it unpleasant to be involved with others. Items created had to be self-descriptive and fit well with the theoretical definition of the octagonal scale it purportedly belonged to (either positive or negative).

Positive relating items were mostly affirmative statements, whereas a number of negatively worded statements were also included to minimise the likelihood of response bias (i.e. the tendency for respondents to agree

or respond in the very same way to all items) (Rattray and Jones 2007). For example, for the UN scale a positively worded item was 'I am able to take control of a situation' and a negatively worded item was 'I have no difficulty telling somebody what to do'.

A number of items were then eliminated. These were items which were ambiguous, redundant, lacked clarity or discrimination from other scales, or lacked adequate fit with their octagonal scale definition. Eventually, 80 items were retained overall (ten items for each scale). From these items, 56 were positive and 24 negative (7 positive and 3 negative for each scale). Items were rated using a four-point scale ranging from 'Nearly always true' (3) to 'Rarely true' (0).

The Main Study

The reliability and validity of the PPROQ were examined by administering an Internet-administered version of the measure (created using Google forms and available through online social media) to 439 Greek students (82.2 % female) of mean age 23.2 (SD = 3.4), along with the following measures:

1. The short version of the Inventory of Interpersonal Problems (IIP-32; Barkham et al. 1996). The IIP-32 measures distress arising from interpersonal sources, such as distress relating to things that a person might find hard to do (19 items; e.g., 'say no to other people', 'be assertive with another person', and 'really care about another person's problems'), and things that a person might do too much (13 items; e.g., 'I fight with other people too much', 'I open up to people too much' and 'I trust other people too much'). Eight subscale scores are derived to reflect difficulties in the four bipolar factors (Barkham et al. 1996): *competition* (hard to be assertive vs too aggressive), *socialising* (hard to be sociable vs too open), *nurturance* (hard to be supportive vs too caring), and *independence* (hard to be involved vs too dependent).
2. The Person's Relating to Others Questionnaire Version 3 (PROQ3; Birtchnell et al. 2013). This is a measure of a person's general, negative relating to others, based on Relating Theory and accommodating the very same eight octant scales (Birtchnell 1993/1996).

3. The Experiences in Close Relationships-Revised (ECR-R; Fraley et al. (2000) is a 36-item measure of adult attachment styles of avoidance (18 items) or anxiety (18 items).
4. The Psychological Well-Being Scale (Ryff 1989; Ryff and Keyes 1995) consists of 18 items, allocated across six scales (three items per scale): autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. This measure was selected because it includes a 'Positive Relations with Others' scale. (e.g. '*People would describe me as a giving person, willing to share my time with others*').

Since the IIP-32, the PROQ3, and the ECR-R measure maladaptive/negative interpersonal behaviour, it was anticipated that negative correlations would be found with the PPROQ. On the other hand, it was expected that the PPROQ would correlate positively with the Positive Relations with Others scale of the Psychological Well-Being scale.

Results

Only a summary of the results will be presented here. The detailed results have been included in the Kalaitzaki and Hammond (in preparation) paper.

Factor Analysis

Since an eight-factor structure was expected, a restricted factor analysis using the oblique multiple group method (Nunnally and Bernstein 1994) was carried out to explore the construct validity of the PPROQ. This has the advantage of allowing the user to examine indices of fit for each factor and each item (see Chap. 4 of this volume) and constrains the items to load on their hypothetical factors as best as the data allow. All items loaded well onto their hypothetical factor, except item 75, which belongs to the NC scale and seems to load on the UC factor rather than NC. Experience suggests that fit indices should exceed 0.8 for a reasonable fit. The factor fit indices found here ranged from 0.71 (UN) to 0.92 (ND), which suggests that the data fitted the eight-factor model reasonably well.

Classical Item Analysis

Classical item analysis on the PPROQ data was then conducted in order to evaluate the psychometric viability of the eight subscales (Table 11.1). Reliability estimates used were Cronbach's alpha and the factor model based omega (McDonald 1999; see Chap. 4 of this volume). The analyses were first carried out on each seven-item scale and were then repeated after omitting the two weakest items from each scale. Weak items were identified as those conveying the smallest amount of information in factor analytic terms (McDonald 1999), serving to optimise the omega estimate of reliability. Two scales (ND and LD) remained weak with coefficients below 0.70 with both alpha and omega.

Validity of the PPROQ

All subsequent analyses were carried out on the shorter refined scales of five items each.

Initially, an examination of the inter-scale correlations was used as a test of convergent and divergent validity. The positive correlations between all pairs of adjoining octant scales (e.g. UN/UC, UN–UD, NC/LC) supported the measure's convergent validity, while the negative or low correlations between several opposite scales (e.g. NC–ND, LC–ND,

Table 11.1 Classical item analyses on the PPROQ scales

	7-Item scale				5-Item scale				Items omitted
	M	SD	α	ω	*M*	SD	α	ω	
UN	14.30	3.48	0.67	0.71	10.29	2.87	0.69	0.74	1 and 4
UC	16.07	3.54	0.75	0.79	11.97	2.70	0.76	0.80	2 and 4
NC	14.09	3.65	0.68	0.72	11.34	2.77	0.69	0.74	1 and 3
LC	12.93	3.59	0.69	0.72	9.97	3.01	0.71	0.76	4 and 6
LN	14.36	3.49	0.68	0.72	10.58	2.76	0.67	0.72	2 and 3
LD	13.44	3.26	0.59	0.65	10.13	2.59	0.58	0.66	1 and 5
ND	12.62	3.33	0.54	0.60	8.56	2.81	0.56	0.65	2 and 3
UD	11.29	3.59	0.68	0.72	8.69	2.87	0.68	0.74	2 and 7

M mean score, *SD* standard deviation, α Cronbach alpha, ω McDonald omega, *UN* upper neutral, *UC* upper close, *NC* neutral close, *LC* lower close, *LN* lower neutral, *LD* lower distant, *ND* neutral distant, *UD* upper distant

LC–UC) supported its divergent validity. The mean of adjoining octant scale correlations was significantly higher than the mean of the remaining correlations (0.38 vs 0.13).

Convergent (or concurrent) and discriminant validity was also demonstrated by correlating the PPROQ with related and/or dissimilar established measures with adequate validity (Bowling 1997). More specific, evidence of divergent validity was attempted by correlating the PPROQ scales with measures of maladaptive/negative interpersonal behaviour (i.e. the IIP-32, the PROQ3, and the ECR-R) and convergent validity was shown by correlating the PPROQ scales with the Psychological Well-Being scales (Table 11.2). As anticipated, all correlations were either very low or negative, except those with the Psychological Well-Being scales. There were several meaningful negative correlations between the PPROQ and the IIP-32 scales (such as UN-assertive, LD-aggressive, NC-sociable, NC-open, UC-supportive/caring, NC-involved). Again as anticipated, the avoidant attachment scale of the ECR correlated negatively with the NC and LC scales and positively with the ND of the PROQ3. In line with expectations, the UN scale correlated positively with the self-acceptance, autonomy, personal growth, and environmental mastery scales of the psychological well-being Scale, NC with the positive relationships scale, UD with the autonomy scale, whereas ND correlated negatively with the positive relationships scale.

Gender differences provided additional evidence of discriminant validity. Women had significantly higher scores than men on four PPROQ scales (UC, NC, LC, LN) as well as the overall positive scale, whereas men had significantly higher scores than women on four of the negative PPROQ scales (UN, LC, ND, UD) as well as the overall negative scale, which is in agreement with the men's higher scores on the PROQ3 scales of UN and UD.

Discussion

Although a factor analysis showed that the data fitted the eight-factor model reasonably well, results were weaker than those found for the PROQ3 in four national samples (Birtchnell et al. 2013). Classical item

Table 11.2 Correlations between the PPROQ scales and the scales of other measures

PPROQ	UN	UC	NC	LC	LN	LD	ND	UD	TOT
ECR_R									
Anxiety	–0.238**	0.036	–0.163*	0.103	–0.116	–0.022	0.086	–0.271**	–0.126
Avoidance	–0.077	–0.123	–0.418**	–0.299**	–0.230**	–0.186**	0.258**	–0.048	–0.241**
IIP-32									
Assertive (H)	–0.433**	–0.061	–0.234**	0.092	0.002	–0.016	0.023	–0.435**	–0.246**
Aggressive (T)	–0.099*	–0.058	–0.184**	0.049	–0.218**	–0.074	0.039	0.000	–0.124*
Sociable (H)	–0.382**	–0.203**	–0.441**	–0.056	–0.160**	–0.061	0.176**	–0.280**	–0.324**
Open (T)	–0.168**	–0.091	–0.180**	–0.036	–0.138**	–0.044	0.051	–0.154**	–0.175**
Supportive (H)	–0.117*	–0.408**	–0.397**	–0.150**	–0.287**	–0.246**	0.125**	0.04	–0.329**
Caring (T)	–0.105*	0.314**	0.056	0.088	0.061	0.01	–0.006	–0.165**	0.056
Involved (H)	–0.167**	–0.238**	–0.490**	–0.243**	–0.298**	–0.132**	0.252**	–0.043	–0.313**
Dependent (T)	–0.294**	–0.159**	–0.199**	0.190**	–0.103*	–0.079	–0.114*	–0.231**	–0.225**
Total	–0.336**	–0.172**	–0.394**	–0.007	–0.212**	–0.126**	0.107*	–0.245**	–0.320**
Well-Being									
Positive relationships	0.248**	0.296**	0.443**	0.251**	0.341**	0.107	–0.300**	0.123	0.331**
Self-acceptance	0.400**	0.108	0.278**	–0.06	0.116	0.132	–0.011	0.289**	0.275**
Autonomy	0.321**	0.115	–0.027	–0.260**	–0.143*	–0.006	0.196**	0.315**	0.113
Personal growth	0.268**	0.117	0.202**	0.026	0.197**	0.067	–0.096	0.211**	0.218**
Environmental mastery	0.442**	0.009	0.182**	–0.179**	0.068	0.082	0.046	0.383**	0.226**
Purpose in life	0.135*	0.063	0.145*	0.034	0.181**	0.188**	–0.026	0.136*	0.188**
Total	0.392**	0.161*	0.318**	–0.043	0.208**	0.121	–0.089	0.280**	0.295**

UN upper neutral, *UC* upper close, *NC* neutral close, *LC* lower close, *LN* lower neutral, *LD* lower distant, *ND* neutral distant, *UD* upper distant, *TOT* Total score, *ECR-R* the Experiences in Close Relationships-Revised Questionnaire, *IIP-32* the short version of the Inventory of Interpersonal Problems, *Well-Being* the Psychological Well-Being Scale
Note: *significant at $p < .05$; ** significant at $p < .01$;

analysis suggested the elimination of two items per scale. However, two scales (ND and LD) remained weak. This is consistent with previous studies which used the negative scales of the PROQ3. Three items of the LD scale of the PROQ2 (Birtchnell and Evans 2004) were replaced in the shorter version (PROQ3; Birtchnell et al. 2013) to improve its discriminant validity. Even so, the alpha for the revised lower distant (LD) scale remained relatively low and the factor loadings for this scale were consistently lower than those for the remaining seven scales, which suggest that the revision of the LD items was not as successful as hoped (Birtchnell et al. 2013). This caveat has remained in the LD scale of the positive version of the PROQ3. This may be because LD has been found to be the most difficult octant to define. Further work may be required to develop ND and LD, but for now, the PPROQ may be used with this caveat.

The internal consistency for the majority of the scales was satisfactory as shown by both the alpha and omega reliabilities, although they were lower for the five-item scales, which is justified by the diminished number of items (see Chap. 4). They were, however, in agreement with those found for the PROQ3 (Birtchnell et al. 2013).

The validity of the PPROQ was in general satisfactory. The inter-scale correlations were as expected (Kalaitzaki and Nestoros 2003); there were positive correlations between all pairs of adjoining octant scales supporting its convergent validity, and low correlations between the opposite scales supporting its divergent validity. In addition, a circumplex-type structure was revealed (i.e. moving from the diagonal the size of the correlations decreases and then increases again), which, however, needs to be further examined. These results are in line with the results of the PROQ2 (Birtchnell and Evans 2000; Birtchnell and Shine 2000) and PROQ3 (Birtchnell et al. 2013).

The correlations with related and dissimilar established measures demonstrated evidence of additional convergent and divergent validity. They were as expected, with low or negative correlations with dissimilar measures (e.g. ECR-R and IIP-32) and with high and/or positive correlations with a similar measure (i.e. well-being). In general, the PROQ3 correlated negatively with the positive scales of the PPROQ and positively with the negative scales of the PPROQ. The concurrent validity of the PROQ3 has been repeatedly demonstrated (e.g. Birtchnell et al. 2013).

For instance, high correlations were found between the PROQ2 and the PDQ-IV scale scores (Birtchnell and Shine 2000). Discriminant validity was also supported by gender differences, which were in general in agreement with those found in Kalaitzaki and Nestoros' study (2003) for the negative PROQ2. Women were more positively close and lower than men, whereas men were more negatively upper and distant than women. Overall, the analyses of the psychometric properties of the PPROQ indicated that a 40-item instrument with eight 5-item subscales is a viable measure, although additional research is required.

The Usefulness of Developing a Measure of Positive Relating

Locating the client's strengths in his/her interpersonal domain would help the therapist to work in enhancing further client's interpersonal competencies. In essence, the therapy would emphasise building upon and strengthening client's capacities, besides working on ameliorating his/her relating deficiencies/difficulties. For instance, a person might relate positively from the upper position with his/her employees (e.g. leading, advising, and guiding), but negatively from the same position with his/her partner (e.g. boastful, insulting, manipulative) or from the lower position (e.g. being self-denigrating, subservient, and irresponsible). The therapist should highlight the positive relating features to the client and work towards generalising these skills in his/her relating with other persons too. The therapist may also help the client to practise these skills with his/her partner so that to promote optimal functioning (e.g. the client should learn to be guiding, advising, and decisive with his/her partner or less subservient and irresponsible towards him/her). If a person is clinging to his/her partner and is fearful of losing him/her (negative closeness), though concurrently he/she needs space from other people (positive distance), the therapist needs to bring about the positive qualities of distance to his/her relationship with his/her partner.

Across the vertical axis, upperness and lowerness are complementary poles and commonly no relating problems occur in the relationship between an upper and a lower relater. However, if one person is, for instance, a

negatively upper relater and the other a positively lower relater, that would cause extreme stress. The positively lower relater would seek direction, guidance, and advice, which, the negatively upper relater (who will be pompous, boastful, dominating, and insulting), would be reluctant to offer.

Harbin et al. (2014) administered a newly developed instrument, the Inventory of Therapist Work with Client Assets and Strengths (IT-WAS), in a sample of therapists to examine its psychometric properties. They found that the therapists placed great importance on working with clients' strengths, through: (1) incorporating Positive Psychology theory in their practice, such as enhancing resilience ('Theory of Intervention' scale), (2) focusing clients on the advancements they make in therapy and praising them ('Supporting Progress' scale), and (3) assessing clients' strengths ('Assessment of Strengths' scale). The same study was conducted in Greece. The IT-WAS measure was administered to 159 psychotherapists, psychologists, psychiatrists, and social workers (Loudianou et al. 2015). Mean scores ranged from 1 (*not important*) to 7 (*extremely important*) and averaged to 6.2, 5.7, and 5.5, for the 'Theory of Intervention', 'Supporting Progress', and 'Assessment of Strengths' scales, respectively. The results of these two studies revealed that therapists seem to place great emphasis on, and are willing to incorporate strengths-based approaches in, their therapeutic practice. More specifically, they seem to be willing to bring about positive concepts in their practice, and should any progress be made by their clients in therapy, they highlight, evaluate, and appraise it. Therefore, a questionnaire measuring positive relating features seems to be more than welcomed by therapists.

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Part III

Applications of Relating Theory to Clinical Psychology

12

Relating Therapy

John Birtchnell

Introduction

Relating Therapy is a form of psychotherapy that is based upon Relating Theory (Birtchnell 1993/1996). It is described in Birtchnell (1999/2002, 2001), and there is a fuller description of it in Birtchnell (2014). The primary focus of attention in Relating Therapy is the reduction of more negative forms of relating and the reinforcement or enhancement of more positive forms of relating. Just as Attachment Therapy draws upon Attachment Theory (Bowlby 1969), Relating Therapy draws upon Relating Theory (see Chap. 1 for a detailed presentation), and for this reason it will only briefly be described here. Relating Theory proposes that relating can be defined within the eight positions of the Interpersonal Octagon (Birtchnell 1994), which are upper neutral, upper close, neutral close, lower close, lower neutral, lower distant, neutral distant, and upper distant. Each one of these eight positions is called a 'state of relatedness'.

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_12

The Two Principal Axes of Relating

The PROQ is based upon the fact that relating can take place across two principal axes: a horizontal one concerning either becoming closely involved with others or being securely separated from them, and a vertical one concerning either relating to others from above downwards or relating to them from below upwards (Birtchnell 1993/1996). The versatile relater should be capable of adopting any one of these four positions, called 'states of relatedness', without causing offence. On the horizontal axis, ideally the patient should be neither excessively clinging nor excessively withdrawn and on the vertical axis the patient should be neither excessively dominating nor excessively dependent. During the course of psychotherapy the therapist and patient should each have the opportunity to adopt any one of these positions in relation to the other. Whilst there may be an understanding that the therapist should always be the upper one and the patient should always be the lower one, it may be possible for the therapist sometimes to offer the patient the opportunity to adopt the upper position by inviting him/her to take the initiative. On the other hand, the reverse may be the case: that the patient may reveal that sometimes he/she has difficulty adopting a lower position in relation to another person; and this may even apply to how he/she relates to the therapist. In such a situation the therapy may need to be directed towards understanding how the patient came to be this way and helping him/her to trust the therapist enough to allow it to happen.

Positive and Negative Relating

For each state of relatedness there is a (desirable) positive version and an (undesirable) negative version. Where positive relating is respectful, acceptable, and inoffensive, negative relating is disrespectful, unacceptable, and offensive. Certain forms of negative relating may have become second nature to the patient to the extent that he/she is unaware that they are causing offence to others. Sometimes a person may relate negatively out of fear; for example, he/she may cling tenaciously to another person for fear of losing a relationship or he/she may avoid involvement with

other people in general out of fear that they may not consider him/her to be an acceptable person. At other times a person may relate negatively as a way of imposing his/her will upon others; for example, he/she may try to dominate or suppress others.

We are not born with the ability to relate (Birtchnell 1993/1996). Gradually over the course of our early years, as a result of our interactions with others, we acquire a variety of relating skills. Such skills may be positive or negative; but whichever they may be, they gradually, over the course of time, become established and reinforced. By the time we reach adulthood they are more or less set in place. A person may not be particularly aware of whether he/she relates positively or negatively, though others may complain about certain aspects of his/her relating behaviour. It is perhaps only when a person seeks the help of a therapist for some other reason that they are brought to light, and the therapist is then able to pass comment upon them.

The Process of Relating Therapy

Relating Therapy is a relatively recent development. Hayward et al. (2009) used the term 'Relating Therapy' to describe their own particular method of treating schizophrenic patients who hear voices. The form of Relating Therapy that will be described here may share certain similarities with this approach, but essentially it will be more closely linked with identifying and modifying the more negative versions of each of the eight positions of relating within the Interpersonal Octagon.

The relating therapist needs to have a clear understanding of the nature of positive and negative relating for each one of the eight positions of the octagon and the ability to reduce the negative versions and enhance the positive versions. It would seem unlikely that a therapist would wish to specialise in the treatment of relating disorders. It is more likely that the conventional psychotherapist would choose to familiarise him/herself with Relating Theory and add to his/her range of therapeutic approaches an awareness of the positive and negative versions of each position of the octagon and develop skills for eliminating the negative versions. An exemplary attempt is that of *Synthetiki Psychotherapy* (Kalaitzaki and Nestoros 2006), which has incorporated concepts from Relating Theory.

The therapist may cautiously draw the patient's attention to certain negative ways of relating to others, enquire how these may have come about, and propose possible ways of modifying or eliminating them. Some patients may have tended, over the years, to avoid certain forms of relating (e.g. they may fear getting close to others) and the therapist may help to uncover the reasons for such avoidance and encourage the patient to sometimes risk relating in such a way.

Early on in the therapy the therapist may tactfully ask the patient how he/she may consider that other people might respond to being related to in what are perceived by the therapist to be forms of negative relating. This is not necessarily intended to evoke guilt or shame in the patient, though it may incidentally do so. At an early stage the therapist should try to clarify for the patient the difference between positive and negative forms of the various kinds of relating and explain that the main objective of the therapy will be to reduce the negative forms and reinforce the positive ones.

The Outer Me and the Inner Me

The relating therapist would also need to bear in mind the difference between that which is called the '*outer me*' and that which is called the '*inner me*' (Birtchnell 2003). The outer me refers to those forms of thought and behaviour of which we are consciously aware and which are deliberately thought out and acted upon by us, whereas the inner me refers to those aspects of thought and behaviour which occur quite spontaneously, without our needing to think about them. Much of what we do was initially deliberately thought out by the outer me, but gradually, over the course of time, our actions and thoughts become displaced into the inner me where they happen quite spontaneously, without thinking (see Chap. 1). This procedure is greatly to our advantage since, over time, it frees us up in order to concentrate more upon situations and circumstances which are new and unfamiliar. During psychotherapy, much of that which takes place between the patient and the therapist occurs at the spontaneous, inner me level, but from time to time, both the patient and the therapist need to operate at the outer me level in order that they

can make sense of what would appear to be going on. The patient may be thinking 'What is he/she trying to tell me?' and the therapist may be thinking 'How did he/she come to relate to people in this particular way?' and 'what will I need to do in order to persuade him/her to relate differently?'

Identifying Negative Relating

There are two ways of identifying a patient's negative relating: firstly, by allowing him/her the opportunity to talk freely about his/her life circumstances, those people who are most prominent in his/her life, and how well or otherwise he/she may consider that he/she is able to get on with them; and secondly, by inviting him/her to complete a self-administered questionnaire designed specifically to measure negative relating. Such a questionnaire is called the Person's Relating to Others Questionnaire (PROQ; Birtchnell et al. 1992; Birtchnell and Evans 2004; Birtchnell et al. 2013). This is fully described in Chaps. 3 and 4 of this volume. The reason for inviting the patient to talk freely first, is that this will provide the opportunity for him/her to get into the way of thinking about people in general and how he/she considers that he/she relates to them. The scores of the PROQ can be represented graphically and this will reveal to the patient those areas which are considered to be negative and upon which the therapy should be focused. The PROQ can be repeated from time to time in order to chart the patient's progress in therapy.

From an early age individuals strive to become close, distant, upper, or lower. This is so because these are the only four directions in which they are able to move. At some level people may perhaps be aware of these four possibilities, though they may not think or speak of them in such definite terms. Children in particular do not refer to the four objectives of relating. They may not even be conscious of their striving to attain them. If being close is what they want then the means by which they strive to attain it does not matter to them. Unfortunately negative relating is not a pleasant way to behave, so the psychotherapist would strive to identify it and establish how it may have been adopted by the client. To take closeness as an example, a person may cling anxiously to certain other people

for fear of losing them. The therapist may reassure the patient that there is no reason why others might reject his/her efforts to get close to them.

The Effects of the Relating of Significant Others upon the Patient's Current Relating Tendencies

It is possible that a patient's negative relating may be a consequence of the negative relating of certain significant others towards him/her. Such relating may have been in the past or it may be continuing into the present. The therapist would need to enquire about this. If it has been in the past, but has now come to an end, the issue of detaching the patient from such a persistent experience may now be a relatively easy one. He/she should be invited to recount his/her earlier experiences with the person and try to dissociate him/herself from them. If the person was of considerable importance to him/her, then dissociating him/herself from him/her could prove to be quite a disturbing experience. One strategy might be for the patient to imagine that the person is in the room and to tell him/her how much he/she meant to him/her, but to add that it is may now be necessary to move on. This may evoke the release of strong emotion but it may also have a liberating effect upon the patient. If the patient is still in a relationship with this influential other person then the breaking of the bond could be a long and painful process. It may be possible to renegotiate the relationship, in order that it may continue but with a different balance of relating.

Interrelating Therapy

Interrelating is the relating that takes place between two specified people, or within a specified group of people. This can be explored by inviting members of a couple, or even members of a larger group, to work together in the company of a family therapist. There is a modification of the Person's Relating to Others Questionnaire, called the Couple's Relating to Each Other Questionnaire (CREOQ; Birtchnell et al. 2006), which is fully described in Chap. 5. This comprises four questionnaires, by which each person describes how he/she believes that he/she relates

to the other and how he/she considers that the other relates to him/her. By putting the questionnaire scores together it is possible to determine who is doing what to whom. It may even be helpful to show the graphic representation of the questionnaire scores to each individual as a means of revealing to him/her what appears to be going on between them. This may then lead to an exchange of views concerning how and why each member believes that this form of interaction may have come about. The resolution of the tensions between them may require a number of therapy sessions. Further completion of the questionnaires will show whether the relationship has improved.

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13

Negative Relating and Psychotherapy

Argyroula Kalaitzaki and John Birtchnell

Introduction

Negative Relating

Through the process of maturation a person is expected to gain the skills of relating positively to another/others across all eight states of relatedness (Birtchnell 1990, 1993/1996). However, most people fail to fully acquire these skills and, consequently, they relate negatively in a number of states. Negative relating to another/others has been defined previously (see Chap. 1 of this volume). In brief, it consists of troubled relating behaviour, which results in a unidirectional or bidirectional dissatisfying relationship

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_13

between two persons (see Kalaitzaki, Chap. 17). Negative relating can be defined as the result of a person's lack of competence to relate positively to another/others (Birtchnell 2014). This may have stemmed from his/her past interpersonal experiences (e.g. with parents or significant others). It is also likely that a person's negative relating is the result of his/her response to a certain other's negative relating behaviour (Birtchnell 1993/1996).

Social learning theory (Bandura 1986) offers the rationale and etiological underpinnings of this phenomenon, suggesting that behaviours are acquired through direct observation and imitation of others' behaviours, which are subsequently reinforced and maintained should the person acknowledge favourable outcomes. If an individual's parents purposefully reinforced a certain state of relatedness when he/she was a child, it would have been extremely difficult for the child to acquire and relate comfortably in the opposite state. For example, if the parents preferred to keep the child in a state of lowerness (i.e. to behave in an obedient and respectful manner), they would have been likely to discourage any attempt made by the child to move to a state of upperness because they would likely have felt abashed to let the child stand up for his/her rights.

There are predominantly three types of negative relating: avoidant, insecure, and disrespectful (Birtchnell 1993/1996, 2014). An avoidant relater will avoid a certain state of relating and possibly relate within the opposite one. An insecure relater will cling to a certain state of relating and fear losing this state. A disrespectful relater will enforce a certain state of relating upon another person, and disregard that person's relating needs. These patterns will have become rigid and difficult to change as a result of the person's repetition of them in his/her everyday life. For example, a negatively distant person will insist on avoiding closeness and will constantly seek withdrawal and disregard the needs of others (such as his/her partner's need for closeness).

The Link Between Negative Relating and Psychopathology

Few clients are likely to admit experiencing certain relating difficulties when they first enter psychotherapy. Most will have sought psychotherapy because of certain mental health problems (such as anxiety or

depression). However, problems in interpersonal relationships are often fundamental in psychiatric patients, which they are either reluctant to admit or, even worse, they attribute them erroneously to others. It is well acknowledged, though, that relationship problems are closely associated with many psychiatric disorders, such as personality disorders (PDs) (American Psychiatric Association 2013; Birtchnell and Shine 2000). Widiger and Kelso (1983) have suggested that PDs, in part at least, represent maladaptive variants of interpersonal relatedness.

A voluminous literature has considered interpersonal deficiency as one of the core impairments of dysfunctional personality (e.g. Benjamin 1996; Horowitz 2004; Kiesler 1986; Leary 1957). In their review, Widiger and Hagemoser (1997) reported that researchers have sought to accommodate PDs within the octants of the interpersonal circle (e.g. Wiggins and Pincus 1993; Von Zerssen 2000). DeJong et al. (1989) managed to accommodate all of the PDs within the circle but none was located on its 'love' side, whereas Kiesler et al. (1990) accommodated only three PDs. Attempts to relate the DSM PDs to interpersonal features have also been made by Interpersonal Octagon theorists (Birtchnell and Shine 2000). Birtchnell (1997) sought to explain the ten DSM-IV PDs in terms of negative forms of relating, as described for each of the eight octants of the Interpersonal Octagon according to Relating Theory (Birtchnell 1993/1996; see Chaps. 1 and 2). He speculated on their allocation within the Interpersonal Octagon by reading their descriptions in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association 1994).

Later, Birtchnell and Shine (2000) empirically examined the placement of PDs on the octagon by administering the Person's Relating to Others Questionnaire Version 2 (PROQ2; Birtchnell and Evans 2004), which is based upon the Interpersonal Octagon (see Chap. 3), and the Personality Diagnostic Questionnaire (PDQ–IV; Hyler 1994), which is based upon the DSM-IV classification of PDs, to 107 prisoners admitted to a unit for the treatment of PDs. The two instruments were highly correlated ($r = 0.63$ and rho = 0.65), which suggested that PDs do share common features with modes of negative relating (Birtchnell and Shine 2000). The proposed placement of the PDs across the eight states of relatedness of the Interpersonal Octagon was partially confirmed. Therefore,

Birtchnell and Shine (2000) concluded that, to varying degrees, most PDs can be defined in terms of negative relating features.

Interpersonal difficulties have been recognised as prominent criteria for classification across a wide range of psychological disorders (Birtchnell 2001; Tyrer et al. 2015; see also Sroufe et al. 2000), and a resurgent interest in the association of PD with interpersonal impairments (Dimaggio 2015; Hopwood et al. 2013; Tyrer et al. 2015) and their classification within the interpersonal circle (Hopwood et al. 2013; Wright et al. 2012) has been observed since the release of the DSM-5 (American Psychiatric Association 2013). Many authors (e.g. Hopwood et al. 2013; Wright et al. 2012) have proposed that a substantial improvement over the DSM-IV is the redefinition of personality psychopathology by the DSM-5 by placing greater emphasis on interpersonal dysfunction in the form of maladaptive schemas for self and others. The two-step process of diagnosis, beginning with the presence of deficits in self (identity or self-direction) and interpersonal (empathy or intimacy) functioning (Criterion A) and followed by specific maladaptive trait elevations (Criterion B) (American Psychiatric Association 2013) places interpersonal impairments in the centre of personality psychopathology. In fact, Hopwood et al. (2013) proposed that personality pathology is, at its core, fundamentally interpersonal. Thus, the DSM-5 is aligned with the interpersonal circle literature.

However, interpersonal problems can be both a cause and a consequence of a mental disorder. Interpersonal theorists (e.g. Leary 1957; Sullivan 1953; Wiggins 1991) have acknowledged that the development and maintenance of psychopathology could be the result of interpersonal problems. Such a view is also a feature of Attachment Theory, which maintains that insecurely or ambivalently attached infants are particularly prone to develop chronic levels of anxiety later in life (Bowlby 1973). The examination of this association longitudinally has shown that ambivalently attached infants have higher levels of school phobia at 11 years of age (Bar-Haim et al. 2007) and anxiety disorders at 17.5 years of age (Warren et al. 1997). On the other hand, recent literature reviews have suggested that secure attachment is linked to lower levels of anxiety symptoms in childhood and adolescence (see Brumariu and Kerns 2010; DeKlyen and Greenberg 2008). Another perspective conceptualises relationship problems as being the consequence of psychopathology

symptoms. Undoubtedly, whenever a disorder develops, interpersonal relationships are likely to be affected. Studies have shown that children and adolescents who experience anxiety symptoms are more likely to experience poor peer relationships (see Kingery et al. 2010).

Changing Negative Relating Through Psychotherapy

Negative relating can be modified through the course of psychotherapy (Birtchnell 1999/2002, 2002). Whether or not the problem that the client initially brings to therapy is a psychological one, it is expected that psychotherapy assuages relating difficulties too, either intentionally or incidentally. Relating Therapy is a form of psychotherapy that is specifically directed towards reducing negative relating and replacing it with positive relating (Birtchnell 1999/2002, 2001, 2002, 2014). It is based upon and has been developed through Relating Theory (Birtchnell 1993/1996, 1994 see Chap. 1), an extensive account of which can be found in Chap. 12 of this volume. Interrelating Therapy is an extension of Relating Therapy that is applicable to couples and families (Birtchnell 1999/2002, 2001, 2002, 2014). Interpersonal forms of psychotherapy, that may or may not be grounded in Attachment Theory, are specifically targeted towards improving a client's interpersonal relationships and functioning by arousing their awareness of their relating difficulties and enabling them to overcome such difficulties. Even though conventional psychotherapists may not intentionally direct their attention towards the amelioration of a client's relating difficulties, a 'side effect' of the therapy would likely be the amelioration of the client's major interpersonal difficulties. This has been found in two studies conducted by the authors and their colleagues. In both of these, the clients were receiving individual psychotherapy, essentially aimed at symptom relief. In the first study, Kalaitzaki et al. (2010b) examined whether the therapy also had a beneficial effect upon the clients' negative interrelating with their parents and other family members, and in the second study, Kalaitzaki et al.'s (2014) attention was directed towards whether the therapy had improved the clients' relating to others in general and also their interrelating with their partners. In the first study clients were psychotic or neurotic and in the

second they were suffering mainly from a mood or an anxiety disorder. Both studies concluded that individual psychotherapy had brought about significant improvements in the clients' particular relating and interrelating difficulties, even though these issues had not been specifically addressed through the course of therapy and certain other persons (with whom the clients were interacting) had not been involved in the therapy. These results are discussed in more detail in Chap. 17 of this volume.

Diverse therapeutic formats could potentially incorporate principles from Relating Therapy into their theoretical background and clinical practice for the assessment and improvement of a client's relating difficulties. Such an example is the Greek version of psychotherapy integration that is called *Synthetiki Psychotherapy* (Nestoros 1997, 2001). The evolution of this model for the treatment of individuals with schizophrenic symptoms can be found in Nestoros' therapeutic experience and related research. Synthetiki Psychotherapy has integrated Relating Theory into its theoretical base and clinical practice in order to advance its understanding, assessment, and intervention in families of persons with psychotic symptoms, in which dysfunctional interrelating patterns exist. The model and its psychotherapeutic process have already been described elsewhere (Kalaitzaki and Nestoros 2006).

Regardless of the therapeutic format, negative relating patterns need to be abandoned and replaced by positive ones (Birtchnell 1999/2002). Thus, therapists from any perspective need to identify and change the negative relating patterns of their clients and of the persons with whom they relate, or the circumstances under which these patterns are sustained. In all cases at least one other person will be involved. The therapist should direct the client's attention towards the way that he/she relates towards that specific person or the way that he/she responds to that person's relating (Birtchnell 2014).

It is likely that the patient would be unwilling to abandon his/her well-established patterns of relating. For example, a negatively upper relating client would likely be boastful, dominating, stubborn, and insulting. Thus, he/she would probably be unwilling to let others take control and give up authority. A negatively lower relating client, on the other hand, would likely be helpless, self-denigrating, subservient, fearful of disapproval, and consequently, reluctant to move to a position of upperness. A negatively

close relating client would be overly clinging, desperately seeking intimacy and thus, reluctant to relinquish that particular state of relating and move to a distant position, whereas a negatively distant relating client would find it extremely difficult to be involved with others and assign intimacy in his/her relationships. For full descriptions of the states of relatedness, see Chap. 1 of this volume.

Regardless of his/her particular relating deficiencies, the client needs to discuss with the therapist which specific negative relating patterns need to change. The therapist can also make suggestions as to which relating patterns the client might wish to change, through his/her observation of his/her client's relating behaviour towards him/her (Kalaitzaki and Nestoros 2006). These changes need to be agreed upon by the client. The therapy can then be targeted at helping the client to develop positive relating patterns in order to form positive relationships with others. The therapist, for instance, might help a negatively upper client to acknowledge that relating from a positive lower position can also have its advantages; it offers the possibility of receiving care, direction, guidance, and advice. The therapist can then encourage the client to feel comfortable about abolishing his/her negatively upper position and to risk sometimes relating from a lower position. Likewise, the negatively lower client should acknowledge the advantages of relating from an upper position, such as leading and advising. The negatively close client should learn that personal space and privacy are required and the negatively distant client should become comfortable in being closely involved in intimate relationships. The therapist should be prepared to give feedback to the client about his/her relating patterns during therapy (Kalaitzaki and Nestoros 2006). Role-play might also be used to facilitate the adoption of his/her newly acquired relating patterns (Birtchnell 2014), such as that used in psychodrama, a form of therapy concerned with the way an individual responds to a particular situation by focusing on his/her behavioural responses, belief system about him/herself and others, and the consequences of their response (Jefferies 2005).

Sometimes the person(s) with whom the client relates might relate more negatively than the client himself/herself which can deter or hinder client's progress through therapy. They are also likely to reinforce clients' presenting difficulties, whether intentionally or not. For instance,

a negatively close client pushes his/her withdrawn partner away into more distance, or a domineering upper person does not allow his/her subordinate partner to take the lead. The therapist should direct the client's attention towards both the way that he/she relates towards that specific person and to the way that the other person relates to the client. Moreover, the focus should be directed to the way that the client responds to that person's relating (Birtchnell 2014). Sometimes inviting that person into therapy may facilitate change of the client's negative relating, provided that the person is willing to be involved (Kalaitzaki and Nestoros 2006). If the person is willing to recognise and eventually abandon negative relating patterns, both the client and the other person will change together. If the other person is unwilling to engage in therapy, the therapist should aim at safeguarding his/her client from the negative relating of that person.

Measuring Negative Relating in Psychotherapy

Having a diagnostic tool for measuring a person's negative relating to others will provide the therapist with an accurate assessment of his/her client's relating difficulties. The Person's Relating to Others Questionnaire (PROQ; Birtchnell et al. 1992) is such a tool. It is now in its fourth revision (the PROQ3 following on from the PROQ, PROQ2a, and PROQ2). The PROQ3 has been translated and tested in four languages (Birtchnell et al. 2013). For a full account of this measure and its revisions see Chap. 3 of this volume.

A well-adjusted client would receive low scores on the PROQ and a maladjusted client would receive high scores. Several studies have repeatedly confirmed that psychiatric patients obtain significantly higher PROQ scores than non-patients. Psychotherapy patients (Birtchnell 2002; Birtchnell and Evans 2004; Birtchnell et al. 2013) and patients with severe personality disorders (Birtchnell and Shine 2000) scored higher on several PROQ2 scales compared to non-patients. Forensic patients have also been shown to have higher mean PROQ scores than members of the general population (Birtchnell et al.

2009; Shuker and Newberry 2010). Kalaitzaki et al. (2010a) examined whether perpetrators and victims of aggression by their dating partners had more negative relating tendencies than those who were neither aggressors nor victims of aggression. Although a few significant differences were found, the relating profile of the abusers and the abused was more negative in certain octants than was that of the relating profile of those who neither abused, nor were abused. Figure 13.1 presents the relating profiles of the perpetrators who inflicted injury against their partners and of those who were neither perpetrators nor victims. It should be remembered that more shading indicates more negative relating in these particular octants.

Psychotherapy may bring about more awareness in the client about his/her relating problems and help him/her to admit these difficulties. In these cases, scores obtained through the course of therapy may be higher than the pre-therapy ones. However, if the client works on these difficulties and gradually relinquishes his/her negative relating patterns, the post-therapy scores may be similar or even lower to the pre-therapy ones. In fact, relating measures have proved efficient in monitoring

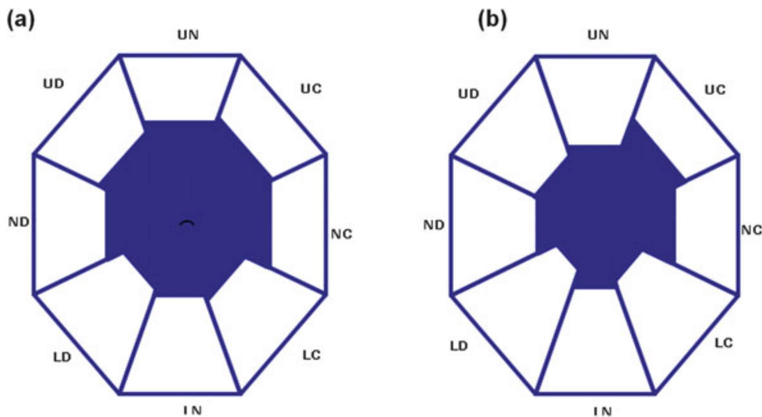

Fig. 13.1 Mean PROQ2 scores of the perpetrators of injury against their partner **(a)** and those who neither abused nor were abused by a partner **(b)**

improvement over the course of psychotherapy. A number of studies, applying various psychotherapy modalities (e.g. cognitive analytic therapy; Birtchnell et al. 2004) have consistently shown that PROQ scores tend to reduce significantly after psychotherapy (Birtchnell 2002; Birtchnell et al. 2009, 2013; Shuker and Newberry 2010; Kalaitzaki et al. 2014). The study by Kalaitzaki et al. (2009) showed that many of the end of therapy scores of the patients and their parents were more similar to those of the non-patients' scores. Kalaitzaki et al. (2014) examined whether psychotherapy of a short duration improved 60 outpatients' psychiatric symptoms, negative relating to others, and interrelating with their partners. The therapy was conducted by ten different therapists practising mainly humanistic, psychoanalytic/psychodynamic, or behavioural/Cognitive Behavioural Therapy (CBT). Figure 13.2 presents the start of therapy PROQ3 scores and those after only 2 months of therapy. Even though the therapy may have not specifically been intended at improving patients' relating difficulties, it seemed to have had some effect.

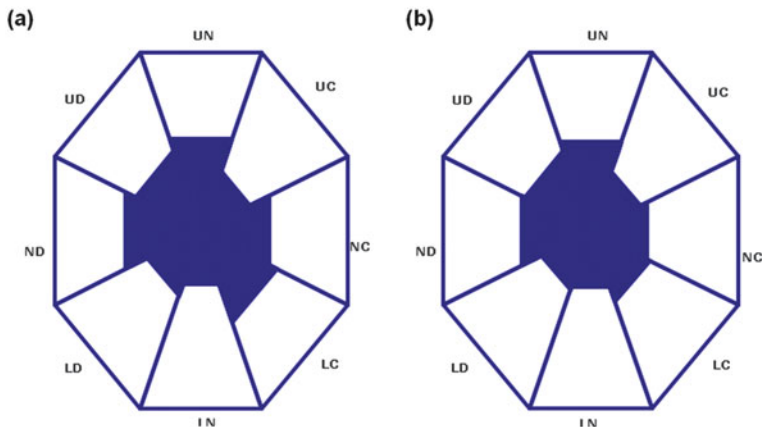

Fig. 13.2 Outpatient PROQ3 scores at the start of therapy **(a)** and after 2 months of therapy **(b)**

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14

The Use of the Couple's Relating to Each Other Questionnaire (CREOQ) in Couple Therapy

Deidre Gordon

Introduction

The first interview with a couple, experiencing relationship problems, can be very stormy, as pent-up feelings are expressed. The agendas the individuals bring to this session often appear to be representing totally different relationships. Each partner wants the therapist to act as judge and jury to their dispute, so long as the judge finds them totally innocent of any crime. The other partner must take all the punishment.

When working with an individual in therapy, the focus is entirely on the individual and his/her view of the world. The therapist works through a relationship built up on a one-to-one basis. Transference and projection are the helpful tools for the therapist towards understanding the problems of the patient.

When faced with a couple, there is effectively a triangle in the room. Each partner, in turn, will often try to 'seduce' the therapist into a role as his/her supporter. It can take time to encourage the partners to understand

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_14

that they are not being seen as two individuals. The actual patient that they have brought into therapy is the disturbed relationship. The early contributions of the couples often make the consulting room more like a battlefield, than a therapeutic place to discover the nature of their current difficulties. They act out their pain and hurt in differing ways, sometimes by being uncooperative or silent and sometimes by using cruel language against the partner. The room becomes full of smokescreens and diversions from the real picture about the true nature of their relationship. The key issue is encouraging them to communicate with each other about their relationship, which is often a skill they have lost as their relationship has deteriorated over time.

The idea that their individual agendas within the relationship are determined by the cause and effect of their interpersonal relationship skills is a difficult issue to introduce to a couple determined to fight to the death in the consulting room. A tool that stimulates their interest in the workings of their interpersonal skills, starting with the ability to communicate with each other, often shortens the time taken to establish the true nature of the work for the couple.

The CREOQ and the US

An introduction to John Birtchnell and his Relating Theory (Birtchnell 1993/1996) provided a tool that not only helped to solve some of these initial problems, but also instigated a new approach and understanding of the mechanics of interrelating in couple therapy.

Birtchnell's Couple's Relating to each Other Questionnaire (CREOQ; Birtchnell 1999/2002; Birtchnell et al. 2006; see Chap. 5 of this volume) was a development from his original Person's Relating to Others Questionnaire (PROQ: Birtchnell et al. 1992). The CREOQ items are designed to identify the effects of the interpersonal skills of a specific couple in relation to their partner, rather than their levels of ability to maintain relationships in general.

The CREOQ consists of four questionnaires, two for each partner. Each partner is asked to complete one questionnaire to rate how he/she feels about his/her partner in the relationship and the second one to describe his/her partner's feelings towards himself/herself. Each set consists of

80 items assessing negative relating which are responded to on a four-point Likert scale (3 = 'Mostly Yes', 2 = 'Quite Often', 1 = 'Sometimes', and 0 = 'Mostly No'). Sixteen positive items are also included to relieve the negativity of the experience; they are not scored. Indicative CREOQ items of man/woman about self (MS/WS) are: *I easily give into him/her*; *I try hard not to let him/her get the better of me*; *I don't communicate very much with him/her*. Indicative CREOQ items of man/woman about the partner are: *Does not like me to go out without her/him*; *Invites me to dominate her/him*; *Makes hurtful remarks to me*.

Completing the CREOQ enables the feelings of the couple to be converted into scores, rather than having to be uncovered from examples of the behaviours described during the sessions. Most patients find this approach interesting and they quickly engage with it. Their negative scores can also be shown on a chart, divided into eight segments (which represent the eight octants of the Interpersonal Octagon – Birtchnell 1994), indicating where they were experiencing different levels of difficulty. The positive scores also help couples to understand the nature of their interpersonal skills. See Fig. 1.1.

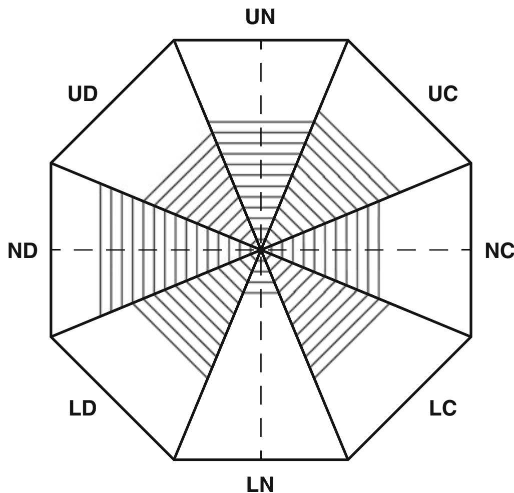

Fig. 14.1 An example of a chart representing negative CREOQ scores from one of the author's unidentified patient responses. *UN* upper neutral, *UC* upper close, *NC* neutral close, *LC* lower close, *LN* lower neutral, *LD* lower distant, *ND* neutral distant, *UD* upper distant

Figure 14.1 depicts indicative negative relating features across the eight segments of the Interpersonal Octagon. It represents features of closeness through to lack of any closeness (described as distance) on the *X*-axis and features of dominance (described as upperness) through to lack of dominance (described as lowerness) on the *Y*-axis. These characteristics might be experienced either in the self or the other. High scores in a segment such as upper close (shown as UC in Fig. 14.1) would reflect an intrusive, restrictive, and/or possessive interpersonal relating style in that relationship. Similarly, a high score in the lower distant segment (shown as LD) reflects an acquiescent, subservient, and/or withdrawn interpersonal relating style. The negative scores are shown to the couple as shading in particular segments.

The octagon introduces a visual representation of a person's relating styles/difficulties, and gives the couple an extra incentive to be engaged with where the problems lie. Many couples find this helpful when trying to understand their feelings and behaviours within the relationship. The couple is then in a more informed position to start the process of considering what direction the therapy might take. For example, if the chart/octagon depicting how the woman feels about herself in the relationship is very different from the one depicting the man's opinion about her, this can help to instigate useful areas to explore in the therapy. The man may be experiencing her as confident and dependable, whilst the women might have indicated, from her scores, that she feels unloved and insecure in the relationship. These different patterns can then be explored so that the couple can work towards addressing these areas of conflict in their relationship in less destructive ways.

As part of the CREOQ assessment process each partner also completes a short measure of 20 statements called the US, which measures the satisfaction or dissatisfaction levels of each partner with their relationship. These statements, beginning with 'we', are rated as true or false. A low score means the couple is satisfied with their relationship and a maximum score of 20 indicates total dissatisfaction with the relationship. Examples of the statements are: 'We are good friends'; 'We rub each other up the wrong way'; 'We are not good for each other'; and 'When we want different things we compromise'.

Most of the patients are keen to complete the measures. Some see it as a means of 'getting back' at their partner, but soon they realise that these questionnaires are not that sort of instrument. Each partner

is invited to complete his/her questionnaires in private and send them back, individually sealed for scoring, to ensure their personal privacy and confidentiality. They do not discuss the process at all until both have sent off their responses. If one partner has initially attended the sessions alone, exploring the results usually tempts the reluctant partner to join the therapy sessions. Often they will then agree to continue to come and work on the pressure points that have been highlighted. They feel less anxious once they have been offered some direction and indications of what they will have to contribute in the therapy.

The Study

The research described in this chapter was designed to explore whether adult relationships might be affected by relating skills that had been learned from early sibling situations. The first hypothesis examined whether partners coming from similar sized families would be less likely to attend relationship therapy in the future. Hypothesis 2 examined whether there was a statistically significant difference in the number of cases falling into the different groups (defined by sibling size). Hypothesis 3 examined whether the US scores depended upon the birth order position of each partner. In other words, it examined whether the sibling effect of different birth order positions would have some influence over the levels of satisfaction experienced by individuals within their intimate couple relationships. Hypothesis 4 examined whether the different birth order positions cast an influential shadow of dissatisfaction experienced in adult intimate relationships, which is most apparent in relationships that are breaking down. Hypothesis 5 explored the total scores for each of the CREOQ statements across the three groups to see if the higher ones might be associated with sibling influences as well as being generated by the influences of the current relationship.

Method

The CREOQ and the US were administered to 40 couples who attended regular therapy at a Relate Centre in the UK (though it was not a condition of the therapy) and a control group of 120 couples in long-term,

ongoing relationships, who were not attending therapy. All couples were heterosexual. The patients completed the CREOQ at the beginning of their therapy. The couple data were collected over a period of 2 years through personal contacts for the control group and through the patients attending the Relate Centre. The anonymous patient and control questionnaires were scored by the author and John Birtchnell, respectively. As there was also interest in the early sibling relationships, participants were asked to complete a simple birth order chart so they could be identified as an eldest, youngest or middle child.

Results

To examine Hypothesis 1 groups were arranged according to sibling size. Group 1 consisted of partners who came from the same sibling sized family; Group 2 were from adjacent sized families (i.e. one from a family of two children whose partner was either an only child or from a three-child family); Group 3 were partners who were not from adjacent or same-sized families (e.g. one partner could have two siblings and the other have four or more siblings). It was interesting to observe that Group 1 ($n = 8$) was considerably smaller than Group 2 ($n = 16$) and Group 3 ($n = 15$) which could indicate that those coming from the same level of 'noise' in their childhood were less likely to present for couple therapy in their later years. A chi-square test showed no statistical evidence to support the first hypothesis that different sibling size combinations had any significant effect on later marital relationships (patients: $x^2 = 2.92$, $p = 0.23$; control group: $x^2 = 1.76$, $p = 0.41$).

To test Hypothesis 2 the cases from the patient and control groups with four or more siblings in their family of origin were added together to increase the sample (64 cases overall). The groups were arranged so that couples in Group 1 ($n = 11$) came from families with the same number of siblings, or one more or one less siblings than their partner; in Group 2 ($n = 18$) the partners were separated by two siblings; (e.g. one partner had four siblings and the other partner had two siblings, or one partner had three siblings and the other partner had five siblings and so forth); Group 3 ($n = 21$) partners were separated by three siblings (e.g. 4/1, 9/6);

Group 4 ($n = 8$) were separated by four siblings (e.g. 4/8); and Group 5 ($n = 6$) included the remaining couples, including two cases where one partner was one of 10 siblings. The results of a chi-square test supported the hypothesis, indicating that sibling size had some impact on later relationships ($x^2 = 13.03$, $p < 0.01$) though the results did not reveal what that impact was.

For Hypothesis 3 the birth order groups were classified as Group 1 for all first-borns, which included only children; Group 2 contained all last-borns; Group 3 contained all middle children who were neither first- nor last-borns. Non-parametric Mann–Whitney U tests were conducted to compare the mean scores of men and women between the different group pairings. The results indicated that if one of the partners was a middle child (Group 3) there was a significant difference in their dissatisfaction with their relationships. (US scores). The female partners of middle men reported more dissatisfaction in their relationships than the female partners of eldest or youngest men. The MS and WS CREOQ scores of the middle children were then examined in order to identify whether they may have been acting out their earlier personal history within their current adult relationship which may have generated the dissatisfaction of their partners shown in the US. Non-parametric Mann–Whitney U tests were conducted to compare MS and WS scores for Group 3 in their possible different partnership situations. The results indicated that a man who is the middle sibling in his family and who is in a relationship with a woman who is the eldest sibling in her family obtained higher scores on the lowerness scales (i.e. feelings of meekness, humiliation, or subservience). This suggests that the partners were experienced as behaving in a way that was related to their birth order position within the current couple relationship.

The octant scores by group (patient or control) and by gender were examined across each birth order group using the Mann–Whitney U test to test Hypothesis 4. The results showed no statistically significant differences in the WS octant scores between the eldest and youngest groups in either the patient or the control groups. However, when the middle children were paired with partners from either Group 1 (eldest or only children) or Group 2 (youngest children) there was a significant difference for the upper distant (UD) and upper close (UC) scales for the

patient group and a significant difference for the neutral distant (ND) and lower close (LC) scales for the control group.

These results suggest that in the patient group their partner was perceived as sadistic, intimidating, or tyrannising (UD) or intrusive, restrictive, or possessive (UC), and in the control group a middle child experiences his/her eldest child partner as suspicious, uncommunicative, and self-reliant (ND), whereas when the partner is either an eldest or youngest child the middle child relates with him/her with fear of rejection or disapproval (LC). The men in general tended to be reticent about scoring highly on the CREOQ items, which may have resulted in fewer significant differences on the octant scores between men and women, but even so, the main octants in which men scored higher than the women were Lower Close and Lower Neutral.

Total scores for each of the CREOQ statements across the three groups were analysed to explore whether the higher ones might be associated with sibling influences or influences of the current relationship (Hypothesis 5). The highest scores for the upper close octant are presented in Table 14.1 in bold type across the three groups. For Group 1, the first born women's highest total score was '*I seem to know what is best for him*' which; for Group 2, the youngest women's highest scoring item was '*I feel he needs looking after by me*'; and for Group 3, the middle women's highest scoring item was '*I'm not sure he can look after himself*'. Results for the other CREOQ octants are presented in detail in (Gordon 2004).

Discussion

This study tested five hypotheses. The first examined whether partners coming from similar sized families would be less likely to attend relationship therapy in the future, and findings suggested that sibling size did not have a significant effect on later martial relationships. The second hypothesis examined whether there was a significant difference in the number of cases falling into the different groups, and findings indicate that sibling size does have some impact on later relationships.

Table 14.1 The sum of individual patient group scores for different items in WS upper close octant across the three sibling groups

WS patient group Upper close Items	Eldest Group 1	Youngest Group 2	Middle Group 3
04. I find I make a lot of decisions for him	33	20	3
10. I seem to know what is best for him	**34**	15	4
31. I find it hard not to make a fuss of him	13	14	9
36. I can be the responsible partner	18	7	8
42. I feel I know him better than he knows himself	29	13	2
61. I am inclined to organise his life for him	30	18	3
75 I tend not to let him think things out for himself	19	15	3
81. I'm not sure he can look after himself	25	21	**11**
89. I feel he needs looking after by me	26	**25**	10
92. I'm not happy about him going out with other people	12	15	8

The third hypothesis examined whether US scores depended upon the birth order position of each partner. In other words, it examined whether the sibling effect of different birth order positions would have some influence over the levels of satisfaction experienced by individuals within their intimate couple relationships. Findings indicated that if one of the partners was a middle child there was a statistically significant difference in their dissatisfaction with their relationships. The women partners of middle men reported more dissatisfaction in their relationships than the female partners of eldest or youngest men, which suggests that middle children could be more likely to bring complex sibling issues to their later relationships than eldest or youngest children. This finding also suggests that the dissatisfaction is more a function of their own personal dissatisfaction or disappointment with their relationship than that of their choice of partner.

When these findings were explored further by examining the dissatisfaction of middle children, it was found that a man who is the middle sibling in his family obtained higher scores on the lowerness scales (i.e. more feelings of meekness, humiliation, or subservience), which suggests that the partners are experienced as behaving in a way that is related to their birth order position within the relationship. This appears to trigger a man's negative experiences as a middle child and can also introduce elements of

transference into their relationship. Kapelovitz (1987) defined transference as 'the inappropriate repetition in the present of a relationship that was important in a person's childhood' (p. 66). *Webster's New World Dictionary* (Guralnik 1970) had earlier defined transference as 'a reproduction of emotions relating to repressed experiences, especially of childhood, and the substitution of another person … for the original object of the repressed impulses'. These definitions suggest that some change in the couple's relationship (such as a wife wanting to branch out into a new career) has changed the dynamics of managing the home and family, and has rekindled long-forgotten negative feelings in the husband that he has previously experienced possibly towards his older sister. These powerful feelings have been stored unconsciously, but once triggered are usually inappropriate in their current situation. Often communication has become poor between the couple and their normal patterns of relating have become damaged. The use of the CREOQ can help to start the process of exposing these damaging negative feelings and help to trace their origins. Once the feelings become conscious they can be addressed and the couple has a chance to re-evaluate their relationship to accommodate the new changes one or both want to make at the present time. It is a chance for the couple to understand that the ghosts of unresolved childhood relationships, not just with their parents, but also with their siblings, are still haunting them and need to be resolved if their couple relationship is to survive.

The fourth hypothesis examined whether the different birth order positions cast an influential shadow of dissatisfaction experienced in adult intimate relationships, which is most apparent in relationships that are breaking down. The results showed no significant differences in the octant scores between the eldest and youngest groups in either the patient or the control groups, although when the middle children were paired with partners from either Group 1 (eldest or only children) or Group 2 (youngest children) there was a significant difference for the UD and UC scales for the patient group and a significant difference for the ND and LC scales for the control group.

The fifth and final hypothesis explored the total scores for each of the CREOQ scales across the three groups to explore whether the higher ones might be associated with sibling influences as well as being generated by the influences of the current relationship. For Group 1, the first

born women's highest total score was '*I seem to know what is best for him*'. This statement is about taking responsibility for others, which is likely to resonate with a woman who has possibly had to look after and take responsibility for younger siblings. If this behaviour takes away the initiative of the partner the woman can become disillusioned with having to carry too much responsibility within the partnership. For Group 2, the youngest women's highest scoring item was '*I feel he needs looking after by me*'. This item may carry an underlying message that the woman may not know what to do about it and may/or may not want to look after her partner. They are aware of the partner's needs but find it difficult to meet them. This is possibly because as a youngest child they have been used to having their needs met by family and older siblings without having to do the same in return. They can be fearful of taking responsibility for others. For Group 3, the middle women's highest scoring item was '*I'm not sure he can look after himself*'. Once again the item may suggest that the partners are expecting others to take responsibility for them. Middle children tend to seek solutions through diplomacy, make the best of things, and seek recognition for their achievements. They do not want a partner who is overly dependent upon them. In sum, by examining the highest scoring CREOQ items it is possible to gain insights into the way that the scores were generated.

Conclusions

The current study indicates that there are variations in the way the CREOQ scores are spread across different birth order groups and that sibling order could influence these differences. These results may indicate to the therapist that some behaviours and negative feelings experienced in relationships may have roots in sibling issues that are still unresolved in adult life.

Using the CREOQ it became apparent that this measure has value as a general tool for assessing the relationship of the presenting couple. On occasions the couple was offered a longer session so both partners could complete the CREOQ at the beginning of the session. It only added some 20 minutes to a session. This gave the clinician/therapist

extra insights into their unspoken ways of relating. The session following their exercise was often more in depth, as the questionnaires had focused them strongly on where the work lay. Discussing the results in the next session had a similar effect. In this way the CREOQ enabled the clinician/therapist to develop a working pattern, which quickly became established. It created a safe way to work and helped to avoid the trivia often used as a distraction or smokescreen.

Since the completion of the study, John Birtchnell has reworked the CREOQ and developed a shorter version (the CREOQ3 which has 48 statements against the original 96; Kalaitzaki et al. 2014) with slightly different items. Having become so familiar with the original version the author has not worked with CREOQ3 yet, but the use of it as a tool within the consulting room is expected to be similar and is likely to be more effective as the questionnaires take less time to complete. The data from the study (Gordon 2004) were also used in a further publication in 2006 (Birtchnell et al. 2006).

The use of the CREOQ can help to unravel relationship problems in different situations as they focus the attention of the patients on the relationship per se, rather than the symptoms of their dysfunctional behaviour, in a very direct way. The CREOQ is easily adaptable in different relationship situations such as between two siblings, or a parent and a child if this is the relationship in which the problems have arisen. The therapist gains value from the information produced by the CREOQ and the patients benefit from the engagement and understanding they experience completing the questionnaires as well as from the feedback provided by the therapist. The author feels privileged to have had the opportunity to use the CREOQ, not only as a research tool, but also as a method of working with couple relationships.

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15

Interrelating Within the Families of Schizophrenics Before Their First Psychotic Episode

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Introduction

Nowadays, schizophrenia is conceptualised as a mental disorder caused by multiple factors according to the *stress-diathesis model* (e.g. Nestoros 1997, 2001, 2006, 2012). The senior author, Nestoros (1997) places *special emphasis on maladaptive familial interrelations*, which are considered the main stressor underlying the emergence of schizophrenia. In this chapter, we interpret the family interrelationships of cases (referred to with pseudonyms) exhibiting schizophrenic symptoms with Birtchnell's Relating Theory. Naturally, the time period in their lifespan which deserves description is the one preceding the onset of their first schizophrenic episode.

Relating Theory (Birtchnell 1993/1996) is based primarily on a biaxial system of a horizontal and a vertical axis. The two edges of the horizontal axis are concerned with a person's tendency to form close or distant relationship with another person, whereas the two edges of the vertical axis

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_15

are concerned with the tendency to form relationships from a position of relative psychological strength or weakness. Correspondingly the poles are called Closeness, Distance, Upperness, and Lowerness. An octagon is formed with the addition of four intermediate poles, which represent the blending of the qualities of the adjacent poles; these positions are called Upper Close, Lower Close, Upper Distant, and Lower Distant (see Fig. 1.1). The Interpersonal Octagon depicts both the adaptive (positive) and maladaptive (negative) eight states of relatedness a person may seek (see Chaps. 1 and 2).

Three case studies are presented below which demonstrate the relevance and application of Birtchnell's (1993/1996) Relating Theory in understanding schizophrenic symptoms as a reaction to extremely stressful negative interrelating within the family. Their detailed presentation, including their psychotherapy sessions, has been published in Greek (see Nestoros 1993/2012).

The Case Studies

Angelo

Angelo Poulos was born in 1957 in Venezuela and was a resident of Chicago, Illinois. Although his father died from a heart attack when Angelo was only 6 months old, his mother told Angelo that his father had died at a later date when Angelo was 4 years old. According to her story, when his father had fallen to the ground, he had begged Angelo to bring him his pills since Mrs Papas made no attempt to. After the death of her husband, Mrs Papas immigrated illegally with her young son to the United States. Immigration laws were strict and Mrs Papas described stressful situations with them being constantly on the move, sleeping (always together) in different places, often being followed and betrayed, never trusting anybody but themselves, living in constant fear that they would be found and deported. Mrs Papas was with Angelo on a 24-hour basis. Eventually she obtained US citizenship and did well financially. Mother and son continued to sleep together and at the age of ten Angelo started having sexual intercourse with his mother. She pretended

to be asleep, yet Angelo knew that she was awake 'because she was not snoring'. Their 'symbiotic relationship' was at a state of 'equilibrium'; Angelo was performing well at school and both of them seemed happy until Mrs Papas decided to marry an older rich gentleman, George Papas. Angelo, who was 12 years old, was very much opposed to this idea. He repeated: 'We are perfectly happy like we are! We have plenty of money! Why change our perfect family situation?' His mother insisted that nothing was to change in their daily life as 'this was not a real marriage' (they would have no sexual interactions), that she would simply be a nurse for an old man and in return their financial situation would improve.

Eventually, Angelo agreed. In the hotel room next door in Las Vegas, where the newlywed couple chose to spend their honeymoon, Angelo started to exhibit his first schizophrenic symptom (i.e. an olfactory hallucination and the belief that he smelled like 'shit' and that his mother was poisoning his food and using witchcraft to influence him). Mrs Papas later admitted that she did engage in magical ceremonies and put various substances in her son's food, believing that their magical powers would cure him. Angelo started praying to God to cause the death of his future stepfather but when these prayers failed, he prayed to the Devil asking him to transform him into a werewolf (lycanthrope), because as he said: 'It is natural for a young werewolf to eat a useless old man. No society will find such an action condemnable!' One evening, a month after the marriage, Angelo entered the couple's bedroom carrying a large knife. He was noticed and immediately transferred to a psychiatric hospital in September1969.

There, Angelo was diagnosed as suffering from an 'acute psychotic episode of schizophrenic type'. He experienced auditory hallucinations, hearing werewolves howling at him, had ideas of persecution that his mother was poisoning him and wanted to kill him, bizarre behaviour, inappropriate affect and many other symptoms. His psychiatrist argued that his mother's recent marriage had led to Angelo's psychotic disorganisation and schizophrenic symptoms because of their 'symbiotic relationship'. The psychiatrist described Mrs Papas as 'a very disturbed personality', hovering over the child and disobeying his advice to distance herself from her son. Between 1969 and 1983 Angelo was treated repeatedly and in 1981, after attempting to kill his mother by setting the house on fire, he

was judged innocent by reason of insanity but sentenced to involuntary psychiatric treatment. His mother received permission from the court to take him to receive an experimental treatment developed by the senior author at McGill University, Canada, which involved high doses of diazepam (Nestoros et al. 1982), cholecystokinin (Nair et al. 1982) and integrative psychotherapy.

Analysing the 'symbiotic relationship' of Angelo and his mother according to Birtchnell's (1993/1996) Relating Theory, it is clear that Mrs Papas related to her son in an extremely negative upper neutral (UN) way by completely dominating him, upper close (UC) by being possessive of him, and neutral close (NC) by maintaining the symbiotic relation with him. Angelo mostly related to his mother with negative lower and close features as he was helpless and obedient (lower neutral; LN), but also dreaded being rejected and disapproved of by her (lower close; LC). Both were extremely dependent on each other and exhibited fear of separation and being alone (neutral close; NC). Mapping these onto the Interpersonal Octagon (Birtchnell 1994), one could say that mother's relating behaviour mostly represented the upper-right quadrant of the octagon, whereas Angelo's relating predominantly represented the lower-right quadrant. The scarce positive elements of their relationship were destroyed by the mother's need to have her son totally and permanently dependent on her.

The senior author treated Angelo from June 1983 to February 1984 using daily integrative psychotherapy sessions and pharmacotherapy. It was the main theme in all sessions that in order to eliminate schizophrenic symptoms it was a prerequisite to normalise the son–mother relationship and make Angelo aware that he had thoughts, emotions, wishes, and interests different from those of his mother. Mrs Papas, although initially agreeing to have psychotherapy herself, attended only six and a half one-hour sessions. Her interaction with Angelo produced grave deterioration in his schizophrenic symptoms. Distancing them for 15 weeks led to the disappearance of Angelo's symptoms, whereas their reconnection deteriorated his mental state. However, Angelo's individual integrative psychotherapy as well as the six joint sessions with his mother and the mother's individual sessions produced enough improvement in their interrelating, which resulted in them living together in separate rooms outside a psychiatric hospital from February 1984 to the present.

Eric

Born in 1952 in Canada, Eric Singer was diagnosed as suffering from the 'paranoid subtype of schizophrenia' in 1977 at the age of 25, even though his first psychotic symptoms appeared at the age of 8 (auditory and visual hallucinations accompanied by delusions of grandeur). Eric had two older sisters, Esther and Risa, but he was an unwanted child himself. His mother, Jobina, wanted to terminate the pregnancy because she was suffering from various medical problems and felt exhausted after her last pregnancy. However, Eric's father, Job, argued that the child would be a son who would bring pride and joy to the family. Eric's father was a prominent major of his small town in Poland before the Second World War. After the war and especially after Eric's birth, he developed serious psychiatric problems and life-threatening medical problems which required twice-weekly visits to hospital. Eric's mother worked to support the family whilst he stayed at home taking care of the children. For years, she was exhausted, desperate, and on the verge of a breakdown as forewarned by the doctors. His father was moody, irritable, angry, cruel, and dictatorial. For example, he monitored his wife's earnings and was verbally and emotionally abusive towards Eric and Esther. He always spared Risa, even though she also grew to despise him. When Eric was 5 years old his father attacked him with a butcher's knife because he refused to eat. After repeated similar incidents, Eric's father entered a psychiatric clinic on two occasions. A third admission occurred when he banged his head against the wall in a burst of anger and developed a brain haemorrhage, but a neurosurgeon saved his life.

When Eric was seven his father forbid him to play with his toys, arguing that he was no longer a child, and not to paint because the smell of the crayons displeased him. Being overprotective he prevented Eric from playing with other children without his supervision. At school Eric was isolated and unable to concentrate, escaping into countless daydreams. When his father attended his routine visits to the hospital, Eric stayed at home reading the books of his oldest sister.

During his childhood Eric was terrified of his father, felt rejected by him and was rebellious and angry towards both his parents; he hated his father for oppressing him, overcontrolling him, and attacking him; he

was also angry at his mother for not protecting him from his father. In his everyday life, he tried to remain quiet, usually hiding somewhere at home, trying to avoid any contact with his father who pretended that he did not know Angelo's hiding place in order to avoid conflict. Thus Eric spent most of his early years alone, terrified, and escaping into the world of fantasy. His two sisters systematically ignored and avoided him because he had the same sex as their father whom they despised. *In Eric's family being feminine was desirable and being masculine was despised*. Eric initially reacted to the violent behaviour of his father by refusing to eat which led to a vicious circle of threats and violence from both sides. He soon surrendered and started to overeat. Eric asked help from his mother who was simply condolatory, advising Eric: '*You must be a good boy, even when daddy is angry. Try to be good, better even. Don't fight with him, he's a sick man. He wasn't always like this. Before the war he was different*.' Eric begged her to send him away, like she had promised if he hit him but she replied: '*He is on medication now; he'll be okay. I can't commit him, I still love him. Hitler did terrible things to people*.' She often cried at this point and Eric would promise anything.

In time, Eric began to be 'frightened of something vague and evil inside the house'. Under daily family stress experiences, *Eric experienced the first psychotic symptoms at the age of eight*. Being alone in his room, he had visual and auditory hallucinations (i.e. imagined what the neighbours were saying and doing), which initially helped him feel less lonely, but soon the voices became hostile, saying that they hated Eric, because he was '*his son*'. He also heard his parents quarrelling and believed that his father kept his mother up, explaining loudly that Eric was not his child. His mother replied: '*Leave him alone. He's only a child*.' Eric realised that his parents 'voices' were a product of his imagination when once while hearing a verbal fight, he saw his parents sleeping. During that time, Eric thought that his mother believed that he was under the influence of an evil force, saying '*the devil is in him*'. Eric was terrified. He wanted to explain to her how she kept hurting him, forcing him to behave worse. Eric started to pretend not to hear and eventually he really did not hear. Around that time Eric, who felt completely alone, unprotected, and unloved, started believing that he was Jesus Christ, 'because so many people loved him'.

According to Birtchnell's (1993/1996) Relating Theory, it is clear that Angelo's father related from the negative upper states of the Interpersonal Octagon, being dominating, insulting (upper neutral; UN), imposing his will, and being violent (upper distant; UD). Although he related in a positively close manner (neutral close; NC) toward his wife and daughter Risa, he was extremely withdrawn and avoided communication with Eric and Esther (neutral distant; ND). He was also restrictive and possessive towards Eric (upper close; UC). Both Eric and Esther felt helpless to deal with their father, ended up submitting to his wishes (lower neutral; LN) and became suspicious and uncommunicative (neutral distant, ND) like him. Eric and Esther were also subservient and withdrawn (lower distant; LD). Placing these tendencies onto the octagon, the father related from the upper-left quadrant of the octagon, whereas Eric related from the lower-left quadrant.

Eric sought care and protection from his mother (positive lower closeness; LC) but was also subservient and helpless (lower distant; LD and lower neutral; LN). Jobina related to her husband from a neutral close (NC) and lower close (LC) state as she feared losing him and being left alone, and also from a position of lowerness, whilst she related from a position of upperness with her son.

We believe that *the interpersonal relationship with his father was the main triggering factor* for Eric's schizophrenic symptoms (see Nestoros 1993/2012). It is worth mentioning that in his adolescence and adult life Eric repeatedly entered into homosexual relationships with men who were about the same age as his father. When he went through a period of male prostitution Eric told himself full of pride: '*My father hates me, yet all these men desire me and are willing to pay a lot of money so they can touch me*!' Moreover, Eric had the most severe schizophrenic episode of his life and attempted suicide when his partner Jules, with whom he had lived for 4 years, decided to terminate the relationship. Jules was about the same age as Eric's father and he had the delusional belief that Jules was his physical father.

When Eric began treatment in 1978 he was floridly psychotic with delusional ideas of reference and persecution, believed that other people could hear his thoughts and that our sessions were transmitted in outer space. Eric was treated by the senior author with integrative psychotherapy

and without any pharmacotherapy from 1978 to 1982 with a total of 295 sessions of individual therapy lasting 60 minutes each, once or twice a week.

We discussed his schizophrenic symptoms after they were no longer present. The focus of therapy was to explore Eric's relating with family and significant others and on exploring their views about Eric. Eric acknowledged himself not as a person suffering from schizophrenia but as someone being stressed by extremely negative family interrelationships. Furthermore, he understood that his parents behaved the way they did because they were also under stressful life circumstances. Eric realised that he had control over his future life, and at the end of psychotherapy his schizophrenic symptoms disappeared and he related to his parents from a position of positive upper closeness (UC) and to his sisters from positive neutral closeness (NC). Furthermore, the co-authoring with the senior author of the book *Eric's Odyssey* (see Nestoros 1993, 2012) made his parents very proud. Since 1982, he has been free of any schizophrenic symptoms, is happily married, and is the director and owner of a highly regarded nursing home for retired people in Montreal, Canada.

Vivianna

Vivianna was the senior author's patient for several years because of a schizophrenic episode which occurred in 1988 when she was a 20-year-old university student. Her father rarely worked because he was a chronic alcoholic. He would go on drinking binges and disappear from the house to be eventually found by Vivianna beaten up, bleeding, and penniless. Her mother also sent her to receive her father's salary before spent it on alcohol. Vivianna felt emotionally closer to her father, whom she considered to be more emotional, of high intellect, and some sort of an uneducated philosopher. Vivianna also believed her father's story that he was drinking to forget how much he was in love with her mother, who rejected him because 'he was mundane, unimaginative, and asexual'. Vivianna had a younger sister who was born with cerebral palsy, tetraplegia, and epilepsy. Her mother, frustrated by her husband's alcoholism, daughter's medical problems, and poor financial state, used Vivianna, in her words 'as her punching bag'.

Vivianna grew up entirely ignored by her parents, having no other parental substitute. Her father wanted a son and treated her like a boy. Until she reached puberty she thought of herself as a boy, even dressing and behaving accordingly. As an adolescent she developed a reputation that she was a lesbian, and although she had erotic proposals from lesbians, she was never attracted to them.

Both her parents were very strict and always imposed their will on her, making her believe that people have no free will. Her parents propagandised that she should avoid any sexual contact with men because it always leads to pregnancy which destroys a girl's future. She therefore suppressed all of her sexual desires and dressed and behaved as an asexual creature until she entered university. There she discovered a new world and realised that she, too, had sexual desires – in fact very strong ones. She became particularly fascinated with one of her classmates, Peter, with whom she shared her interest in poetry and painting. Peter showed his interest in Vivianna, who was invited to a party where he was waiting for her. Naturally, all these were in grave conflict with the beliefs implanted by her parents.

As a reaction to this stressful situation, Vivianna developed *heavy menstruation* long before the time she was supposed to have it, which turned into extreme *dysmenorrhea*, causing her pain, nausea, vomiting, headaches, and other symptoms. Furthermore, she became *confused and disoriented*. On top of this she developed *schizophrenic symptoms* with predominant delusions that everybody wanted to rape her, even telepathetically (she arrived at the senior author's office wearing one pair of pants, five layers of toilet paper, one corset, two pairs of shorts, and a pair of trousers and said that an experiment had *castrated everybody*. Later, she said that *she was 51 % male and 49 % female*.

In addition to individual integrative psychotherapy three times a week, she was also initially treated with pharmacotherapy. She was disoriented in time and exhibited delusions of reference (i.e. she believed that everything and everybody was referring especially to her) and persecution, delusions of grandeur, auditory hallucinations, and severe disorder of the thought processes. She thought that she was created from the most beautiful parts of the 60 wisest men on Earth and that all politicians were watching her. Vivianna became completely well within a few months of

therapy but had a second short psychotic episode in 1992, when she was not attending therapy, after she had a sexual experience with a married man. Ever since she has had a normal sexual life, is free of schizophrenic symptoms and has become an accomplished poet and painter.

According to Relating Theory, Vivianna was obedient and compromising against her parents' rules (lower neutral; LN) and dominated by them (lower distant; LD), yet she was very fond of her father and took care of him (positive upper close; UC). Her father's relating towards her included both upper and distant relating features. He imposed his will on her (upper neutral; UN), he was rejecting and controlling (upper distant; UD) and uncommunicative with her (neutral distant; ND). Her mother was judging, beating, ruling, and dominating Vivianna (negative upper distance; UD) and not attempting to be close to her (neutral distant; ND).

During psychotherapy we discussed Vivianna's life experiences with her parents, sister, and maternal grandfather, who attempted to sexually abuse her when she was 12 years old. By acquiring self-acceptance and self-respect and by learning to trust her own thoughts and feelings, she gradually understood that her experiences should not influence her future life. She became able to stand up to them and at the end of psychotherapy she related to her parents and sister from the positive upper close (UC) state of relatedness, and her mother stopped relating to her from a position of upper distance (UD) and neutral distance (ND).

Discussion

The multifactorial stress-diathesis model for the emergence of schizophrenic symptoms (Nestoros 1997) when combined with the information provided by Relating Theory (Birtchnell 1993/1996) may predict not only the individuals who will present schizophrenic symptoms but also their severity and their morphology. The Person's Relating to Others Questionnaire (PROQ3; Birtchnell et al. 2013) could be a useful tool to help the therapist assess the patient's familial relating puzzle and provide data for the patient to come up against the extreme stress which underlies the onset of schizophrenic symptoms (Nestoros 1997, 2001, 2006).

The impact of the familiar environment on a person is of great importance. Studies have shown that negative intrafamilial relations and between the patient and his/her parents may be a detrimental factor for the appearance and prognosis of schizophrenia (e.g. Bateson et al. 1956; Fromm-Reichmann 1948). We believe that intrafamilial relations are the main stressor in the emergence of the first schizophrenic episode, according to a model of stress and anxiety which integrates the neuroscientific evidence with the evidence stemming from psychological theories (psychodynamic, behavioural, existential, etc.) (Nestoros 1984). It has been proposed that extreme stress and anxiety lead to ideas of reference and persecution as a life-protective response of Homo sapiens established over the past 5 million years (Nestoros 2001, 2006).

Many researchers agree that high levels of stress and high-Expressed Emotion (EE) in the family, namely criticism, hostility, and over-involvement (Leff et al. 1987), or other maladaptive familial relations may affect patient relapse rate (e.g. Brown et al. 1972; Cechnicki et al. 2013; Kavanagh 1992). Possible alterations in abilities and habits affect the rest of the family, and especially the caregiver, leading to stress and high-EE (Koutra et al. 2014). The most important issues that therapy must target are parents' high-EE. On the other hand, the burden of care of the schizophrenic patient may cause family relationships to deteriorate (e.g. Gopinath and Chaturvedi 1992; Kalaitzaki 2005). It must be emphasised that in the individual integrative psychotherapy model, applied by the senior author, called *Synthetiki Psychotherapy*, the patient is trained to understand both himself/herself and the mechanisms causing his/her relatives' high-EE. This is why people who improve themselves have such a beneficial influence on intrafamilial relationships (Kalaitzaki et al. 2010). However, the authors agree with the combination of individual and family therapy when it is advantageous (Berglund et al. 2003; Dyck et al. 2000; Kalaitzaki and Nestoros 2006).

Last, but not least, since schizophrenia is generally considered to be a brain disorder (Onitsuka et al. 2013), it is of heuristic value to demonstrate that psychotherapy, i.e. talking therapy, has such a profound effect on brain function and structure (Collerton 2013).

Conclusions

This chapter has presented three case studies to evidence that family interrelating is a co-triggering factor for the emergence of schizophrenic symptoms and that Relating Theory (Birtchnell 1993/1996) can offer a theoretical conceptualisation for the explanation of a schizophrenic's relating towards his/her parents. It was fascinating to observe that for all case studies *working through the stressful family interrelations led to the disappearance of schizophrenic symptoms without ever making the schizophrenic symptoms themselves the focus of the psychotherapeutic session*. We hope that this chapter will constitute an important addition to our understanding of schizophrenia's aetiology and that the findings of modern research, as displayed above, will be useful for the evaluation and treatment techniques for the amelioration of schizophrenia.

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16

Relatedness Reflected Through the Group Analytic Mirror

Marion Brown

Introduction

Group Analysis

Foulkes (1948) described a therapy group as a 'microcosm of society' as a heterogeneous group of individuals are brought together by the group conductor (therapist) to undertake a particular piece of work around problematic intra- and interrelational difficulties. The problem as identified by the individual and perhaps by the referrer might be phrased more around the symptom or some other problematic issue, but in assessment it might become clear that the underlying issue is around difficult and often intractable relational patterns stemming from early life to the present day.

Each group member eventually replicates his/her habitual pattern of relating in the group since people tend to carry their history with them as well as their internal groups (i.e. the internal templates of the dynamics

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_16

of their historical and important group experiences) and their habitual position within those groups. Over time the dynamics of the individual's relational patterns become visible and felt within the group, since individuals relate and respond to each other on multiple levels, just as they do in everyday life. These multiple levels include unconscious aspects such as the transference level which we might see enacted in relation to the group conductor, other group members and/or to the group as a whole. It may be seen through unconscious primitive defences such as projective identifications, projections, splitting, or through subgrouping in the group. It permeates every level from the everyday social level through to the primordial level. Foulkes and Anthony (1965) describe group analysis as 'a horizontal analysis, conducted within a circle of equals, among whom problems rooted in the past can be played out and modified' (p. 42). Group analysis works on the interactions and reactions between members, the group conductor and the group as a whole.

Although people's relational patterns may become evident in any type of group over time, the difference with an analytic group is the implicit and explicit focus on group process and relationships at all levels. The group examines itself and each of the individuals who comprise the group. The focus is on the individual and the group, the individual within the context of this group and of his/her life groups, for example their family, social and/or work groups. Through this multiplicity of reacting and relating the group members are well placed to ascertain the relational patterns of each group member.

Arguably their understanding of each other could be distorted or clouded by this very multiplicity. However, over time the group as a whole is able to provide a remarkably accurate 360 degree reflection of each individual within the group, how they see themselves, the defences they have formed over time and which influence their relational patterns, how others see them and why others react or relate to them in particular ways. The accuracy of these reflections may be due to a particular group process described by Foulkes and Anthony (1984) as 'The Hall of Mirrors' where each member reflects their perceptions of the other. Perceptions distorted by the factors described above tend to be compensated for by other members not caught in a particular unconscious dynamic, and by the group conductor who is also experiencing how the member relates and what it is like to be relating to that member.

The mirroring takes place through both feedback and spontaneous reactions to what the member is doing, how they are communicating, what they are communicating, how they are behaving within the group, how they interact with specific members and/or the group as a whole and how they react to particular stimuli or topics. Reactions from other members of the group or the group conductor may be very similar to the reactions they receive from others in their everyday life, which may be confusing, frustrating, or difficult to understand. The group, through its examination of these reactions, is able to shed light on this. In addition, the group as a whole forms a group mirror which reflects what is happening in the group itself, adding an extra dimension to the perception of where the member sits within the group and how he/she reacts and relates to the group as an entity.

Over time strong reactions and repeated problematic interactions in the group tend to be linked to a pattern of problematic interpersonal relationships outside of the group and in the person's past, illuminating the powerful and problematic internal conflicts and relational templates which influence how the member responds or reacts to particular relational factors or stimuli. The understanding of and working through of these reflections and processes are the work base of the analytic group. Insights and changes to relating experienced within the group are inevitably transposed to the group members' relationships outside of the group, making sense of others' reactions and responses to them and their own part in problematic patterns of relating.

Why an Analytic Group Lends Itself to Using Relational Measures

Foulkes (1964) claims that 'The group provides a stage for actions, reactions and interactions within the therapeutic situation' (p. 82). The focus on the here and now interactional level of the group, inherent within the group analytic situation, lends itself to the experiencing and exploration of members' patterns of relating. As described earlier, over a period of time members find themselves caught up in the same problematic interactional patterns that beset their relationships outside of the group.

These patterns are familiar as they are likely to have formed a part of most significant relationships in their lives. Although familiar, these patterns may not be consciously recognised or understood, the group member may not be accustomed to thinking about their own part in a problematic relational pattern, or what it is that draws them to such relational difficulties, what this may draw out of them in reactions and responses and how this in turn feeds the dynamic.

Analytic groups work on the relational patterns of each group member through the development of the interrelational level of the group. Foulkes called this 'a transpersonal network' (Foulkes and Anthony 1984, p. 259), meaning that individuals within the group directly impact on each other's inter- and intrapersonal processes on both conscious and unconscious levels, repeating their relational patterns and the positions they occupy within these. Observation of self and other and of the relationship between, and observation of the processes operating between other group members, including the conductor, is actively encouraged in order to determine what maladaptive and adaptive relational patterns are operating, why they are operating in these relationships and how they have been developed and are maintained. 'Group analysis is psychotherapy of the group, by the group, including the conductor' (Foulkes 1986, p. 3) and of all of the processes within it. Thus the analytic group lends itself to close examination of the member's relational patterns. Using the developing awareness derived from this, members of the group are in a good position to record their experience and observation of the relational pattern of each of the other members of the group. This could be used to form the basis of a measurement of the here and now individual relational patterns in the group in terms of closeness and distance from other. Their own experience of relating to another member and their observation of how that member is relating to others enables them to perceive how much control individual members appear to exert on others.

A person's view of how he/she relates may not be how he/she really does relate. It may not even correspond with how others consider that he/she relates. Birtchnell et al. (2006) demonstrated this by inviting members of an analytic group in a therapeutic community prison to assess both their own relating tendencies (using the PROQ) and those of every

other group member (using the OPROQ). The ‘I’ of the PROQ items was replaced with the ‘He’ or the ‘She’ of the OPROQ items. Over the course of psychotherapy, it was found to be therapeutically advantageous to invite the patients to examine the discrepancy between their own view of themselves and the other group members’ view of them.

The Current Study

The effectiveness of relational measures in two analytic group settings (a therapeutic community prison and an analytic group within an NHS Mental Health Psychological Service) were explored by Birtchnell et al. (2006) and the author of this chapter (Brown, formerly Panchkowry 2006), respectively. Panchkowry et al.’s study has been summarised above, and so the remainder of this chapter provides an account of the analytic group within the mental health service.

Method

Participants

The group in which the OPROQ3 was piloted was a long-term, slow-open heterogeneous group (i.e. a mixed group of long duration where members leave and others join at varying time periods throughout the life of the group). The group consisted of six members (three men and three women) and their diagnoses were recurrent severe depression, moderate to severe anxiety, obsessive compulsive disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders–Fourth Edition (DSM-IV, American Psychiatric Association 2000), or emotional deregulation often with co-morbidity. Three of the members had been previously hospitalised, all had self-reported long-standing relational difficulties, and most had experienced significant workplace relational difficulties. The group had been running for a few months before the measures were introduced, so relational dynamics had already formed in the group.

Measures

The Person's Relating to Others Questionnaire (PROQ3; Birtchnell et al. 2013; see also Chap. 3) is a 48-item self-report measure which assesses negative relating in the eight octants of the Interpersonal Octagon (Birtchnell 1994; see also Fig. 1.1) which are: upper neutral (UN); upper close (UC); neutral close (NC); lower close (LC); lower neutral (LN); lower distant (LD); neutral distant (ND); and upper distant (UD). There are six items per scale (five reflect negative relating and one positive relating) which are rated on a four-point scale of 3 ('Nearly always true') to 0 ('Rarely true'). Responses are scored by computer software to produce a score of 0–15 for each scale. Research has reported acceptable internal reliabilities for all scales (Birtchnell et al. 2013).

Participants rated each of the other group members using the Observed Person's Relating to Others Questionnaire (OPROQ; Birtchnell et al. 2006), which measures the same eight scales as the PROQ3, but because it is intended for people to rate others, items are phrased in the third person.

Procedure

Participants completed the PROQ3 and then the OPROQ3 to assess each of the other group members on the basis of their personal experience. Responses remained anonymous and the PROQ3 and OPROQ3 were matched based on a code created by each group member. Once the responses were analysed, the results were returned to the group members for discussion.

Results

Impact on the Group

Unexpectedly, the questionnaires were completed and returned without too much prompting and there was interest in what the results might show. Group members found some of the questions difficult to answer,

particularly in relation to other group members, not being sure if they should base their scoring on what they had directly experienced in relation to a member in the group or on what the member had divulged about their relationships and manner of relating outside of the group. Some members had experienced this as conflicting. For instance, a member might have been perceived as controlling in the group but the members' reporting of outside relationships might be of him/her feeling controlled and powerless. This, however, was useful in opening up a discussion about why another person's perceptions of them may be different from how they saw themselves.

The reports were anticipated with curiosity. Interestingly, the reports were discussed in several subsequent sessions with perceived inaccuracies being debated and members providing good rationales for their perception of each person's relational pattern. For some group members the report confirmed their view of themselves and their struggles in relating and thus, the report was experienced as validating; they felt they had been seen and heard. Other members were surprised at how they were perceived; it was not how they viewed themselves, and they did not particularly like the reflection they were seeing in the group mirror. This brought forth some interesting discussions.

Although the questionnaires had been anonymised, some members chose to disclose why they had rated another person in a particular way, speaking of their experience of that person in the group and challenging some members' faulty perceptions of self. Interestingly, some of the transference issues became more recognisable to group members during the completion of the measures and subsequent discussions, perhaps due to the explicit focus on the member's interpersonal style of relating to self and other, and each member's subjective experience of the other/s. The group members did not of course refer to it as transference although they recognised that sometimes the reaction to the 'here and now' relational level of the group was skewed, or over and above what might be expected from the interchange. This opened up a discussion around why members were relating to specific others in a particular way and to what the group as a whole represented for them. At these times the group seemed to enter the cognitive realm, engendering more of a focus on reality checking, that is, the question of whether a member's experience of another was based

on what was happening in the group or was intertwined with historical and present-day relational dynamics (transference).

Comparison of PROQ3 and OPROQ3 Scores

The mean PROQ3 scores (i.e. the perceptions of one's own relating) and the observers' OPROQ3 mean scores (i.e. one's rating of other members) for group member 1 are shown in Table 16.1 (first row and below this, respectively). The comparisons between the mean scores show how well the other group members' observations correspond with the person's self-observation. This member sees himself as very upper (i.e. bossy, dominating, and controlling) and most of the group agree. Everyone agrees that he is *not* lower neutral (LN; helpless, self-denigrating, etc.) and there is fairly general agreement that he is also not lower distant (LD; acquiescent, subservient, withdrawn). There is considerable disagreement on neutral distance (ND), however; members 3 and 6 see him as very distant but members 2 and 5 do not think he is distant at all.

Table 16.2 reports the differences between the PROQ3 score for each member of the group and below this the OPROQ3 mean scores of all group members for that particular member. For member 4 the mean scores are very close. There is a small difference for members 5 and 6, while there is a marked difference for member 3.

Table 16.1 PROQ3 and OPROQ3 ratings for member 1

Member 1	Observer	UN	UC	NC	LC	LN	LD	ND	UD	Total
PROQ3	Member 1 self observation	15	10	08	15	01	04	13	05	71
OPROQ3	Member 2	15	12	06	15	00	03	00	12	63
OPROQ3	Member 3	15	13	02	09	00	06	15	11	71
OPROQ3	Member 4	10	06	04	12	01	03	09	07	52
OPROQ3	Member 5	07	11	07	13	01	03	01	08	51
OPROQ3	Member 6	13	12	01	15	00	00	15	12	68
OPROQ3	Mean score	12	11	04	13	00	03	08	10	61

Higher scores reflect higher levels of negative relating (15 is the maximum score for any scale)

PROQ3 Person's Relating to Others Questionnaire, *OPROQ3* Observed Person's Relating to Others Questionnaire

Table 16.2 Differences between self (PROQ3) and combined other (OPROQ3) scores for each group member

	Member 1	Member 2	Member 3	Member 4	Member 5	Member 6
PROQ3	71	78	55	65	50	67
OPROQ3[a]	61	69	73	64	45	73

[a]Combined scores of all group members

Discussion

Using measures repeatedly within an analytic group raises a concern for some group conductors (e.g. Horneland et al. 2011; Leu et al. 2010; Newton and Levinson 1973; Ogrodniczuk et al. 2010) about its impact on the analytic level. The concern is that completing a self-report measure as an examination of relational dynamics and group process could move members and the group as a whole from the deeper unconscious working level to the cognitive level, potentially negatively impacting on the multiple transferences, multiple projective identifications, projections, and splitting inherent within the group modality and central to its theoretical orientation. This concern does not seem to be substantiated in practice. Chris Mace, a group analyst and researcher, in his 2006 paper, 'Setting the world on wheels: Some clinical challenges of evidence-based practice', says there is no reason why session feedback cannot be done in a group. He argues that 'Therapy by the group is likely to be supported by feedback for the group …' and goes on to say that 'The real (and broadest) clinical challenge here becomes how a group integrates objective feedback about members' progress that is direct, repeated and normative, right there in the room' (p. 318).

There are particular problems in researching slow-open heterogeneous groups, such as the one used in this study. This is due to the multiplicity of problems and symptoms experienced by the members of the group. There is often co-morbidity and varying degrees of complexity, all of which is complicated by changes in membership, albeit that the latter tends to be over a long period of time. However, despite these difficulties, research has been successfully undertaken using variety of methods.

Randomised control trials (RCTs), whilst considered the gold standard of research, are acknowledged to be the most difficult to undertake

with analytic groups. The most recent published RCT in the field was conducted by Lorentzen et al. (2013): a three-year comparison study of short- and long-term group analytic psychotherapy with 18 groups of mental health patients over three sites. A difficulty with these studies is that important elements such as selection to and composition of groups are sacrificed to randomisation, which is likely to skew development of relational patterns and transference relationships which enable the recapitulation of the primary family group (Yalom 1985).

Outcome studies involving self-report data such as Barbara Dick's (1975) ten-year outcome study of long-term analytic outpatient groups showed good results. Dick used measures of life 'acceptability' covering physical health, leisure, relationships, sex, work, self-image, and self-understanding at 6, 18 and 30-month follow-up intervals and found that 87 % of patients who remained in the study to the end demonstrated positive change, most of which was independent of psychiatric services. Although self-report measures are subjective, personal reports of symptom reduction and ease of relating are important as they clearly indicate the patient's view of improvements to their lives and well-being. However, they do not allow for the assessment of how others experience them.

Methods of measuring relating patterns from observation have been developed. In his Group Therapy Interactional Chronogram, Cox (1989) ordered patient notes from the beginning, middle and end of sessions to identify patterns, whilst Brown et al. (2012) identified patterns of relating and changes in relating patterns over time through the use of a computer-generated program. These methods of assessing relating are equally subjective in that they use the therapist's recollection of interactions, but nevertheless provide an interestingly visual way of monitoring change over time. The Clinical Outcomes in Routine Evaluation (CORE; Barkham et al. 1998) is a measure which can be used across a wide spectrum of psychological disorders and treatments including analytic groups. Although it is preferable to use it with other measures in order to capture the intricacies of relating, it allows for both patient and therapist reporting so that there is more of a sense of self and other experience of change.

Group process measures have also been developed, such as the Group Climate Questionnaire (MacKenzie 1983) to record members' experiences of being in the group. Again this is subjective, but it captures a

member's thinking about the group and how the group is relating. It does not focus on how an individual's patterns of relating might change but rather looks at this from the viewpoint of the group as a whole and how this changes over time. Combining some of these methods, for instance the Group Climate Questionnaire in conjunction with the CORE and other self-report measures provides a more rounded view of relational change within an analytic group.

It seems to the author that the PROQ3 and OPROQ3 measures make better use of the intra- and interpersonal relational aspects of analytic groups than those which are subjective, as they drill into the member's experience of the relational patterns of each of the other group members, and their own reactions and responses to this. What is missing is the group conductor's experience of the members. The author wonders if this would be different, given their more objective clinical eye, even though the conductor also experiences what it is like to relate to each of the group members.

Despite its advantages, the Interpersonal Octagon does have some limitations for the group analyst/researcher who seeks to measure intrapersonal change, symptom reduction, and problem resolution in order to ascertain the impact of changing entrenched relational patterns. Prior to the start of this study, the author had shared the concern that using self-report measures in the group would move group members to an intellectual, rational level of thinking and relating which it did, to an extent; however, this concern was only partially borne out, as the group did not remain there. The discussions generated by the results of the PROQ and PROQ3 soon reactivated the relational and emotional levels exposing internal conflicts in relation to self and other. What the author noticed was a developing ability within the group for members to engage in their own process, yet be able, in varying degrees, to stand outside of this and make sense of it. The resulting discussions added to and helped make more immediate sense of the reflections from the group mirror.

We would expect an analytic group to gradually develop the kind of matrix that would enable members to become more able to think about and experience how they and other members are relating to each other, how they relate to the group conductor, how engaged or otherwise the group conductor appears, how members feel about the group itself,

and how they react and/or respond as a group. They move to a position whereby they can consider, sometimes spontaneously, which destructive, pathological or adaptive, constructive processes are operating in the group at any given time. A question for further investigation would be whether a group might get to this point more quickly by using these particular relational measures.

The author found that using the PROQ3 and OPROQ3 measures added a level of increased complexity to the transference at multiple levels. This showed itself in relation to the group conductor (the author), and appeared to be around authority and knowledge, idealisation and denigration. It was also evident in a variety of ways within individual transferences between members. It appeared to highlight existing transferences and to open up new transference reactions which could be discussed and understood in terms of members' historical and everyday life relationship difficulties and their relationship to themselves. This again is not unusual for an analytic group; however, the point is that undertaking the study in the group did not impede this level of working and in some ways appeared to make it easier for members to connect here and now relationships with past relationships and their own internal conflicts. It remains unclear to the author if this would be the case if the measures were used in a new group where the interrelational dynamics in the group had not yet been established and the work of examining the intra- and interpersonal levels had not yet begun. This may be worthy of investigation.

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17

Changes in Interrelating over the Course of Psychotherapy

Argyroula Kalaitzaki

Introduction

Relating Theory (Birtchnell 1993/1996) draws a distinction between relating and interrelating. Relating is a person's attitude and behaviour towards other people or to one particular other person, whereas interrelating concerns the interplay that occurs between any two specified persons. It includes both the relating behaviour of each person towards the other and each person's view of the other's relating behaviour towards him/her (Birtchnell 1993/1996, 1994). Positive interrelating refers to respectful, considerate, and inoffensive relating towards another person, and negative interrelating refers to a more troubled form of involvement (Birtchnell 1993/1996; Kalaitzaki et al. 2014). Negative interrelating involves a unidirectional or bidirectional dissatisfying relationship between any two people (Birtchnell 1993/1996; Kalaitzaki et al. 2014). In other words, it is a non-functional or dysfunctional relationship.

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_17

A number of studies have revealed the effectiveness of individual psychotherapy in reducing a person's negative relating towards other people (e.g. Birtchnell 2002; Birtchnell et al. 2009).

The Rationale of Applying Individual Therapy to Couple and/or Family Interrelating Deficiencies

There are patients who, from the outset of therapy, reveal both psychiatric symptoms and interpersonal problems (Horowitz and Vitkus 1986), and others, for whom the presenting psychiatric problem turns out to be an interpersonal one, involving at least one specified other person, such as a partner or a child (Kalaitzaki and Nestoros 2006). The strong association between individual psychopathology and couple relationship distress (Baucom et al. 2012; Horowitz and Vitkus 1986) may indicate that either psychotherapy modality (individual or couple/family) could be advantageous in treating clients' presenting problems. One could also argue that individual psychotherapy could be effective in addressing both the client's psychiatric symptoms and interpersonal problems, just like individual interpersonal psychotherapy (Klerman and Weissman 1994) has proven effective in treating acute depression by improving interpersonal functioning with important others (e.g. van Hees et al. 2013).

Traditionally, couple and family therapy are the treatments of choice for addressing couple relationship problems (e.g. Snyder et al. 2006) and family relationship problems (e.g. Guo and Slesnick 2013) respectively. The efficacy of systemic interventions in treating couple relationship distress and assisting families in coping with the complexity of systems in which they belong have been well documented (e.g. Bertrando et al. 2006; Carr 2009). Couple and family therapy have also proved effective in treating clients' mental health problems (Carr 2009; Snyder et al. 2006; von Sydow et al. 2010). However, if psychopathology symptoms precede the onset of the interpersonal problem (Whisman and Uebelacker 2009), it is reasonable to apply an individual model to the therapy. Intervening at the individual level and reducing psychopathological symptoms might also be beneficial for the resulting relationship problems. The link between

psychopathology and relationship problems has been well documented (for the rationale and a literature review see Chap. 13 of this volume). A further argument in adopting an individual form of treatment for the alleviation of both psychopathological symptoms and interpersonal deficiencies is the client's unwillingness to be involved in therapy. When the specified other person(s) with whom the client's problem is intertwined is unwilling to be involved in the therapy, the therapist is left with the option of working only with the patient, and in this case, the therapeutic format of choice would be no other than an individual one (Kalaitzaki and Nestoros 2006).

A large body of research and many systematic reviews have demonstrated that individual therapy is undoubtedly effective in treating various mental health problems, such as schizophrenia (Lysaker et al. 2010) and depression or anxiety disorders (Baker et al. 2012; Hawke and Provencher 2011; Reynolds et al. 2012). Its effectiveness has been documented even at the early stages of therapy (Haas et al. 2002; Kalaitzaki et al. 2010; Lutz et al. 2013). Far less attention has been paid to the effectiveness of individually orientated therapies upon the client's marital relationship and/or family system, especially in those instances where the therapy is not specifically directed towards marital or family functioning. However, many studies have demonstrated that individually oriented therapies can be effective for both the partners and the couple (e.g. Brody and Farber 1989; Dewey and Hunsley 1990; Lefebvre and Hunsley 1994). Individual therapy may have positive repercussions, spreading extensively towards the members of an extended family (Roberts 1996). For instance, Robin and colleagues (Robin et al. 1995; Robin et al. 1999) found that family relationships were significantly improved as a result of individual psychotherapy. In the first study (Robin et al. 1995), they compared the effectiveness of behavioural family systems therapy (BFST) and ego-oriented individual therapy on the family relations of 22 adolescents with anorexia nervosa. Individual psychotherapy resulted in significant reductions in negative communication and parent–adolescent conflict, even though the family members never attended the therapy. These findings were comparable with those reported by the families in BFST that attended family therapy sessions. When they later (Robin et al. 1999) repeated the study with a sample of 37 adolescents, the results were similar.

The Effectiveness of Individual Therapy in Improving Family Interrelating

The author and her colleagues (Kalaitzaki et al. 2010) conducted a study with the aim of examining the repercussions that individual psychotherapy may have upon the patient's family members and their interrelating. Specifically, it was examined whether, over the course of individual therapy, the patients' psychopathological symptoms and negative interrelating with their parents improved. A further aim was to examine whether the potential beneficial effect of individual treatment extended to all dyadic relationships within the family (e.g. interrelating between the parents and the patient's siblings and between the parents themselves). It must be noted that no one other than the patient was the recipient of the therapy and that the therapy was not specifically targeted towards reducing the potential maladaptive family relationships (though presumably these issues would have been raised occasionally), but it was directed towards alleviating only the patients' psychological difficulties. This hypothesis was formulated on the basis of the author and her colleagues' observation that the patients' improvement often brings about improvements in their interpersonal relationships too.

A sample of 59 patients (44 psychotic patients and 15 neurotic patients of mean age 25.9, SD = 6.2) were compared with 55 non-patients (with a mean age of 22.3, SD = 8.7). The Greek translations of the Couple's Relating to Each Other Questionnaire (CREOQ; Kalaitzaki 2000, 2005; Kalaitzaki et al. 2002/2012a; see also Chap. 5 of this volume) and the Family Member's Interrelating Questionnaire (Kalaitzaki 2000, 2005; Kalaitzaki et al. 2002/2012b, 2009, 2010; see also Chap. 7 of this volume) were administered to the patients at the start and end of therapy (about 1 year later) and to the non-patients at the start of an arbitrary time period and after approximately 1 year, to measure potential interrelating deficiencies within the couple and the family, respectively. Over the same two time points, the Symptom Check-List 90 (Derogatis et al. 1973) and the Brief Psychiatric Rating Scale (Overall and Gorham 1962) were administered to both samples in order to measure psychiatric symptoms.

In sum, the results (Kalaitzaki et al. 2010) showed that over the full course of psychotherapy, improvements occurred in the patient's interrelating

with his/her parents, in the interrelating between the parents themselves, and between the parents and the patient's siblings. More specifically, it was found that the therapy was effective in reducing both the patients' psychopathology symptoms and also their negative relating with their parents. Patients' symptomatic improvement occurred after only 3 months of individual therapy and was sustained over a period of 1 year. The patients' relating improvements were manifested by the end of 1 year of therapy. Besides this, the patients' therapy appeared to also benefit the interrelating between those family members who had not themselves been involved in the therapy. The parents improved significantly in their negative relating towards the patients and towards the patients' siblings; they also improved their negative *inter*relating, though to a lesser extent. The association between symptomatic improvement and relationship improvement could have occurred in either direction (or both). Because the therapy directly addressed only the patients' individual difficulties, the authors (Kalaitzaki et al. 2010) believed that the familial interrelating difficulties were a result of the patients' psychiatric condition, and that the improvement of patients' psychopathology symptoms had resulted in the alleviation of the interrelating difficulties within the whole family. The authors concluded that the individual therapy may have had positive repercussions for the patient's entire family.

The Effectiveness of Individual Therapy in Improving Couple Interrelating

The second study examined the effect that individual therapy had upon the negative interrelating within the couple in which only one partner was the recipient of therapy. Assuming that the closer a family member was to the patient, the more marked were the interrelating improvements (Kalaitzaki et al. 2010), the authors further attempted to examine the possible interpersonal effects of a brief period of 2 months of individual psychotherapy for the couple and each partner separately (Kalaitzaki et al. 2014). This study (which was a sequel to the aforementioned study), specifically examined whether a short time period of 2 months of individual psychotherapy had the effect of improving the patients' psychiatric symptoms,

the patients' and their partners' relating to others and their (in-between) interrelating. The 60 outpatients were suffering from a mood or anxiety disorder. They consisted of 18 men (30 %) and 42 women (70 %), with an age range for both the patients and their partners of 18–24 (33.3 % and 30.0 %, respectively; range for both: 18–49). Again, only one member of the couple had been the recipient of therapy and neither relating nor interrelating difficulties may have been specifically addressed during the course of therapy. The couples were compared with a control sample of 48 non-patients and their partners over a comparable time period. They were 27 men (56.3 %) and 21 women (43.8 %), with an age of 18–24 (37.3 % and 43.8 %, respectively for non-patients and partners; range for both: 18–59).

The Hospital Anxiety and Depression Scale (Zigmond and Snaith 1983) was used to measure anxiety and depression. The short versions of the Person's Relating to Others Questionnaire (PROQ3; Birtchnell et al. 2013), the Observed Person's Relating to Others Questionnaire (Kalaitzaki et al. 2014), and the shortened version of the Couple's Relating to Each Other Questionnaire (CREOQ; Kalaitzaki et al. 2014) were used to measure negative relating to others, the observed negative relating to others (essentially an other-rating version of the PROQ3), and negative interrelating, respectively.

It was found (Kalaitzaki et al. 2014) that even a short period of individual psychotherapy was beneficial in ameliorating patients' psychopathology symptoms as well as their negative relating to others and towards their partners. Unexpectedly, the patients' therapy impacted negatively upon their partners, who demonstrated some degree of deterioration (although not a striking one), especially in respect of their relating to the patients. This was, however, consistent with previous findings (e.g. Colson et al. 1985; Hurvitz 1967; Kohl 1962; Zeitner 2003). It may be assumed that this was a transient deterioration, due to the fact that the partners were reluctant to relinquish their well-established relating patterns towards the patients and adopt new forms of relating in order to relate competently with the treated patients. Therefore, it is possible that when the partners begin to feel secure in relating with the patient's new ways of positive relating then their own deterioration in relating may also disappear. It was unfortunate though that there were no such records. The study (Kalaitzaki et al. 2014) concluded that individual therapy may

not merely address psychopathology symptoms, but it may have positive repercussions on the patients' relating and interrelating difficulties, though it could – in some instances – also have a detrimental impact upon their partners' relationship with them.

Conclusions

Despite the proliferation of systems thinking and couple therapy, addressing the individual rather than the couple or the family may be advantageous. Research findings indicate that the patient could benefit both in the level of symptom relief and in interpersonal improvement. The therapy outcome could be further advanced and potentially amplified should the therapist focus upon specifically addressing the couple's potential relating and/or interrelating deficiencies and should the therapist routinely monitor and provide feedback to the couple of the patient's progress (e.g. Carlier et al. 2012; Simon et al. 2012).

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Part IV

Applications of Relating Theory to Forensic Psychology

18

Are Specific Criminal Offences Associated with Particular Negative Interpersonal Relating Styles?

Michelle Newberry and John Birtchnell

Introduction

Interpersonal Theory and Offending

Blackburn (1998) examined the relationship between offending behaviour and interpersonal styles using the Chart of Interpersonal Reactions in Closed Living Environments (CIRCLE; Blackburn and Renwick 1996), and found that dominance was significantly correlated with offending in general (number of convictions and custodial sentences) but that there were also some interesting differences between offenders convicted of specific offences. For example, dominance was more strongly correlated with stealing (more than violence or sexual offences). Later, Anderson

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_18

(2002) examined differences in the interpersonal styles of sex offenders and non-sexual offenders using the Revised Interpersonal-Adjectives Scale (IAS-R; Wiggins 1995) and found that child molesters had a tendency to be 'unassured-submissive' compared to violent offenders who were described as 'cold-hearted'. Furthermore, Lawson and Brossart (2013) reported that offenders convicted of partner violence were characterised by a hostile–dominant interpersonal style as measured by the Interpersonal Problems-Short Circumplex (IIP-SC; Soldz et al. 1995).

Blackburn (1998) states that 'Interpersonal theory [...] may [...] provide a fruitful framework for understanding the contribution of personality to crime' (p. 156). However, most studies which have examined offending in relation to interpersonal theory have involved the use of measures developed on the basis of the interpersonal circle or circumplex (Leary 1957; Wiggins 1979). In order to fully understand how offenders relate to others (which may shed light on how they are able to commit their crimes), it is important to assess relating using systems other than the interpersonal circle. No research to date has explored different types of offending behaviour in relation to Relating Theory (Birtchnell 1993/1996) and its associated theoretical structure, the Interpersonal Octagon (Birtchnell 1994).

Relating Theory

Relating Theory (Birtchnell 1993/1996) proposes that humans have a disposition towards the attainment of four principal relating objectives called upperness, lowerness, closeness, and distance. Ideally, over the course of maturation, each person should acquire the competence to attain and maintain each one of them as and when the need arises. The competent and confident capability to relate in any one of these principal ways is called positive and the less than perfect ways of doing so are called negative. Negative relating tends to be more selfish, ruthless, heartless, insecure, and inconsiderate than positive relating. The Person's Relating to Others Questionnaire (PROQ; Birtchnell et al. 1992; PROQ2; Birtchnell and Evans 2004 and PROQ3; Birtchnell et al. 2013) was designed to measure solely negative relating (see Chaps. 3 and 4).

Upperness and lowerness can be represented graphically as the two poles of a vertical axis, upperness being at the top and lowerness at the bottom. Closeness and distance can be represented as the two poles of a horizontal axis, closeness being located to the right and distance to the left. Four intermediate positions can be inserted in between, which together create a theoretical structure called the *Interpersonal Octagon* (Birtchnell 1994; see Fig. 1.1 in Chapter 1 of this volume).

Each octant of the octagon has a two-word name, the first word referring to the vertical axis and the second referring to the horizontal one. When there is reference to one axis, the word 'neutral' appears. Thus, moving clockwise round the octagon, the names of the octants are upper neutral (UN), upper close (UC), neutral close (NC), lower close (LC), lower neutral (LN), lower distant (LD), neutral distant (ND), and upper distant (UD) (see Chaps. 1 and 2 for a more in-depth discussion of Relating Theory).

The Current Study

No research to date has examined the relating tendencies of different types of offender using the PROQ3, and the current study (Newberry and Birtchnell 2011) sought to investigate this. In addition, since the majority of offenders commit multiple offences (Blackburn 1998) the study addressed the limitation of other studies (e.g. Craig et al. 2006) that have not taken previous offending history into account. This is important because it makes it difficult to classify offenders into groups. It is possible, for instance, that an offender who has been convicted of murder (categorised as a violent offence) has no other offences and so can be classified as a 'pure' violent offender. Compare this, however, to an offender whose index offence is murder but who also has a conviction for fraud. In this example, the offender does not fit neatly into the 'violent' category. The current study therefore compared the PROQ3 scores of different offence groups (determined on the basis of index offence) as well as those of 'pure' offence groups. The following hypotheses were examined.

Since one feature of negative distance (ND) is a lack of concern for the feelings of others, and criminals are probably inclined to separate themselves

off from their victims in order to make it easier for them to commit their offences, Hypothesis 1 was that the ND scale of the PROQ3 would be associated with offending behaviour in general. Since the lower close (LC) scale has been most clearly linked with psychopathology (e.g. Birtchnell and Shine 2000), Hypothesis 2 was that LC would also be associated with offending behaviour in general. Since child molesters display a fear of negative evaluation (Overholser and Beck 1986) as well as feelings of loneliness and deficient in intimacy compared to other groups (Seidman et al. 1994), which are both features of lower close (LC) relating, Hypothesis 3 was that sex offenders would score higher on the LC scale than the other offence groups. Finally, given that violent offences represent a way of directly gaining control over someone and that the upperness scales of the PROQ3 reflect dominance, Hypothesis 4 was that violent offenders would score higher than the other offence groups particularly on UN and UD.

In the forensic literature, the risk, need and responsivity (RNR) model (Andrews et al. 1990; Andrews and Bonta 2006) posits that treatment for offenders should be bespoke and tailored according to the individual's *risk* of reoffending, their criminogenic and non-criminogenic needs (criminogenic needs refer to dynamic factors related to offending behaviour), and be *responsive* to an individual's characteristics (e.g. age, gender, ethnicity, abilities, personality, and strengths). If significant associations can be demonstrated between specific offences and particular forms of negative relating, then, in keeping with these RNR principles, the treatment of offenders can be directed towards the improvement of their specific relating deficits.

Method

Participants

Participants were 923 male offenders (age range = 21–67, $M = 35.13$, SD = 8.66), admitted to a therapeutic community (TC) prison in order to address their offending behaviour. They were initially separated into eight offence groups on the basis of their index offence (i.e. their main current offence for which they were serving their sentence): homicide

($n = 270$), violence ($n = 189$), robbery ($n = 82$), a sexual offence ($n = 153$), dishonesty ($n = 68$), firearms ($n = 26$), drug-related offences ($n = 19$), and arson ($n = 16$). As anticipated, the majority of the prisoners had committed more than one offence, either concurrently or over a period of years. For this reason we also identified 'pure' offence groups which contained offenders who had a previous and/or current conviction of only one type of offence.

Measures

The Person's Relating to Others Questionnaire (PROQ3)

The PROQ3 (Birtchnell et al. 2013) is a 48-item self-report measure which assesses the eight negative relating styles shown in the Interpersonal Octagon (Birtchnell 1994). Each scale includes five negative items, which are scored on a four-point scale rated from 3 to 0 ('Nearly always true' to 'Rarely true'), and one positive item (to relieve the overall negative tone of the measure). Thus, the maximum score for each scale is 15 and the maximum total score is 120. The internal reliability of the PROQ3 in four normative national samples (English, Dutch, Irish, and Greek) is acceptable (Birtchnell et al. 2013). In addition, the scales have been shown (Kalaitzaki et al. 2015) to correlate positively and meaningfully with two measures based upon the interpersonal circle (the Interpersonal Checklist-Revised; ICL-R; De Jong et al. 2000), and the Inventory of Interpersonal Problems-Circumplex Scales (IIP-C; Alden et al. 1990).

Procedure

Prisoners gave written informed consent and completed the PROQ3 as part of a psychometric test battery upon admission to the prison. The Offender Assessment System (OASys; Home Office 2002) is used in England and Wales by Her Majesty's Prison Service and the National Probation Service for assessing the needs of an offender and their risk of reoffending, and the OASys offence categories were used as the basis for those in the current study: pure homicide offenders (i.e. conviction of

murder, attempted murder or manslaughter; $n=40$), pure violent offenders (i.e. assault, wounding, grievous bodily harm, robbery or kidnapping; $n=10$); pure sex offenders (i.e. rape, attempted rape, indecent assault, buggery, incest, unlawful sexual intercourse or possession of obscene material; $n=19$), pure dishonest offenders (i.e. fraud, forgery, handling stolen goods, theft or burglary; $n=6$).

Results

Mean PROQ3 Scores for Index Offence Groups

The mean PROQ3 scores of the index offence groups were compared using a one-way analysis of variance (ANOVA) with a Bonferroni correction to control for multiple comparisons (Table 18.1). Levene's test was used to test homogeneity of variances. Where this assumption was violated, the Welch statistic was used in place of the *F*-statistic, and the Games–Howell post hoc test was used in place of the Tukey HSD test. Effect sizes were also calculated in order to assess the practical significance of the findings.

Post hoc tests revealed significant differences between the groups ($p<0.01$) on four of the PROQ3 scales (UN, UC, LC, and UD) and the total score. Dishonest offenders scored significantly higher on PROQ3 total (Cohen's $d=0.54$), UD (0.53), UC (0.51), UN (0.43), and LC (0.42) than homicide offenders, and significantly higher than sex offenders on UD (0.57). Those with an index offence of robbery scored significantly higher on UN (0.29) than homicide offenders and higher on UD (0.54) than sex offenders and homicide offenders (0.53). Violent offenders scored significantly higher on UD than homicide offenders (0.46), sex offenders (0.45), and arsonists (0.71). Interestingly, there were no significant differences between the offence categories on the ND scale even at $p<0.05$. Dishonest offenders and arsonists scored significantly higher on PROQ3 total than all of the other index offence groups. The largest difference was between the dishonest and homicide offenders (0.54), and the smallest was between the dishonest offenders and arsonists (0.07).

Table 18.1 Comparison of mean PROQ3 scores for index offence groups

	UN		UC		NC		LC		LN		LD		ND		UD		Total	
Index group	*M*	SD	*M*	SD	*M*	SD	*M*	SD	*M*	SD	*M*	SD	*M*	SD	*M*	SD	*M*	SD
Homicide	4.4	3.7	3.2	3.5	3.9	3.7	6.4	4.5	5.9	3.8	5.9	3.7	7.5	4.2	5.3	5.3	41.9	20
Violence	5.4	4	4.3	3.9	4.6	4	7	4.2	5.7	3.8	5.4	3.5	8	3.9	7.5	4.4	48	18.8
Robbery	5.5	3.9	4	3.9	3.9	3.6	6.7	4	5	3.7	5.2	3.3	8.7	4	7.8	4.2	46.8	19
Sexual	5.1	4	4.1	4.3	4.7	4.2	7.6	4.4	6.2	4.2	6.4	4.4	8	4.6	5.6	4.1	47.7	21.9
Dishonest	6	3.8	5.1	4.2	5	3.8	8.3	4.5	6.2	4.5	5.7	3.9	8.5	3.9	8	4.4	52.7	19.8
Firearms	5.7	4.4	3.5	3.5	3	2.9	5.5	3.6	4.6	2.7	4.9	3.8	8.6	3.6	7.1	3.9	42.9	19.3
Drugs	6.3	4	5.3	4.2	3.9	4.1	6.1	3.8	4.4	3.3	4.4	2.8	7.8	3.9	7.7	4	44.2	18
Arson	4.1	3.6	5.5	4.2	6.7	4.9	9.2	5.3	7.4	4.1	6.4	3.8	7.5	5.1	4.5	4	51.3	28.3
F	2.97**		3.04**		2.63*		3.30**		2.48*		2.07*		1.49		8.92**		3.29**	

* Significant at $p < 0.05$; ** significant at $p < 0.01$

Mean PROQ3 Scores for Pure Offence Groups

The ANOVAs were repeated for the pure groups to explore whether the pattern of differences was similar to that found for the index offence groups. The mean PROQ3 scores for the pure groups are reported in Table 18.2. Post hoc tests revealed that dishonest offenders scored significantly higher on UC than violent offenders (Cohen's $d = 2.56$), sex offenders (1.37), and homicide offenders (1.23) ($p < 0.01$). In addition, dishonest and violent offenders scored significantly higher on UD than homicide offenders (0.13 and 0.18, respectively) and sex offenders (1.50 and 1.44, respectively) ($p < 0.01$). The most striking difference was the much higher UD score of violent offenders compared to sex offenders ($M = 7.6$ vs 3.0). The differences between the pure offence groups on UC and UD are consistent with the differences found between the index offence groups. In addition, for both types of categorisation the mean ND score was higher than the means for the other scales which is in keeping with the fact that ND was the only scale on which the index offence groups did not differ (see Table 18.1).

Do Offenders Convicted of Particular Offences Have a Clear-Cut Relating Characteristic?

In an attempt to identify offenders who had a clear-cut relating style, the number of offenders (in both index and pure groups) who had a very high score (13 or above out of a possible 15) on a scale (but a score of less than 10 on the remaining scales) was counted. Of the 923 offenders, only 6 had a very high score on LN, 2 had one on LC, 17 had one on ND and 12 had one on UD, indicating that it is unusual for an offender to have a very high score on one scale and relatively low scores on the remaining scales.

Discussion

The first hypothesis that the ND scale of the PROQ3 would be associated with criminality in general was supported since both the index and pure offence groups registered the highest scores on ND scale and did

Table 18.2 Comparison of mean PROQ3 scores for pure offence groups

Pure group	UN		UC		NC		LC		LN		LD		ND		UD		Total	
	M	SD	*M*	SD	*M*	SD	*M*	SD	*M*	SD	*M*	SD	*M*	SD	*M*	SD	*M*	SD
Homicide	4.7	4	4.7	4.4	5.8	4.7	7.9	5	7.4	3.9	8.2	4.5	8.3	4.9	5.9	10.4	50.1	25.2
Violence	4.6	4.6	2.6	2.5	4.6	4.3	7.1	2.8	6.4	5.1	5.9	5.1	8.7	3.1	7.6	4.2	47.5	13.3
Sexual	5	3.5	3.7	4.8	5	3.5	9.8	4.8	7.3	4.5	9.4	3.8	8.3	4.7	3	2.6	51.3	19.5
Dishonest	5.5	4.1	5.6	3.5	9	4.1	10.8	3.7	8.5	5.5	9.7	4.5	9.7	3.2	7.2	3.5	70.3	19.9
F	0.1		4.22**		1.56		2.16		0.3		1.59		0.19		4.99**		1.59	

** Significant at $p < 0.01$

not differ significantly. These findings are not surprising since one aspect of distance is a lack of concern for the feelings of others, a posture that criminals need to adopt in order to make it easier for them to commit their offences.

In line with previous results (Birtchnell and Shine 2000; Birtchnell et al. 2009), the second hypothesis, that the LC scale would be associated with criminality in general, was also supported since this was one of the scales which offenders scored higher on (particularly arsonists and dishonest offenders). A possible explanation for this finding is that being in prison may engender feelings of helplessness and submission.

Although not significantly so, sex offenders scored higher than five of the seven other index offence groups as well as higher than two of the three other pure offence groups on LC which partially supports the third hypothesis. This is also consistent with reports that sex offenders display a fear of negative evaluations (Overholser and Beck 1986) and are lonelier and more deficient in intimacy than violent offenders (Seidman et al. 1994). Marshall and Barbaree (1990) suggested that negative experiences during early development can lower an individual's sense of self-confidence and result in negative attitudes and beliefs about others, which may subsequently inhibit the development of skills necessary to achieve normal intimate relationships with adults (Marshall and Barbaree 1990).

Finally, the fourth hypothesis was partly supported. Violent offenders (both index and pure) scored significantly higher on UD than homicide offenders and sex offenders. This could be attributed to number of convictions, since Blackburn (1998) reported that dominance measured using the CIRCLE (Blackburn and Renwick 1996) was significantly correlated with number of convictions and previous custodial sentences. Violence attracts lighter sentences than homicide and so violent offenders have more opportunity to generate a higher number of convictions. However, the most striking difference with regards to UD was between violent offenders and sex offenders, which is consistent with reports that the personality profile of violent offenders is 'cold-hearted' (Anderson 2002) which is akin to the sadistic, intimidating, and tyrannising relating of the UD octant.

Since one would expect violent offenders to be more dominant than those convicted of dishonesty offences, an unanticipated finding was that

dishonest offenders scored higher on UN than six of the seven index offence groups and all other pure offence groups. Interestingly, Blackburn (1998) also found that dominance was more strongly correlated with stealing (a dishonesty offence) than either violent or sexual offences. It would be interesting to explore whether this relating tendency is inherent in other samples convicted of dishonesty offences.

It is particularly surprising that the violent offenders scored relatively low on the UN scale compared to some of the other PROQ3 scales, which suggests that criminals tend to view themselves as relatively lowly individuals and/or that they experience other men as being upper in relation to them. It was also found (Newberry and Birtchnell 2011) that UN was the only scale on which the offender sample overall, the majority of which had been convicted of violent offences, scored significantly lower than a sample of non-offenders. This is supported by the fact that offenders also scored higher than non-offenders on two of the three lower scales, indicating that offenders may perceive themselves as less dominant than they really are or than people might believe. It could be that offenders resort to crime because they do not have the confidence to compete with other men on equal terms. This ironically would lead one to suppose that having a high UN score would protect men against criminal behaviour. On the other hand, it is possible that offenders may only perceive themselves as lower since being convicted; for some offenders imprisonment may encourage a more submissive way of relating. There will always be offenders who misbehave and try to assert authority over other inmates/staff, although these incidents are fewer in a TC prison (Newton 2010). It would therefore be interesting to compare the PROQ3 scores of prisoners in a TC prison with those in a mainstream prison.

Limitations of the Study

Consistent with previous assertions (e.g. Blackburn 1993), most of the prisoners had committed more than one type of offence. The ideal would have been to have selected substantial numbers of prisoners who had committed only one type of offence, but even within the very large sample (n = 923), the numbers of such prisoners proved to be small. Thus,

the findings from the pure offence groups must be treated with caution. Although the current findings suggest that there is no such thing as a murderer or a sex offender once previous offending history is taken into account, but that most criminals are just criminals, future research is needed to confirm this with other offender samples.

The incentive to commit a criminal offence may be unrelated to a person's long-term relating tendencies. Some offences – homicide or rape for example – may occur only once in a lifetime and within a brief period of time and some offences may mainly be committed to make money (e.g. robbery or drug offences). It could be argued therefore that at the time the offenders had committed their earlier offences, they may have exhibited different relating tendencies. This is unlikely, however, because Relating Theory (Birtchnell 1993/1996) maintains that, from early adulthood onwards, relating characteristics remain relatively stable. Whilst it has been demonstrated that PROQ3 scores improve during a prisoner's stay in a TC (Birtchnell et al. 2009), the prisoners in the current study had all been tested shortly after admission and before any such change would have taken place.

A social desirability bias may have affected the results; prisoners may have presented themselves in a more positive light when completing the PROQ3. Conversely, given that prisoners volunteer to participate in TC treatment and that there are only limited placements, they might exaggerate their problems (Newberry and Shuker 2012). Considering this, PROQ3 scores may not necessarily be an accurate reflection of how offenders really relate to others.

Implications of the Findings for Therapy

The current findings have implications for offender therapy. Negative relating can be improved and positive relating can be reinforced by therapeutic intervention, either in the form of traditional psychotherapy (Birtchnell 2002a, b) or as it is experienced in a TC prison (Birtchnell et al. 2009).

This study has identified the ND and LC scales of the PROQ3 as those most significantly associated with criminality. ND is manifested as

a reluctance to become closely involved with others, so therapy should be directed towards exploring why the prisoner does not trust other people and exploring past experiences of rejection. One reason why criminals are criminals is that they are unlikely to be concerned about the harm they do to others. It is not easy to encourage them to consider the effect that they have upon others, since this would make it more difficult for them to continue to function as criminals. LC is manifested as a fear of rejection and disapproval, so therapy should be directed towards exploring experiences of having been let down by previous caring figures. A prisoner whose offending is characterised by fear of rejection is likely to have different problems compared to one who is dismissive of the value of closeness (Hudson and Ward 2000). Consequently, the assessment of an individual's relating or attachment style and their associated social goals should be a necessary precursor to treatment.

Although the findings of this study suggest that particular forms of negative relating are associated with certain types of offending behaviour, it would be appropriate to focus on the PROQ3 scales upon which the individual being assessed has high scores, even though these may not necessarily be the scales that have been highlighted in the current group comparisons.

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19

Interpersonal Relating, Risk-Taking Behaviour and Alcohol Use in Young Adults

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Introduction

Problematic alcohol use like binge drinking, defined by the World Health Organisation (WHO 2014) as consumption of four or more standard drinks for females and five or more standard drinks for males on one single occasion, remains a persistent problem in adolescents and young adults. In Europe, in 2010, 69.5 % of the 15–19-year-olds could be classified as 'current drinkers' and an additional 14.5 % as 'former drinkers'

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_19

(WHO 2014). An alarming 31.2 % reported that they engaged in *heavy episodic drinking* (HED; consumption of about six or more standard drinks, i.e. 60 or more grams of pure alcohol, on a one single occasion at least monthly; WHO 2014). Comparing this percentage to the prevalence of HED (16.5 %) across the total European population aged 15 and over, it is clear that HED and binge drinking are serious problems in adolescents and young adults (WHO 2014). Adolescence is a period of increased vulnerability to many psychiatric disorders, including depression, schizophrenia, violent delinquency, alcohol, and substance abuse (Steinberg 2005; Witt 2010). Alcohol consumption at this age is associated with consumption levels later in life and it seems that heightened consumption in adolescence presages alcohol problems in adulthood (McCambridge et al. 2011; Stautz and Cooper 2013).

Research seeks to define and understand potential underlying mechanisms for alcohol use and specific problematic patterns of drinking (e.g. HED, binge drinking), including starting points that may help identify at-risk youth. Numerous factors have been implicated such as gender, age, ethnicity, socio-economic status, and familial risk factors which are known to impact upon alcohol use (Anda et al. 2002; Donovan 2004; Sher et al. 2005; WHO 2014). Of special interest are personality characteristics that may relate to alcohol consumption, for these can, to some extent, be altered. Since personality traits are associated with consistent patterns of cognition, affect, and behaviour, elevated levels of certain personality traits may predispose an individual to alcohol problems (Sher et al. 2000). Adolescence is also characterized by impulsivity, sensation seeking, venturesomeness, and novelty seeking (Steinberg 2008). Heightened levels of risk-taking behaviour have been identified as a risk factor for excessive and problematic alcohol use, particularly during adolescence (Stautz and Cooper 2013). During adolescence, peer influences (e.g. modelling behaviour, provision of alcohol, and encouraging use) are considered to be of major importance in initiating alcohol use (Newcomb and Bentler 1989). Yanovitzky (2006) showed that sensation seeking influenced alcohol use in college students directly, but also indirectly in a way that high sensation seekers were motivated to associate more frequently with alcohol-using peers. Moreover, strong similarities in drinking patterns have been found between heterosexual partners, implying that interpersonal relations can influence alcohol use (Nolen-Hoeksema 2004).

However, there are still significant gaps in our understanding of the aetiology and consequences of heavy adolescent drinking (Hermens et al. 2013; Witt 2010). Since interpersonal relating is associated with both interactions with peers and risk-taking behaviour, it might be that this new angle of interest could fill some of the gaps in our knowledge. The aim of this study was to explore the association between relating and binge drinking in young adults and to examine whether risk-taking behaviour plays a mediating role in this relationship. Gender differences have been reported in levels of alcohol consumption, with men typically displaying higher consumption levels (WHO 2014) in risk-taking behaviour, with men being more likely to engage in risk-taking behaviours and women being more risk-averse (Byrnes et al. 1999; Eriksson and Simpson 2010). Besides, women need to consume less alcohol to reach the same state of inebriety as men due to their average lower body weight, a smaller liver capacity to metabolise alcohol, and a higher proportion of body fat (Smarandescu et al. 2014; WHO 2014). Gender differences have also been reported in relating and so we hypothesised that different outcomes would be anticipated across genders.

Method

Participants

Participants ($N = 6002$) aged 18–30 years ($M = 22.10$, SD = 2.50), completed the online Utrecht Student Survey (USS; de Haan et al. 2012) after providing online informed consent. One of the aims of the USS was to assess personality characteristics, level of risk-taking behaviour, and their relationship with alcohol consumption. The local Medical Ethical Review Board reviewed the study protocol as appropriate according to Dutch law.

Measures

The Person's Relating to Others Questionnaire Version 3 (Birtchnell et al. 2013)

The Person's Relating to Others Questionnaire Version 3 (PROQ3) comprises 48 items across 8 scales which correspond to each octant of the

Interpersonal Octagon (see Fig. 1.1). Its scales, named after the octants of the octagon, are called upper neutral (UN), upper close (UC), neutral close (NC), lower close (LC), lower neutral (LN), lower distant (LD), neutral distant (ND), and upper distant (UD). Of the six items for each scale, one refers to positive relating and is unscored and the other five refer to negative relating. Items are scored using a 4-point Likert scale (3 = 'Nearly always true' to 0 = 'Rarely true'). Scale scores are obtained by summing specific item scores and range from 0 to 15. The Dutch version of the PROQ3 has shown adequate reliability and its proposed eight-factor structure and octagonal order were supported (Birtchnell et al. 2013).

The Risk Taking Questionnaire-18 Items (de Haan et al. 2011)

The Risk Taking Questionnaire-18 (RT-18) was developed from the Impulsiveness–Venturesomeness–Empathy questionnaire (Eysenck and Eysenck 1978; Eysenck et al. 1985), the Temperament and Character Inventory (Cloninger et al. 1993), and the Zuckerman Kuhlman Personality Questionnaire (Aluja et al. 2006; Zuckerman 2002). Items are rated on a 'yes'/'no' scale, receiving either zero or one point. Three items are reverse-scored and scores are summed. The RT-18 examines two factors: risk-taking and risk assessment, each of which have nine items. High scores on risk-taking indicate a high level of actual risk-taking (i.e. engagement in risky behaviours), whereas high scores on the risk assessment subscale indicates less consideration of possible consequences (i.e. acting without thinking). Throughout this analysis risk-taking will refer to one of the two RT-18 scales, whereas risk-taking behaviour will comprise both subscales. Adequate internal consistency ($\alpha = 0.89$), test–retest reliability ($r = 0.94$), convergent validity (i.e. significant correlations with the Cambridge Gambling Task and Stimulating-Instrumental Risk Inventory), and discriminant validity (i.e. significant differences across genders) have been reported (de Haan et al. 2011).

Alcohol Consumption

Data from the USS were used. Items from the Quick Drinking Screen (Sobell et al. 2003) were assessed in three possible drinking scenarios;

consumption of solely alcohol (i.e. beer or wine or unmixed liquor), alcohol mixed with energy drinks, and alcohol with other mixers (e.g. cola, juice). Alcohol consumption data from all three scenarios were combined into pooled alcohol consumption data. Typical alcohol consumption per occasion was extracted, and the subjects who indicated that they drink alcohol also reported the number of days that they engaged in binge drinking during the previous month (with a binge drinking day defined as consuming more than four – for females – or five – for males – alcoholic drinks consecutively on one occasion). Participants were classified, based on both self-report alcohol measures, as belonging to one of three groups: (1) *abstinent*; (2) *typical non-binge drinker who did not report any binge drinking days in the past month*; (3) *typical binge drinker who did report at least one binge drinking day in the past month*.

Data Analysis

ANOVA or Kruskal–Wallis tests, as appropriate, were conducted to examine which of the eight PROQ3 and which of the two RT-18 subscales means differed across the three alcohol groups. Pearson or Spearman correlation coefficients, as appropriate, were conducted to examine correlations between the PROQ3 and RT-18 subscales. The scales that differed across the alcohol outcome groups were entered into a multivariate model.

The relationship between the PROQ3 scales, alcohol use, and RT-18 subscales was then examined using a multiple multinomial logistic regression model. Because of known gender differences in both RT-18 scores and alcohol use, an a priori stratified logistic regression model of three steps was used. The crude model contained only age, which is also known to confound alcohol consumption and/or risk-taking behaviour (Steinberg et al. 2008). Model 1 contained age and the PROQ3 scales that differed significantly across the alcohol outcome categories, whereas in the final model (i.e. Model 2) the risk-taking behaviour scales that were significantly different across the outcome categories were added. Odds-ratios and their 95 % confidence intervals (CIs) were examined, and model fit was assessed with chi-square likelihood ratio tests and the so-called pseudo-R^2 statistics. Chi-square likelihood ratio tests for nested models were conducted to compare the models. To examine the potential

confounding effect of the PROQ3 scales on alcohol use by risk-taking behaviour, an additional moderator analysis was conducted to test for possible effect modification.

Eventually, based on the final models from the multinomial logistic regression analyses, a path analysis was conducted to examine the relationship between the PROQ3 scales that were significantly related to alcohol use and the role that risk-taking behaviour might play in this relationship. Structural equation modelling (SEM) examined both the direct effect of the PROQ3 scales on alcohol use (abstinent, non-binge drinker, and binge drinker) and the indirect effect through risk-taking behaviour. The level of significance was $p < 0.05$ and CIs that did not contain zero were considered significant.

Results

From the initial sample ($N = 6002$) 3566 participants continued to part two. Eventually, 2962 participants (83.1 %) were eligible for analysis (e.g. they had no missing data). From these, 515 participants were classified as abstinent (17.4 %), 484 as non-binge drinkers (16.3 %), and 1963 as binge drinkers (66.3 %). A Kruskal–Wallis test for age (KW-$\chi^2_{(12)} = 16.46$, $p = 0.171$) and a chi-squared test for gender ($\chi^2_{(1)} = 1.38$, $p = 0.240$) showed no significant difference between study and omitted respondents (3040).

Table 19.1 depicts mean age, PROQ3, and RT-18 scores across gender, grouped by level of alcohol use. The three alcohol use groups for men did not differ significantly in terms of age, but it did for women. For men, all PROQ3 scale means except for upper neutral (UN) and neutral close (NC) differed significantly across the three alcohol use groups. For women only three of the eight scales differed significantly (LN, ND, and UD). RT-18 subscale means for risk-taking and risk assessment were significantly different for both men and women across the three alcohol use groups.

Spearman correlation coefficients between the PROQ3 and RT-18 scales were calculated. For men, seven of the eight PROQ3 scales were significantly correlated with risk-taking, although most correlations

Table 19.1 Means for PROQ3 and RT-18 scores across alcohol use groups by gender

	Males				Females			
	Abstinent	NB drinker	B drinker	KW-χ^2	Abstinent	NB drinker	B drinker	KW-χ^2
Age	22.0(2.7)	22.4(2.7)	22.2(2.5)	2.4	22.1(2.7)	22.3(2.5)	21.8(2.4)	8.2*
PROQ3	–	–	–	–	–	–	–	–
UN	6.9(3.4)	6.8(3.4)	7.1(3.1)	1.2	5.9(3.3)	6.2(3.2)	6.3(3.1)	5.1
UC	3.4(2.8)	2.9(2.8)	3.7(2.8)	11.1**	2.6(2.7)	2.5(2.6)	2.7(2.6)	2.5
NC	3.9(2.7)	4.1(2.7)	4.0(2.5)	0.2	3.9(2.8)	4.0(2.7)	4.1(2.7)	1.6
LC	5.4(3.5)	5.0(3.4)	4.5(3.1)	8.2*	5.3(3.8)	5.3(3.4)	5.1(3.5)	1.5
LN	5.5(3.5)	5.3(3.1)	4.7(2.8)	9.7**	4.9(3.3)	4.8(2.8)	4.5(3.0)	7.4*
LD	4.7(3.0)	5.0(3.0)	4.0(2.6)	16.6**	5.2(3.3)	5.3(3.1)	4.9(2.9)	5.8
ND	6.2(3.2)	6.6(3.3)	5.6(3.1)	13.4**	5.8(3.6)	4.8(2.8)	4.9(3.1)	20.2**
UD	4.5(3.5)	4.6(3.3)	5.4(3.1)	16.6**	3.0(2.8)	2.9(2.6)	3.5(2.8)	22.6**
RT-18	–	–	–	–	–	–	–	–
RT	3.2(2.4)	3.4(2.3)	5.1(2.7)	96.3**	2.2(2.1)	2.6(2.1)	4.0(2.5)	188.7**
RA	1.3(1.7)	1.3(1.6)	2.3(2.1)	59.0**	1.4(1.8)	1.3(1.6)	2.3(2.2)	113.9**

NB drinker non-binge drinker, *B drinker* binge drinker, *UN* upper neutral, *UC* upper close, *NC* neutral close, *LC* lower close, *LN* lower neutral, *LD* lower distance, *ND* neutral distance, *UD* upper distance, *RT* risk-taking, *RA* risk assessment, *KW-χ^2* Kruskal–Wallis test

*$p<0.05$; **$p<01$

were weak. LN (–0.16), LD (–0.14), and UD (0.22) showed the strongest correlations. When risk assessment was examined alone there were significant correlations with UC (0.43), NC (0.28), and UD (0.54). When examining the correlations for women, a different pattern emerged, where only risk-taking was significantly correlated with UN (0.10), LN (–0.08), LD (–0.09), and UD (0.19), whereas risk assessment was significantly correlated with all PROQ3 scales (correlations ranging from 0.04 to 0.20), except for LC and ND.

All multinomial logistic regression models were significantly better than the null models, and for both genders, successive models significantly improved. For men, chi-square likelihood ratio tests for nested models yielded Model 1 vs crude: $\chi^2_{(12)} = 63.89$, $p < 0.001$ and Model 2 vs Model 1: $\chi^2_{(4)} = 88.02$, $p < 0.001$. For women, chi-square likelihood ratio tests for nested models yielded Model 1 vs crude: $\chi^2_{(6)} = 58.64$, $p < 0.001$ and Model 2 vs Model 1: $\chi^2_{(4)} = 209.03$, $p < 0.001$. The effects of the predictors showed some distinct differences for each of the three contrasts when looking at both tables for both males and females. Due to space limitation, the values of the analyses are not reported here but they are available on request.

For men, there were no significant predictors found for non-binge drinking vs abstinents, and age did not play a significant role in any of the models. In Model 1 for the binge drinkers vs non-binge drinkers, three PROQ3 scales (UC, LD, and ND) were significant contributors to the model. When risk-taking and risk assessment were added to the model (i.e. Model 2), they yielded significant effects, along with the three relating scales (LD, UC, ND). At the final contrast (i.e. binge drinker vs abstinent) different predictors were significant (LC and UD) for Model 1. When adjusted for risk-taking behaviour, the effect of LC remained, but the UD effect was no longer statistical significant, indicating clear confounding of this scale with one or both of the RT-18 subscales. Moderator analysis did not reveal any significant interaction terms of the risk-taking behaviour subscales with the UD scale for men.

For women, ND was a highly significant predictor of the no binge drinking vs abstinent contrast (Model 1), that remained unaltered in the second model, and was joined by the risk-taking subscale. For binge vs non-binge drinkers, age was significant in all three models. UD was the only PROQ3 predictor of alcohol use in Model 1, but, when adjusted for

risk-taking behaviour, this effect was lost. Moderator analysis revealed no significant interaction terms. Examining the binge drinkers vs abstinents contrast in women, age was only significant in Model 1. Both ND and UD were significant in Model 1, and these effects remained after adjusting for risk-taking behaviour in Model 2. Again UD confounded with risk-taking behaviour, but no effect was found in the moderator analysis.

A path analysis was performed with the PROQ3 scales that were initially significant predictors of alcohol use in Model 1, but which decreased or even lost their effect after adjusting for risk-taking behaviour. This was the UD scale in the binge drinker vs abstinent contrast for men and in the binge drinker vs non-binge drinker and binge drinker vs abstinent contrasts for women. Figure 19.1 depicts both the direct effects of UD on alcohol use and the indirect effects through either risk-taking or risk assessment. By adding the direct and indirect effect, the total effect was obtained. All the direct and indirect as well as all the total effects were similar and close to zero, indicating that UD had a significant but small association with alcohol use, and approximately half of the total effect could be explained as a direct effect of UD on alcohol use, whereas the other half could be explained as an indirect effect exerted through risk-taking behaviour.

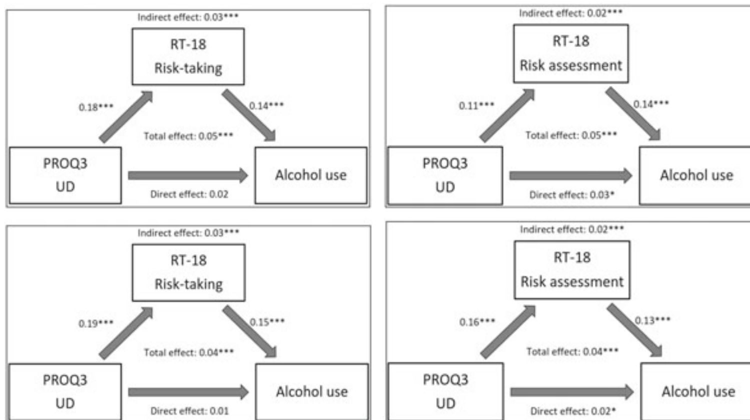

Fig. 19.1 Path analysis for interpersonal relating, risk-taking behaviour, and alcohol use by gender. *Note*: The upper panels depict effects for males and the lower panels depict effects for females. *$p<0.05$; **$p<01$; ***$p<0.001$

Discussion

This study examined the relationship between negative relating and binge drinking in young adults and the mediating role of risk-taking behaviour. Gender differences were also explored. Results showed that a somewhat complex pattern of PROQ3 scales predicted the alcohol consumption of males, specifically for binge drinking compared to non-binge drinking. The UC scale increased the risk of binge drinking in such a way that the odds of belonging to the binge drinker group, even after adjusting for age and the PROQ3 scales LC, LN, LD, ND, and UD, increased 1.16 points for every point increase on the UC scale. This effect was not influenced by risk-taking behaviour. Both LD and ND attenuated the odds of being a binge drinker instead of a non-binge drinker. When comparing binge drinking to abstinence, UD predicted increasing odds for binge drinking. However, risk-taking behaviour confounded UD scale scores. Interestingly, LC significantly affected male alcohol consumption in such a way that when adjusted, the odds of belonging to the binge drinking group decreased 0.93 points for every point increase on this subscale.

Both RT-18 risk-taking and risk assessment scores exerted highly significant effects on alcohol consumption level. The heightened odds for binge drinking vs abstinence, attributable to UD, were clearly confounded by risk-taking behaviour. The most significant correlations (although weak) were between these risk-taking behaviour scales and UD, indicating that the more sadistic, intimidating, and tyrannising an individual perceives his/her relating to others, the more likely is that he/she engages in risk-taking behaviours and thinks less about the consequences of these choices. The path analysis that explored the direct effect of UD on alcohol use and the indirect effect via RT-18 risk-taking or risk assessment showed that both were very close to zero. Therefore, we conclude that for males, UD exerted no clinically relevant influence on alcohol use, but that the UD scale shares some variance with both RT-18 subscales, and must therefore measure a part of the same construct. Taken together, it seems that the PROQ3 scales exerted independent and opposite effects on alcohol consumption, whereas UC increased the odds of binge drinking and LC, LD, and ND decreased these odds.

A different pattern of effects emerged for females. Where there was no effect of relating on the non-binge drinking versus abstinent contrast in men, there was a highly significant one for women. ND decreased the odds of belonging to the non-binge drinkers versus abstinents and this effect remained after adjusting for risk-taking and risk assessment. UD (i.e. perceiving oneself as being sadistic and intimidating) increased the odds of binge drinking compared to non-binge drinking, but this effect was lost when the risk-taking behaviour scales were introduced. The odds of being a binge drinker instead of being abstinent were also significantly influenced by UD and ND, even after adjusting for risk-taking behaviour, except for UD which indicates confounding with risk-taking and risk assessment. So, as with the men, UD increased the odds of binge drinking, and was positively related with both risk-taking and risk assessment. Interestingly, ND (i.e. perceiving oneself as being suspicious, uncommunicative, and self-reliant), decreased the odds of alcohol consumption but did not distinguish between non-binge and binge drinking. This effect was not confounded by risk-taking behaviour, and both risk assessment. Risk-taking significantly increased the odds of binge drinking, similar to the pattern found for men, with the exception that risk-taking also increased the odds of non-binge drinking versus abstinence.

UD correlated the most with risk-taking behaviour when assessed as a personality trait using the RT-18, but not when assessed with real-world risk behaviour like (risky) alcohol consumption. The men scored significantly higher than females on UD across all alcohol consumption levels. ND was related to alcohol use but decreased the odds of (risky) alcohol consumption. Interestingly, LC and LD decreased the odds of binge drinking but only for men. Birtchnell et al. (2009) reported that prisoners scored significantly higher on the PROQ2 and PROQ3 (the shorter version) than non-imprisoned men in a medium-secure psychiatric hospital, especially on LC and ND. Scores on UD were higher for prisoners than the non-prisoners as measured with the PROQ2, but not with PROQ3 (Birtchnell et al. 2009). Another study (Newberry and Birtchnell 2011) reported higher UN, LN, and ND scores for offenders compared to non-offenders, and the UD scale differentiated between the type of offences, with, for instance, violent offenders and dishonest offenders scoring higher on UD than sex offenders. ND did not

differentiate offence type. Kalaitzaki et al. (2010) found that the PROQ2 upper scales (i.e. UN, UC, and UD) differentiated the perpetrators of aggression in dating relationships from those who were neither aggressors nor victims of aggression by their dating partners. Moreover, Birtchnell (1997) theoretically proposed and later, Birtchnell and Shine (2000) empirically examined, the placement of personality disorders on the Interpersonal Octagon. Antisocial personality disorder was located in the UD octant. There is a clear link between antisociality and alcohol use disorders, and men are more likely to show symptoms of antisociality and delinquency than females (Nolen-Hoeksema 2004). It could be speculated that the PROQ3 UD scale and the RT-18 risk-taking behaviour scales tap into a source of shared variance, and this source could very well be the very broad concept of behavioural disinhibition. Indeed, Newberry (see Chap. 20) has found that UD is the PROQ3 scale most closely associated with psychopathic personality traits, including secondary psychopathy which is characterised by impulsivity and risk-taking behaviour. High levels of the perception of negative relating, risk-taking behaviour and (risky) alcohol consumption can all be seen as expressions of behavioural disinhibition, for they are genetically linked (Krueger et al. 2005). Moreover, Young et al. (2009) reported behavioural disinhibition in adolescence to be a risk factor for developing externalising spectrum disorders. LC appears to be the most clear-cut indicator of psychopathology; it was correlated with almost all of the DSM-IV personality disorders (Birtchnell and Shine 2000).

Several limitations with this study should be acknowledged. First, it relied on self-report measures which means that there might be discrepancies in how an individual perceives and reports his/her behaviour. Second, only students from Utrecht University participated, which limits the generalisability of the results. Third, since this was an exploratory study, the relationship between relating, risk-taking behaviour, and alcohol use was examined without any prior hypotheses. The effects found in this analysis should be replicated in studies with clear hypotheses regarding this triangular relationship to obtain more insight.

In conclusion, the PROQ3 UD scale appears to overlap with the risk-taking behaviour subscale of the RT-18. However, we cannot explain why the LC, LD, and ND scale scores decreased the odds of drinking

alcohol or binge drinking. Moreover, the distinct differences between males and females could provide a lead towards understanding risky alcohol consumption in young adults. However, more research is needed to further explore the relationships between negative interpersonal relating and risk-taking behaviours.

Acknowledgments The USS was supported by a grant from Red Bull GmbH (Fuschl am See, Austria). Red Bull GmbH was not involved in the design and implementation of the study, collection, management, analysis, interpretation of the data, or the preparation of the manuscript.

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20

Negative Relating and Psychopathy

Michelle Newberry

Introduction

The Core Characteristics of the Psychopath

Various definitions and variants of psychopathy have been posited, many of which refer to 'interpersonal' deficits. Hervey Cleckley in *The Mask of Sanity* (1941, 1976) described the psychopath as someone who is unable to 'maintain important or meaningful interpersonal relations' (p. 397), and Hare (1993) refers to the psychopath's 'deeply disturbing inability to care about the pain and suffering experienced by others' (p. 6). Although other factor structures have been proposed (e.g. the three-factor model by Cooke and Michie 2001), it is the two-factor structure (Harpur et al. 1989) which has received most attention in the literature and which underlies the Psychopathy Checklist-Revised (PCL-R; Hare 1991), considered to be the 'gold standard' for assessing psychopathy in forensic set-

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_20

tings (Edens et al. 2001, p. 54): Factor 1 (Interpersonal/Affective) reflects the core *personality* characteristics of the psychopath such as glibness and superficial charm, a grandiose sense of self-worth, and callousness/lack of empathy, and Factor 2 (Social Deviance) reflects behaviours such as a need for stimulation and proneness to boredom, impulsivity, and juvenile delinquency.

Since these two factors have different associations with external variables (e.g. Factor 1 with high dominance, low anxiety, and venturesomeness, and Factor 2 with antisocial behaviour and substance abuse; Benning et al. 2003), psychopathy can be conceptualised as a multifaceted syndrome comprised of distinct subgroups of psychopaths (Blackburn 1983). It has been argued that two types of psychopathy exist – *primary psychopathy* (PP) and *secondary psychopathy* (SP) – which, although phenotypically similar in that they are characterised by a lack of regard for others and often manifest antisocial behaviour, have different underlying aetiologies: PP reflects a biological affective deficit, whereas SP reflects an affective disturbance caused by environmental factors (Karpman 1948; Porter 1996). More recently, Patrick et al. (2009) posited a triarchic model in which psychopathy represents three distinct phenotypic constructs with different aetiologies: *disinhibition* (a tendency toward problems of impulse control), *boldness* (social dominance, venturesomeness, and emotional resilience), and *meanness* (lack of regard for others, disdain for close attachments, and empowerment through cruelty).

Psychopathy and Interpersonal Relating

Blackburn (1983) suggested that psychopathy (as well as other personality disorders) could be understood by reference to interpersonal space, where variables could be represented in a circular manner around a two-dimensional space (see Plutchik 1980 for a review). The interpersonal circle (Leary 1957; Wiggins 1979) is divided into eight segments, each of which reflects a blend of *Agency* (dominance, status, power) and *Communion* (love, warmth, friendliness). Blackburn and Maybury (1985) were among the first to explore psychopathy in relation to the

interpersonal circle, reporting that in a sample of psychiatric patients, psychopathy clustered in the segment which reflected hostile, cold, and non-compliant behaviour, and a recent study of non-offenders by Rauthmann and Kolar (2013) supports this. Similarly, Salekin et al. (2005) found that in a sample of offenders psychopathy projected into the cold-hearted dominant quadrant of the circle and was strongly negatively correlated with the Big Five personality factors of Agreeableness and Conscientiousness.

Relating Theory (Birtchnell 1993/1996) represents a different theoretical system from the interpersonal circle (see Chap. 2 of this volume and also Birtchnell 2014). It posits that humans have a tendency to strive towards four principal relating objectives (getting closer to others, becoming more distant, relating downwards from a position of upperness, and relating upwards from a position of lowerness (see Chap. 1). Individuals who are able to relate competently from all positions are considered to be versatile and encounter few interpersonal problems (Birtchnell and Evans 2004). These objectives can be represented by two intersecting axes (closeness vs distance and upper vs lower), with four intermediate positions, which together create the *Interpersonal Octagon* (Birtchnell 1994; see Fig. 1.1). Each octant has a two-word name: upper neutral (UN), upper close (UC), neutral close (NC), lower close (LC), lower neutral (LN), lower distant (LD), neutral distant (ND), and upper distant (UD). Relating in each of these octants is measured by the Person's Relating to Others Questionnaire (PROQ; Birtchnell and Evans 2004; Birtchnell et al. 1992, 2013).

Parallels can be seen between the early clinical observations of psychopaths and the different octants of the Interpersonal Octagon. For example, Cleckley (1988) claimed that 'a great many of the people who have attracted attention primarily as sadists have many characteristics of the classic psychopath. Certainly they seem to show extreme callousness to the suffering of others' (p. 291). Such sadistic tendencies are represented in the UD octant of the octagon. Similarly, parallels can be drawn between Patrick et al.'s (2009) *meanness* psychopathy phenotype (disdain for closeness to others and empowerment through cruelty) and UD.

The Current Study

No research to date has explored psychopathy in relation to the Interpersonal Octagon and the current study sought to bridge this gap in the literature. This was considered important because as Salekin et al. (2005) note: 'Establishing psychopathy's place in interpersonal space is an important aspect of construct validation' (p. 456). In order to fully understand how individuals with psychopathic traits relate to others we must not be limited to measuring relating using only the interpersonal circle.

The study investigated associations between total negative relating and total psychopathy (TP), as well as associations between the eight octants of the octagon and primary psychopathy (PP) and secondary psychopathy (SP). The nature of psychopathy, conceptualised either as dimensional (i.e. existing on a continuum) or taxonomic (i.e., people can be classified as either psychopathic or non-psychopathic), has been debated extensively (see Marcus et al. 2004; Walters et al. 2015), but the prevailing view is that it can be best understood as existing on a continuum. Five hypotheses were tested as outlined below.

Males tend to be more forceful and controlling than females (Eagly and Johannesen-Schmidt 2002), features that are reflected by the UN scale of the PROQ3, and males score significantly higher on ND which reflects suspicious, uncommunicative, and self-reliant relating (Birtchnell and Evans 2004). Males also score higher on measures of psychopathy than females (e.g. Wilson et al. 1999), including PP (Levenson et al. 1995). The first hypothesis was therefore that males would score higher than females on the UN and ND scales of the PROQ3 as well as on the TP and PP scales of the LSRP.

Second, given that research has identified maladaptive relating among psychopaths (Pfafflin and Adshead 2004; Van den Berg and Oei 2009), it was hypothesised that overall negative relating, as measured by a person's PROQ3 total score, would correlate positively with, and significantly predict, TP.

Third, given that clinical observations (e.g. Cleckley 1988; Horney 1945) and empirical studies have suggested that psychopathy is associated with relating in the upper quadrant of the interpersonal circle

(e.g. Salekin et al. 2005), it was hypothesised that UN and UD would correlate positively with TP and be significant predictors of TP.

Fourth, since a grandiose sense of self-worth and callousness/lack of empathy are Factor 1 traits which are most strongly associated with PS (Levenson et al. 1995), it was hypothesised that UN and UD would correlate more strongly with PP than SP and would be significant predictors of PP.

SP is correlated with low-quality parental care (Jonason et al. 2014), and lower positive emotionality (related to the experience of emotions associated with engagement with others) due to rejection from others, alienation, and difficulty in social situations (Del Gaizo and Falkenbach 2008). It was therefore hypothesised that LC and NC would correlate more strongly with SP than PP, and would be significant predictors of SP.

Method

A sample of 200 participants from a university campus in the UK (99 males and 101 females with a mean age of 30.47 years, SD = 8.67) completed the PROQ3 (Birtchnell et al. 2013) and the Levenson Self Report Psychopathy Scale (LSRP; Levenson et al. 1995).

The PROQ3 has 48 self-report items which measure the 8 scales of the Interpersonal Octagon. There are five items per scale which reflect people's negative feelings and attitudes towards other people and one positive, unrated item (overall six items); the items are rated on a four-point scale of 3 to 0 ('Nearly always true' to 'Rarely true'). A score for each octant is calculated, ranging from 0 to 15. Research has found that the internal reliability of the PROQ3 is acceptable; five of the scales have a Cronbach alpha coefficient of 0.70 or above (Birtchnell et al. 2013).

The LSRP is a 26-item self-report measure which assesses primary and secondary psychopathy. The *primary* scale assesses an uncaring, selfish, callous, and manipulative orientation toward others, and the *secondary* scale assesses reactivity, impulsivity, and poor behavioural control (Lynam et al. 1999). Items are rated on a four-point scale from 1 to 4 ('Strongly disagree' to 'Strongly agree') and higher scores represent increasing psychopathy. The LSRP has good internal reliability with Cronbach alpha

coefficients of 0.82 and 0.63 for the primary and secondary scales, respectively (Levenson et al. 1995) and the LSRP has been recommended for use with non-institutionalised samples (Lynam et al. 1999).

Results

Hypothesis 1: Males Will Score Higher than Females on UN, ND, TP, and PP

Independent-sample *t*-tests revealed that males scored significantly higher than females on four scales (UN, ND, TP, and PP) as shown in Table 20.1. Hypothesis 1 was therefore supported.

Hypothesis 2: PROQ3 Total Will Be Positively Correlated with TP and Will Predict TP

There was a significant positive Pearson correlation between PROQ3 total and TP (see Table 20.2). In addition, a multiple regression model

Table 20.1 Mean PROQ3 and LSRP scores

	Total sample ($N = 200$)		Males ($n = 99$)		Females ($n = 101$)		
Scale	Mean	SD	Mean	SD	Mean	SD	t
PROQ3 total	47.65	15.63	49.77	14.19	45.56	16.73	1.92
UN	7.65	4.23	8.57	4.43	6.75	3.83	3.10**
UC	4.48	3.73	4.81	3.73	4.16	3.72	1.23
NC	4.12	4.34	3.96	4.38	4.28	4.10	−0.53
LC	5.68	3.99	5.85	4.01	5.50	3.98	0.61
LN	5.18	4.23	4.67	3.88	5.67	4.51	−1.69
LD	5.47	4.05	5.62	4.28	5.33	3.82	0.50
ND	7.33	4.39	8.15	3.91	6.52	4.51	2.72**
UD	7.90	4.19	8.45	4.21	7.35	4.12	1.88
TP	60.44	9.37	62.66	8.68	58.26	9.56	3.41**
PP	37.30	5.57	38.85	5.79	35.79	4.91	4.03**
SP	23.14	5.48	23.81	4.84	22.47	5.99	1.74

**$p < 0.01$

Table 20.2 Correlations between PROQ3 and LSRP scales

Scale	PROQ3 total	UN	UC	NC	LC	LN	LD	ND	UD
TP	0.26**	0.41**	0.24**	0.19**	0.14*	−0.33**	−0.26**	0.08	0.54**
PP	0.21**	0.49**	0.25**	0.09	0.02	−0.41**	−0.23**	0.08	0.51**
SP	0.23**	0.21**	0.15*	0.23**	0.22**	−0.14	−0.21**	0.05	0.39**

*$p<0.05$; **$p<0.01$

which tested whether PROQ3 total/scales could significantly predict TP was significant ($F=11.77$, $p<0.01$). The total variance explained by the model (adjusted R^2) was 32.8 %. However, only UD made a unique significant contribution to the model ($\beta=0.34$, $p<0.01$). Hypothesis 2 was therefore only partially supported.

Hypothesis 3: UN and UD Will Correlate Positively with, and Be Significant Predictors of, TP

Both UN and UD were significantly and positively correlated with TP (see Table 20.2). In addition, a multiple regression model was significant in predicting TP ($F=11.77$, $p<0.01$). The total variance explained by the model was 32.8 %. UD made a unique significant contribution to the model ($\beta=0.34$, $p<0.01$) but UN did not. Hypothesis 3 was therefore only partially supported.

Hypothesis 4: UN and UD Will Correlate More Strongly with, and Will Significantly Predict, PP More than SP

UN and UD were significantly and positively correlated with both PP and SP, although the correlations were stronger for PP (see Table 20.2). In addition, a multiple regression model was significant in predicting PP ($F=12.03$, $p<0.01$). The total variance explained by the model was 30.7 %. Both UN and UD made a unique significant contribution to the model (both $\beta=0.22$, $p<0.05$), as well as LN ($\beta=-0.24$, $p<0.05$), and so Hypothesis 4 was supported.

Hypothesis 5: LC and NC Will Correlate More Strongly with, and Will Be Significant Predictors of, SP More than PP

There was a significant positive correlation between NC/LC and TP and SP but not PP (see Table 20.2). In addition, a multiple regression model significantly predicted SP ($F = 8.98$, $p < 0.01$). The total variance explained by the model was 24.3 %. LC made a unique significant contribution ($\beta = 0.29$, $p < 0.01$) as well as UD ($\beta = 0.46$, $p < 0.01$) and LD ($\beta = -0.17$, $p < 0.05$) but NC did not. Hypothesis 5 was therefore only partially supported.

Additional Correlations

A number of additional correlations were significant (see Table 20.2). PROQ3 total and UC were positively correlated with PP and SP (in addition to TP). LD was negatively correlated with TP, PP, and SP. LN was negatively correlated with TP and PP. Finally, NC was positively correlated with TP and SP.

Discussion

Findings support previous reports that the factors of psychopathy have distinctive relationships with external correlates (Patrick et al. 2009), and more specifically Blackburn and Maybury's (1985) claim that 'psychopathic personalities can be conceptualized as those individuals located in a particular segment of the interpersonal space by virtue of their extreme position on certain behavioural dimensions' (p. 386). However, unlike studies which have involved the interpersonal circle (e.g. Blackburn and Maybury 1985; Rauthmann and Kolar 2013; Salekin et al. 2005), the current study examined the relationship between psychopathy and negative relating as conceptualised by the Interpersonal Octagon. This is important since the octagon and the circle represent two separate theoretical systems (see Chap. 2 and also Birtchnell 2014).

The mean PROQ3 scores for the current sample parallel those reported by Birtchnell et al. (2013), and the finding that males scored significantly higher on ND than females supports Birtchnell and Evans (2004). In their study men also scored higher on UN but unlike the current study, this difference was not significant. Consistent with other studies (e.g. Wilson et al. 1999) is the finding that males scored significantly higher on TP than females, meaning that males are more psychopathic in student (as well as institutionalised) samples, Also in keeping with previous research is the finding that males scored significantly higher than females on PP but not SP (Levenson et al. 1995). Furthermore, findings are consistent with previously reported high endorsement rates on the LSRP among students (e.g. Lynam et al. 1999). Although some readers might find it surprising that students would rate themselves as possessing psychopathic traits, as Levenson et al. (1995) note, individuals with psychopathic attitudes may also possess the attitude that these attitudes are desirable.

The finding that total negative relating was significantly correlated with TP provides support for Cleckley's (1976) belief that a key diagnostic criterion for psychopathy was 'unresponsiveness in general interpersonal relations'. However, as anticipated based on the aforementioned findings of Salekin et al. (2005), it was the UD scale which had the strongest correlation of all with psychopathy (particularly PP as hypothesised) and which was a significant predictor of TP, PP, and SP. These findings are in keeping with Cleckley's early conceptualisation of the psychopath as someone who has a 'callous disregard for the rights and feelings of others' (1976, p. 113), as well as De Ganck and Vanheule's (2015) claim that psychopaths relate to others through identification with an extremely aggressive ego-ideal. For example, one young offender who they interviewed said: 'I'm a cold-blooded human being […]. I once ate a hedgehog … its liver, its heart (…). I drank its blood and ate its flesh […]. I'm a cold-blooded man. I like to see blood […]. Some people are always afraid, I'm not, I always laugh' (p. 4). De Ganck and Vanheule (2015) discuss Valliant (1975) observation that radical identification with 'aggressiveness' or the 'fearless criminal' provides the individual with the sense of *being* someone and enables them to position themselves in relation to others. The current finding that UD was the PROQ3 scale most strongly associated with psychopathy supports these assertions.

The finding that UN was most strongly correlated with PP is consistent with descriptions of the psychopath as 'self-assured and boastful' (Cleckley 1976, p. 47), someone who finds it easy to use intimidation to achieve control over others (Hare and Neumann 2010), and Hare's (1991) PCL-R Factor 1 (PP) item 'Grandiose sense of self-worth'.

LC was significantly (positively) correlated with psychopathy (TP and SP but not PP) and was a significant predictor of SP. It is also worthy of note that NC was significantly (positively) correlated with all three psychopathy scales (although it was not a significant predictor of SP). It has been suggested that interpersonal factors can enable us to understand how psychopathic individuals avoid mutual relationships (Pfafflin and Adshead 2004; Van den Berg and Oei 2009), and attachment avoidance is positively correlated with psychopathy (Mack et al. 2011). The current findings concerning NC and LC, together with those regarding UD, suggest that psychopaths relate in sadistic, intimidating, or tyrannising ways (UD) because they are fearful of separation or rejection (NC and LC), and support De Ganck and Vanheule's (2015) claim that psychopathic behaviour should be understood as a self-protective strategy for managing a fundamentally fearful position. Findings are also consistent with Van den Berg and Oei's (2009) suggestion that psychopaths see others as objects due to having early experiences of being treated this way themselves. When the other is treated as an object, no reciprocity is required and no mutual relationships are sought because 'they carry the risk that overwhelming emotions take over (anxiety and anger at the "separation")' (p. 47).

Some other findings, although not hypothesised, are worthy of note. Consistent with the finding of a negative correlation between psychopathy and the Big Five trait of Agreeableness (Harpur et al. 1994; Lynam et al. 1999), LD was negatively correlated with all three psychopathy scales, indicating that psychopaths are *not* acquiescent or subservient. LN was negatively correlated with TP and PP and was a significant predictor of PP, indicating that, not surprisingly, psychopaths are not helpless and self-denigrating (indeed, a grandiose sense of self-worth is a core characteristic of PP/Factor 1 of the PCL-R (Hare 1991), the most widely used measure of psychopathy in criminal populations.

As noted previously (Mathieu et al. 2013; Schrum and Salekin 2006), most studies on psychopathy have focused on offender populations, even

though not all psychopaths are criminal or socially deviant (Cooke and Michie 2001; Edens et al. 2006). It is therefore important to investigate psychopathy in non-criminal/non-institutionalised populations as Cleckley (1988) noted: 'The disorder [psychopathy] can be demonstrated only when the patient's activity meshes with the problems of ordinary living. It cannot be even remotely apprehended if we do not pay particular attention to his responses in those interpersonal relations that to a normal man are the most profound' (p. 21).

Limitations of the Study

Although some readers will perceive the self-report nature of psychopathy to be less desirable than clinician ratings, Lynam et al. (1999) report that, consistent with other studies (e.g. Lilienfeld and Andrews 1996) 'the traditional distrust of self-report inventories of psychopathy may not be warranted, especially when it comes to studying non institutionalized psychopaths' (p. 129). However, because more extreme levels of psychopathy exist in such populations (Gray et al. 2004), different patterns of relating may be found. It is also necessary to study associations between psychopathy and relating in non-criminal/non-institutionalised samples other than students since the current findings, together with those of previous studies, suggest that students tend to endorse relatively high levels of psychopathic traits.

Implications of Findings

An ideal model of treatment for psychopathy should stem from a clear understanding of what psychopathy is and is not (Polaschek and Daly 2013). Birtchnell (2002) claims that negative relating is a useful component in psychotherapy, and the current findings which suggest that particular forms of negative relating are associated with different variants of psychopathy may therefore have useful treatment implications. For example, an individual who scores highly on PP and the LC scale of the PROQ3 may benefit from a different treatment approach from someone who scores highly on SP and UD. This is in keeping with the risk, need,

and responsivity (RNR) principles (Andrews et al. 1990; Andrews and Bonta 2006) written about at length in the forensic literature and which posit that offender treatment should be tailored for level of risk of reoffending, the needs of offenders, and be responsive to individual needs.

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21

The Sadistic Impulse and Relating to Others

Aisling O'Meara and Sean Hammond

Introduction

The psychological literature does not convey a clear and universally understood conceptualisation of sadism. Sadism is widely explored within the psychoanalytic tradition (e.g. Csillag 2014; Horney 1945) which links sadism to the instinct for mastery in which the object is dominated and controlled (Freud 1915). Horney (1945) highlighted the sadist's interest in disparagement and humiliation of the object and this reflects a prevailing view of researchers (e.g. Shapiro 1981), who noted that the sadist derives pleasure from another's suffering. A natural extension of this is the link between sadism and violent criminal behaviour which has been the focus of much forensic research on personality disordered and violent offenders (Juni 2009; Robertson and Knight 2014; Stone 2010).

However, the literature is inconsistent in its definition of sadism (Brittain 1970; Fromm 1973; Leary 1957; Shapiro 1981). The DSM-III-R

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© The Editor(s) (if applicable) and The Author(s) 2016
J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_21

(American Psychiatric Association 1987) included the category of sadistic personality disorder (SPD) under 'disorders needing further study', but it was ultimately removed from the latest edition (DSM-V; American Psychiatric Association 2013) for a number of reasons. Firstly, concerns were raised that it may be invoked as an exculpatory tool by violent offenders (Spitzer et al. 1991). Secondly, there was potential confusion in diagnosing symptoms due to their overlap with those of many other personality disorders (Fiester and Gay 1995). Third, the heterogeneity of the eight criteria suggested could lead to problems with diagnosing quite disparate patients exhibiting very different symptoms (Stone 2006). A fourth concern was the focus of the DSM classification on pathology. This implies that there can be no graded differentiation between pathological and non-pathological expressions of sadism, and indeed the DSM-V has recognised the need for personality disorders to be understood along a continuum (Kernberg 2012).

In addition to the failure of the DSM to bring clarity to the notion of sadism, a further confound exists which is that the modality of sadistic expression is rarely discriminated. This is demonstrated by the common failure to distinguish between SPD and the paraphilia of sexual sadism, as indicated by research on sex offenders (e.g. Marshall and Kennedy 2003). This fuels the confusion with regard to the discrimination between sadistic personality and sexual sadism and occludes a clear understanding of their common and distinct features. From extensive reviews of the literature a general and widely accepted underlying definition of sadism is: '*Deriving pleasure from the suffering of others*' (see Juni 2009; O'Meara et al. 2011). However, as a root definition, this is quite simplistic and reductive. Firstly, sadism is a characteristic that not only expresses itself through behaviour, but also through cognition. The suffering enjoyed may be of a physical, psychological, or emotional nature and may range from mild to severe (O'Meara in preparation). Similarly, the pleasure gained may take a variety of forms (e.g. sexual gratification, amusement, satisfaction, or enjoyment, pleasure gained due to the suffering of an acquaintance, a loved one, an unknown stranger, or an animal). Any being that has the capacity for suffering has the potential to be the subject of sadistic attention (O'Meara et al. submitted; O'Meara in preparation).

In the definition above, we do not specify whether sadistic individuals actually cause suffering, but merely that they enjoy it. This definition

allows for many levels of engagement on the sadist's part. The sadist may be directly involved in bringing about suffering, but may otherwise simply be a spectator of suffering that occurs by chance or that is brought about by another's behaviour. There is, therefore, scope for both active and passive forms of sadism. Similarly, enjoying the self-inflicted suffering experienced by another individual may be considered a sadistic form of spectatorship (O'Meara 2006). On the more involved side of this passive–active spectrum may be a person who enjoys using bondage discipline/dominance submission/sadism masochism (BDSM) paraphernalia on their consenting sexual partner or a prankster who enjoys playing practical jokes on unsuspecting friends, resulting in their mild pain or humiliation (Cross and Matheson 2006). More extreme involvement may be physical or psychological bullying, sadistic sexual abuse, animal cruelty, or having an overly dominating interpersonal style.

A relevant question is consent (Knoll and Hazelwood 2009; O'Meara et al. 2011), which is the aspect of sadism that brings the construct into the realm of forensics. Sadism is, in essence, forensically irrelevant if the sufferer, submissive partner, or butt of the joke consents to the sadistic acts being carried out. One concern voiced about BDSM enthusiasts is that people might suffer against their will, while there exist safeguards such as the rule of safe sane and consensual (SSC) activities, and the notion of 'play', which asserts that these behaviours are more a form of role-playing than any expression of an actual desire to hurt or humiliate another person (Alison et al. 2001). Once sadistic behaviour, sadistic sexual acts, or sadistic humour are expressed in a non-consensual manner, these expressions enter the realm of forensically significant psychopathology.

The first author has developed a more inclusive definition of sadism: '*Pleasure and enjoyment experienced as a result of witnessing or causing another's psychological, physical or emotional suffering whether the suffering is consensual or otherwise*' (O'Meara in preparation). This definition allows for a dimensional take on the construct and does not impose strict criteria or cut-off points, as the author believes that sadistic personality exists along a continuum, ranging from relatively benign sadistic attitudes to more pathological behavioural expressions. This definition also allows for a passive, more attitudinal aspect of sadism involving the enjoyment of suffering and humiliation without actively causing the harm itself. Furthermore, it approaches sadism as not simply a pathological

condition, but as a construct that may present itself in everyday life (Buckels et al. 2013). This is in keeping with Millon's adaptive–maladaptive take on what he termed the sadistic dominant personality pattern in which, at the well-adjusted end of the continuum, are people who are strong-willed and assertive while at the extreme maladaptive pole are individuals who are domineering and highly aggressive behaviourally (Millon 1996).

Sadism and the Interpersonal Octagon

The Interpersonal Octagon theory espoused by Birtchnell (1990, 1994, 1993/1996, 2014) provides a descriptive model of maladaptive relating to others. The model is built around two orthogonal bipolar axes (see Fig. 1.1). The first, labelled upper vs lower, describes the power dynamic in interpersonal relating. At the upper end the individual relates from a position of power and dominance while the lower end describes relating from a powerless or subservient position. The second axis, labelled close vs distant, indicates the emotional investment in the relationship. Thus, at the close end, relating is viewed as emotionally invested while at the distant end relating involves little emotional involvement. This axis may be analogous to the notion of empathy and emotional indifference. For example, from the second author's clinical observations in forensic contexts, people tend to vary according to their willingness to invest emotionally with others. The four polar facets are complemented by four more that represent mergers of the characteristics of each. Thus upper close (UC), lower close (LC), upper distant (UD), and lower distant (LD) are complemented by upper neutral (UN), lower neutral (LN), neutral close (NC), and neutral distant (ND).

An important feature of the octagon is that it describes adaptive and successful relating as well as maladaptive or problematic relating. For example, adaptive 'upperness' may be seen as protective and offering leadership, while negative 'upperness' may involve domination and belittling behaviours. True to the clinical tradition, measures developed by Birtchnell and his colleagues (Birtchnell et al. 1992; Birtchnell and Evans 2004; Birtchnell et al. 2013) focus upon maladaptive relating in the eight

specific areas described by the upper–lower and close–distant axes, as the challenge is the identification or diagnosis of problematic relating.

The PROQ3 is the latest measure to assess maladaptive relating (Birtchnell et al. 2013). Research applying to the octagon has involved marital therapy (Birtchnell 2001), but understandably the issue of interpersonal relating has a great deal of salience in forensic psychology (Blackburn and Renwick 1996; Birtchnell and Shine 2000; Birtchnell et al. 2009). The octagon has been shown to have an explanatory role in differentiating personality-disordered offenders and also as a means of evaluating therapeutic change (Birtchnell et al. 2009; Kalaitzaki et al. 2014). However, to our knowledge there has been no work yet focusing upon the role that sadistic impulses may have on interpersonal relating.

The maladaptive upper distant (UD) octant explicitly refers to sadistic, intimidating, and tyrannising behaviours. Certainly the discussion above would suggest that the sadistic person might be expected to relate to others in a dominating and forceful manner concomitant with the upper regions of the octagon. However, there can be less certainty in positioning sadism on the distant side of the space. It may well be that a certain coldness is required to facilitate sadistic behaviour but a degree of emotional investment might be expected also. The pleasure from hurting or humiliating another implies empathy in order to appreciate the other's feelings. The remainder of this chapter explores the relationship between sadistic impulses across modality with the Interpersonal Octagon. Some of the results of the first author's PhD research at University College Cork (Davies and O'Meara 2007; O'Meara et al. 2011), in which sadism and interpersonal relating were associated, form the basis of this chapter.

Method

Participants

A general population sample of 2205 individuals participated. They were 1056 males (47.9 %) and 1149 females (52.1 %) aged from 18 to 76 (M = 25.91, SD = 8.6). Participation was achieved through an online presentation of the materials to which individuals were directed through

snowball e-mailing of requests and through a number of social networking websites and forums. Another sample of 74 male prisoners was recruited from four Irish prisons (age range 18–62, $M = 30.7$, SD = 9.3). Quite a diverse range of nationalities were represented, with 60.08 % European, 33 % North and South American, 4.9 % Australasian, 1.4 % African and 1.4 % unspecified.

Measures

Sadism Spectrum Measure (O'Meara et al. submitted)

The Sadism Spectrum Measure (SSM) is a self-report questionnaire designed to tap into various forms of enjoyment obtained from hurting others, both emotionally and physically. It is an enhancement of the short ten-item Short Sadistic Impulse Scale (SSIS; O'Meara et al. 2011) with seven more items added to broaden the scope of this measure. The SSM is scored on a five-point Likert scale from 0 'Not at all like me' to 4 'Very like me'. Psychometric results have been found to be very promising (O'Meara et al. submitted).

Sadistic Humour Cartoon Test (O'Meara in preparation)

The Sadistic Humour Cartoon Test (SHT) consists of 27 cartoons that respondents are required to rate in terms of funniness. The test measures three humour facets: sadistic humour, sexual humour, and 'quirky' humour. For the purposes of the current chapter we refer to only the sadistic humour facet. This measure showed good construct validity and internal consistency with an alpha value of 0.82. A high score indicates the tendency to find cruel jokes funny.

Sadistic Sexual Fantasy Preference Test (O'Meara in preparation)

The Sadistic Sexual Fantasy Preference Test (SFP) uses nine fantasy scenarios each reflecting varying degrees of sexual sadism. Each scenario is presented alongside every other scenario and the respondent simply

indicates which of the two scenarios is preferable. In all, $(n\ (n-1))/2$ or 36 such comparisons were made. Analyses resulted in weights being applied to respondents' preferences to indicate their tendency towards favouring sexually sadistic scenarios.

The Person's Relating to Others Questionnaire Version 3 (Birtchnell et al. 2013)

The Person's Relating to Others Questionnaire Version 3 (PROQ3) is a 48-item measure of negative interpersonal relating with 8 subscales based on the 8 octants of the Interpersonal Octagon (see Chap. 3). While there are six items for each subscale, one of each of these refers to positive relating and so is not included in analysis. As questionnaire items were presented one at a time, with participants required to click 'next' to display the next question, all questionnaire items in this study (for both the SSM and the PROQ3) were intermingled so that participants would not feel overwhelmed with repeated questions about sadistic tendencies one after the other. All response categories were homogenised such that each subscale of the PROQ3 was scored on the same five-point Likert scale as the SSM, with 0 being 'Not at all like me' and 4 representing 'Very like me'. As a result, mean PROQ3 scores range from a minimum of 0 to a maximum of 20 rather than the usual 0–15 range of the standard format PROQ3.

Results

The descriptive statistics of the scales are presented in Table 21.1. The standard deviation of the SSM scores is very large compared to its mean which indicates skewness towards the low end (non-sadistic). Although we decided to retain this distribution to reflect the reality of the distribution of sadistic impulse rather than adopt some artefactual way of transforming it, we must bear in mind that this skew will inevitably truncate the correlations reported in the following analyses.

Two estimates of reliability are presented and both are lower bound estimates of score reliability. Alpha is the most typically employed but omega appears to be a better lower bound estimate (see Chap. 4). All

Table 21.1 Descriptive statistics for the PROQ3 and sadistic impulse scales

			Reliability estimates	
Scale	Mean	SD	Alpha	Omega
Sadism scales				
SSM	15.17	11.08	0.89	0.92
SHT	5.01	3.23	0.83	0.86
SFPT	23.53	10.85	0.77 +	+
Octagon scales				
UN	11.39	3.66	0.74	0.78
UC	7.70	4.21	0.84	0.85
NC	8.24	4.28	0.79	0.81
LC	11.42	4.53	0.80	0.83
LN	8.44	4.17	0.84	0.85
LD	8.96	3.72	0.69	0.72
ND	10.95	4.81	0.85	0.88
UD	9.92	3.95	0.74	0.78

SSM Sadism Spectrum Measure, *SHCT* Sadistic Humour Test, *SFPT* Sadistic Fantasy Preference Test, *UN* upper neutral, *UC* upper close, *NC* neutral close, *LC* lower close, *LN* lower neutral, *LD* lower distant, *ND* neutral distant, *UD* upper distant, + indicates that the SFPT is not based upon summative ratings so alpha and omega are not appropriate estimates of reliability. The value 0.77 indicates the proportion of preference variation accounted for by the one-dimensional BTL model

scale scores appear to manifest acceptable reliability estimates. The lowest reliability estimate is associated with the PROQ3 Lower Distant (LD) scale, indicating that this scale may not as accurately measure LD as other octants measure their associated features of interpersonal relating.

In Table 21.2 the correlations between the sadistic scores and the PROQ3 scales are reported. The statistical significance of correlations is of limited value, as it is influenced heavily by sample size. Thus, we find with samples greater than 2000 that the correlation 0.068 is statistically significant at the 5 % level although it describes only 0.462 % overlapping variance. Nevertheless, we have indicated the statistical significance here as a device for depicting relative strengths of relationships in each column.

A multivariate analysis, in which the joint psychometric space of the eight PROQ3 scales and the three sadistic measures was required to explore the nature of the relationships between each of these scales. Typically such an analysis might involve a canonical variate approach

Table 21.2 Correlations between the PROQ3 scales and the sadistic impulse scales

PROQ3	SFPT	SHT	SSM
UN	0.136**	0.189**	0.383**
UC	0.088**	0.104**	0.278**
NC	−0.047	0.029	0.064**
LC	−0.050	0.101**	0.075**
LN	−0.068*	0.011	−0.062**
LD	−0.079**	0.007	−0.095**
ND	0.135**	0.198**	0.241**
UD	0.192**	0.160**	0.468**

*$p < 0.05$; **$p < 0.01$

(Afifi et al. 2003; Hardle and Simar 2012) but we used a development resulting in a redundancy biplot (Legendre et al. 2011), which has the advantage of presenting the relationships between two sets of variables in a geometric form allowing a graphical representation of the relationship. As a first stage, up to three canonical variates are extracted by an Eigen decomposition.

All three canonical roots were significant at $p < 0.01$, although the last two conveyed very little discriminant information. After thorough investigation of three-dimensional solutions, it was clear that a single dimension best represented the relationships between the sadistic and interpersonal measures, which is summarised in Fig. 21.1. It can be seen that the upper and lower regions are clearly separated, with all sadistic measures clustering amongst all upper quadrants, although the two neutral scales, neutral distant (ND) and neutral close (NC), also imply a separation between close and distant that is not clearly present in one dimension. Also, although it is clear that the sadistic scales are situated in the upper region, there is sufficient space between SSM and the other two, SFPT and SHT, to merit a closer look. Thus, despite the small amount of variance associated with it, we explored the interrelations between quadrants and sadism measures in the two-dimensional model.

As with the one-dimensional solution, the upper and lower regions were clearly distinguished. What this solution added was the insight that sadistic humour and sadistic personality exist very much in the upper half of interpersonal space, while a preference for sadistic sexual fantasy results in one being positioned in the region of ND relating.

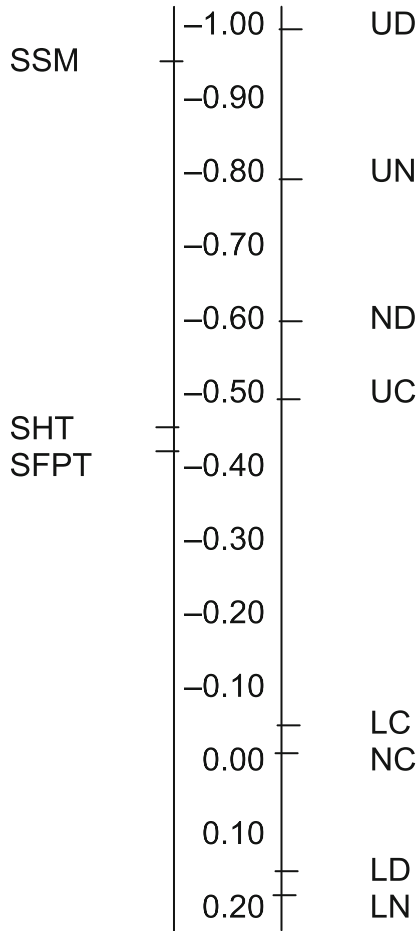

Fig. 21.1 Schematic one-dimensional solution to represent relationships between measures of interpersonal relating and sadism

Discussion

Despite the expectation that the sadistic impulse (SSM) correlations would have been truncated due to the skew in sadistic impulse scores, the correlations of the PROQ3 scales with SSM were higher than those with sexual sadism (SFPT) and sadistic humour (SHT) measures. Nevertheless,

closer scrutiny revealed that all three sadistic measures manifest a similar pattern of relationships, showing stronger correlations with the upper regions of the octagon and weaker or negative correlations with the lower regions. There was also no clear distinction between the PROQ3 scales representing the close and distant regions. This would lead towards the conclusion that sadism is concomitant with relating to others in the upper region of the octagon. This is consistent with findings reported in Chap. 20 (Newberry found that psychopathy was related more strongly to the upper region of the octagon). In other words the sadistic impulse may emerge as maladaptive dominant behaviour. This would be no surprise to most people but the picture may be slightly more nuanced than these bivariate correlations might suggest. For example, the SSM and the SHT reveal a small but significant positive correlation with the lower close (LC) scale while the SFPT shows a non-significant negative relationship.

Canonical variate analysis indicated that the first (vertical) dimension distinguishes the lower from the upper regions very clearly. Of particular interest is that the proximity of SHT and SFPT in the one-dimensional solution is deconstructed in two dimensions. As a result, sadistic humour sits well within the upper region while sadistic sexual fantasy is positioned to the far south close to the ND scale. This may imply that sexual sadism is more closely associated with distant relating while humour is more associated with closeness. However, due to the weakness of the second (horizontal dimension), it is unwise to speculate too freely on this separation. More research is required to tease out these distinctions but it should be clear that any such nuances in defining sadistic impulses ought to be explored through the lens of interpersonal relating behaviours and styles. Similarly, we cannot over-interpret the meaning of these proximities given the contrast with the nature of the correlations. A number of avenues for further exploration have, however, been identified.

Conclusions

This chapter has outlined how, through the use of the PROQ3, we can identify the location of various expressions of sadistic interest within interpersonal space in order to gain a better understanding of both

the overall construct of sadism as well as the intricacies of its expression. This study has shown that sadism is expressed through a number of modalities and that each of these may be associated with a unique format of interpersonal relating. Therefore, sadism can be seen to be quite broad-ranging, multifaceted, and nuanced rather than a behaviourally limited construct.

The varying levels of correlation between modalities of expression and PROQ3 subscales indicated one may present with a sadistic inclination without this necessarily dominating their personality or interpersonal style. For example, those inclined towards sadistic humour may rank high on overall SSM scores but may display a closer interpersonal style than one less inclined toward sadistic humour. In this way, the PROQ3 has been shown to potentially provide a means of distinguishing between the various presentations of sadistic interest.

Contrasts between the unidimensional and two-dimensional proximities found above offer much material for further exploration of this construct, particularly in relation to interpersonal relating. While all sadism measures lie firmly in the upper realm in unidimensional space, the considerable splitting apart in two-dimensional space provides grounds for investigating more thoroughly the intricacies of each aspect of sadistic expression, as well as their interactions.

Further work on both adaptive and maladaptive relating and sadistic impulse is required to gain a more thorough understanding of the cumulative and multifaceted nature of sadistic expression. Use of the PROQ3 with the above three measures of sadism in a variety of contexts and with a range of populations is warranted to fully expand our knowledge in this area.

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22

Using the Person's Relating to Others Questionnaire (PROQ) to Support Offenders with Intellectual Disability and Personality Disorder

Jon Taylor

Introduction

The approach presented for working with offenders with intellectual disability (ID) and personality disorder (PD) who experience interpersonal difficulties is Relating Theory (Birtchnell 1993/1996) which proposes that human beings have an innate tendency to relate to others around four relating objectives. Often conceptualised as being dimensional in nature, these objectives are depicted across two intersecting axes; one concerned with intimacy on the horizontal axis (closeness and distance) and hierarchy on the vertical axis (upperness and lowerness). Each of the four positions carries advantages for the individual and no single position is either better or worse than any other. There are four intermediate states that result from a blending of the horizontal and the vertical state, called upper close, lower close, upper distant, and lower distant. The four

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_22

pure states (which are called neutral) and the four intermediate states are organised into a theoretical structure known as the *Interpersonal Octagon* (see Fig. 1.1).

For some people these relating objectives are likely to present challenges. For some, managing intimacy and how to relate skilfully when either close or distant from another may be problematic, while for others, managing hierarchical relationships may prove somewhat difficult. Competent relating is called positive and relating that falls short of competence is called negative. Each section of the Interpersonal Octagon has both positive and negative features for each particular relating style. For a detailed description of Relating Theory see Chap. 1 of this volume.

Defining Personality Disorder and Intellectual Disability

Although the concept of PD remains controversial there is increasing recognition regarding the three areas of difficulties encountered by people who access both psychiatric and criminal justice services: difficulty maintaining a stable and integrated representation of both oneself and others, the capacity to develop and sustain mutual and affiliative relationships, and the ability to function adaptively in social groups. Livesley's definition clearly points towards the need for services to develop assessment strategies and treatment interventions that have an explicit focus on such individuals' interpersonal difficulties.

Similarly, a diagnosis of ID relies on the presence of three criteria: a significant impairment of intellectual functioning (typically considered an IQ of 70 or below as measured by a formal intellectual assessment), significant impairment of adaptive/social functioning, and an age of onset before childhood (British Psychological Society 2000). The World Health Organisation defines ID as a significantly reduced ability to understand new or complex information and to learn and apply new skills (impaired intelligence), resulting in a reduced ability to cope independently (impaired social functioning), that begins before adulthood, with a lasting effect on development. Those people who have both an ID and PD would therefore seem to face particular challenges in their

everyday relationships and are likely to require support from services if they are to develop relational styles that will support them to experience more enriched and more sustained interpersonal contacts.

Personality Disorder and Offending

Fazel and Danesh (2002) estimated that approximately 46 % of prisoners meet the DSM-IV criteria for antisocial personality disorder (APD) and up to 15 % would meet the criteria for the more severe form of personality disorder conceptualised as psychopathy as measured by the Psychopathy Checklist-Revised, clearly highlighting the entrenched interpersonal difficulties of such diagnoses. Higher rates of individuals meeting the criteria for at least one PD (two-thirds) have been found in both prisoner samples (Coid et al. 2006) and high secure hospital samples (Blackburn et al. 2003). Similarly, individuals with a PD are more likely to have a criminal conviction and have served a custodial sentence than those who do not have such a diagnosis (Coid et al. 2006; Howard et al. 2008).

Although the relationship between PD and offending behaviour is questionable, it would seem reasonable to assume that the interpersonal, cognitive, and affective features of PD play a significant contributory role in offending and risk of further offending. As a consequence, offenders' interpersonal styles would seem to be a crucial consideration when designing treatments.

Intellectual Disability and Personality Disorder

In order to have a sound understanding of PD it is necessary to have a comprehensive model of personality and its development. While such models exist in the mainstream literature, models for people with ID are lacking. There is an assumption that models of personality development can be extrapolated to this particular population and indeed some research (Zigler and Burack 1989) supports this, linking personality variables within this population to psychopathology. In addition, Lindsay et al. (2007) found a similar factor structure for

PD in offenders with ID as has been found for other offender groups (Blackburn et al. 2005), suggesting that PD may be a valid construct for those with ID.

Furthermore, Emerson (2003) suggests that people with ID are more likely to have the early experiences that are believed to be associated with PD, whilst also being less resilient to the impact of these experiences. Studies have also found that children with ID are more likely to be diagnosed with attention deficit hyperactivity disorder, or conduct disorder (Emerson 2003), which could both be predictors of adult psychopathy (Johansson et al. 2005). Furthermore, Moran et al. (2009) concluded that low childhood IQ may be an important factor in the development of PD.

Further evidence of the enduring nature of relational difficulties for those with ID can also be found in research into attachment. Numerous studies have reported more attachment difficulties in children with ID than peers without ID (Al-Yagon 2007, 2010; Bauminger and Kimhi-Kind 2008; Green and Goldwyn 2002). Furthermore, Wiener (2004) suggests that for some children with ID, social skills deficits are inherent in the disability itself and subsequently interfere with social relationships and promote the development of internalising behaviour problems.

It seems likely that even when the disability itself does not interfere with interpersonal relationships, those with ID remain highly vulnerable to developing such difficulties. Thus it seems possible, if not probable, that those with ID may be at higher risk of developing PD and experience the range of associated interpersonal difficulties than their non-disabled peers. Given the association between PD and offending behaviour and/or mental health difficulties, this again suggests that services for people with ID need to be mindful of the core difficulties of PD and develop strategies to address these difficulties. This need is perhaps most apparent when we consider the difficulties demonstrated by offenders with ID and PD.

Offenders with ID and PD

The high prevalence of PD within forensic populations would suggest that many offenders with ID would also have PD, and therefore struggle

to develop appropriate adult relationships. The prevalence of PDs ranges from 39.5 % up to 57 % in a high secure ID setting (Lindsay et al. 2006), which compares to prevalence rates found in high secure hospital patients without ID (Blackburn et al. 2003). In addition, Johnson and Morrissey (2010) found that a diagnosis of PD significantly differentiated *within* a forensic ID population on the dimensions of risk-related behaviour and both externalising and internalising behaviour problems. Those with PD were more extreme on all these variables compared to those without, suggesting that the interpersonal and affective deficits of PD exacerbate individual difficulties and are therefore likely to require further intervention.

Torr (2008) noted that a diagnosis of antisocial personality disorder is associated with placement in higher security settings, serious and repeat offending, and poorer long-term outcomes for people with ID. Furthermore, it has been found that ID offenders with a PD discharged from a medium secure unit were more likely to reoffend than ID offenders without a PD (Alexander et al. 2006; Gray et al. 2007).

Taylor (2014a, 2014b) identified difficulties with relationship stability and conflict and a variety of factors that could be linked to the reciprocal nature of relationships (perspective taking, empathy, entitlement, and interpersonal manipulation/impression management) as key areas of treatment need for offenders with ID and PD. Taylor's study suggests that relational difficulties are highly significant areas of need and risk for offenders with ID and implies that forensic settings for this population will need to incorporate relational components in their treatment setting if positive outcomes are to be achieved.

Treatment of Relating Styles in Offenders with ID and PD: Overview and Outcomes

A treatment model for people with mild ID and antisocial PD that incorporated a clear focus on relating styles was described by Miles (1969a, 1969b) who argued that the Therapeutic Community (TC) model provided the patient with the opportunity to develop pro-social and healthy relationships with both peers and the staff team.

Little appeared in the ID literature in relation to treatment settings that explicitly focused on the interpersonal relationships for this population until the publication of a series of papers describing work conducted at the national High Secure Learning Disability Service at Rampton Hospital Taylor et al. 2012; Taylor 2013). Significant changes in interpersonal behaviour were found, including reduced interpersonal hostility and violence, reduced anxiety, and impression management (Morrissey et al. 2012), feeling less defective and shameful about themselves, less vulnerable to harm, more confident to express emotions and having a reduced sense of entitlement (Morrissey and Taylor 2014). Taylor (2015) replicated findings in a medium secure service for men with ID and PD.

Using a similar, Cognitive-Analytic Informed treatment model which aimed to promote supportive relationships among offenders with ID and PD across medium and low secure settings, other research (Clayton and Crowther 2013; Crowther et al. 2013) has reported reduced violence and increased skills of negotiation, compromise, and perspective taking.

In sum, findings highlight the relevance of the interpersonal context when considering effective treatments for offenders with ID and PD. It stands to reason that treatment will be enhanced if such services can utilise an assessment tool that highlights their relational difficulties and present findings in a manner that is accessible for people with ID. The Person's Relating to Others Questionnaire (PROQ) has been adapted and developed in order to facilitate this process. The remainder of this chapter describes the adaptation of the PROQ for offenders with ID and concludes with a case illustration of how the tool, based on Relating Theory (Birtchnell 1993/1996), can add value to treatment for people with these complex needs.

Development of the PROQ for Offenders with ID and PD

The PROQ (Birtchnell and Evans 2004; Birtchnell et al. 1992, 2013) was designed to measure negative relating. The psychometric properties of the shorter version (the PROQ3) are satisfactory (Birtchnell

et al. 2013) and a range of norms have been established, including with offender populations. Similarly, the PROQ3 has been shown to measure change over time in offenders with PD (Birtchnell et al. 2009). As the PROQ is used routinely in prison-based therapeutic communities (e.g. see Birtchnell et al. 2009) it was necessary to adapt the measure in order to retain it as a core measure in newly opened TCs for prisoners with ID (and has subsequently been used as a core outcome measure in a health-based medium secure forensic ID service). The language content of the PROQ3 was adapted in order to increase understanding, whilst the initial flavour of each item was retained. This adapted measure has been named the Person's Relating to Others Questionnaire Adapted for Intellectual Disability (PROQ-ID). In order to establish its reliability, 40 volunteers were asked to complete it along with the original PROQ and the results on each of the 8 scales were then compared to ensure that the adapted version returned similar profiles to the original one. High correlations between the two versions suggested that the intent of the original scale has not been lost in the process of adaptation and that the adapted version continued to measure the same constructs as the original PROQ.

As the PROQ-ID measures negative patterns of relating it highlights particular relating styles where an individual may experience difficulty. It is also important to consider that an individual may also have skills in each different relating style and the profile does not imply overall deficits per se, but rather areas for further development.

Piloting the PROQ-ID

A total of 48 men completed the PROQ-ID from across the four therapeutic communities for offenders with ID; three of these were located within Her Majesty's Prison Service and one in a medium secure mental health service in England and Wales. The mean age of the prisoner sample was 34.0 (SD = 8.9) compared to 26.0 (SD = 3.9) for the patient sample. There was an entrenched pattern of antisocial behaviour across both service provisions and an average period of detention of approximately 6 years. Both prisoners and patients began offending at a young age (M = 16.0 vs. 15.0), though the prisoner group had a greater number

of convictions ($M = 20$ vs. 6.0). Perhaps unsurprisingly, the patients had a more significant level of ID than the prisoners. The PROQ-ID was administered in the form of a semi-structured interview accompanied by guidelines for delivering psychometric assessments to people with ID. PROQ-ID scores were used to contribute to the identification of offenders' treatment needs and a treatment pathway.

Case Study

Figure 22.1 provides a typical profile of relating difficulties experienced by male offenders with ID and PD. As is evident, some difficulties are apparent in all areas of relating though the degree of these difficulties is typically relatively minor in some domains. The most prominent areas of interpersonal difficulty appear to occur in *distant* relating, particularly upper distance (UD) and neutral distance (ND). These difficulties may arise because people with ID are typically in need of greater support from carers (or teachers, family members, etc.) and may therefore develop *functional dependence* (and therefore closeness) on others in order to achieve tasks of daily living. This type of dependence may inhibit the development of relational skills that are fundamental to distant relating.

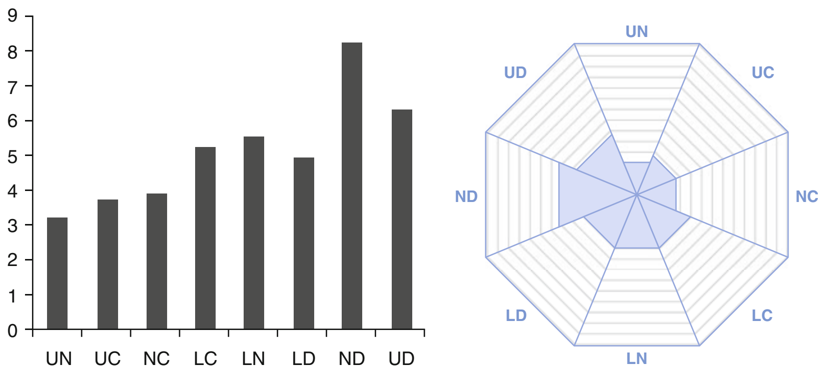

Fig. 22.1 An example PROQ-ID profile for a male offender with intellectual disability and personality disorder

In other words, as people with LD may be embedded in support networks that promote closeness they may have little opportunity to rehearse the skills necessary for more (positive forms of) distant relating.

A significant difference was shown between the distant relating (neutral distant and upper distant) and close relating (neutral and lower close). Similarly, there was a significant difference between some distant relating scales (upper and neutral distant) and one neutral relating scale (upper neutral), but no significant differences between the upper and lower relating scales. This would suggest that a typical profile of the relating tendencies of offenders with ID would be somewhat intimidating, suspicious, and uncommunicative, perhaps as a consequence of the prominent difficulties that are typically experienced when trying to relate from an upper or distant style.

Practical Application of the PROQ-ID

The strength of the PROQ-ID lies in its ability to represent a complex concept in a meaningful and motivational manner. A unique feature of all versions of the PROQ is the way in which the scores can be represented as shaded areas within the Interpersonal Octagon (see the far right of Fig. 22.1). When working with individuals with ID, the presentation of information in a pictorial style can facilitate learning and comprehension and the PROQ-ID therefore supports those with ID to understand their patterns or relating in a more clearly presented manner.

To develop the use of the pictorial octagon further, individual offenders can be taught about the relating deficiencies within each section of the octagon. Again, these can be presented pictorially and/or can be labelled in relation to specific deficient behaviour that a particular person demonstrates. For example, in Fig. 22.2 an individual's three primary areas of deficient relating have been highlighted and represented in a pictorial manner. The specific pictures used were developed with the individual himself in order to enhance the personal meaning of the octagon. Finally, examples of an individual's relating deficiencies are used to highlight how difficulties interfere with quality of life and positive relationships.

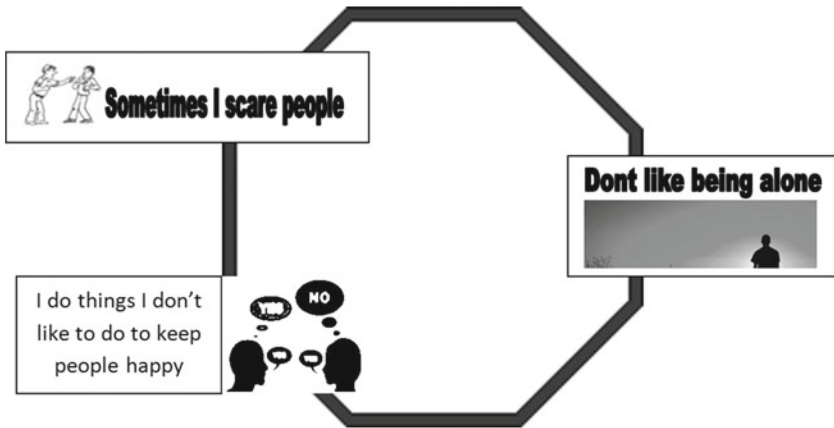

Fig. 22.2 Pictorial representation of an intellectually disabled offender's problematic relating tendencies

Relating deficits can then be turned into an 'approach goal' in order to motivate prisoners/patients to engage with treatment (see Fig. 22.3). The emphasis in Relating Theory is that the various relating styles are not problematic per se, but rather the means utilised whilst relating from a particular position cause interpersonal difficulties. The theoretical basis of the PROQ-ID therefore allows the treatment to emphasise the skills that a person does have in any particular octant. Drawing on an individual's positive capacities alongside their difficulties, this models many of the interpersonal qualities that treatment seeks to promote and provides prisoners/patients with lived experience of healthy and sustainable styles of relating.

Discussion

The adaptation of the PROQ for use with people with ID allows services to replicate the benefits found in non-ID services. The adapted version described in this chapter (the PROQ-ID) has been found to correlate highly with the original PROQ3, ensuring that clinicians in ID services can use the measure with confidence that it continues to assess the same

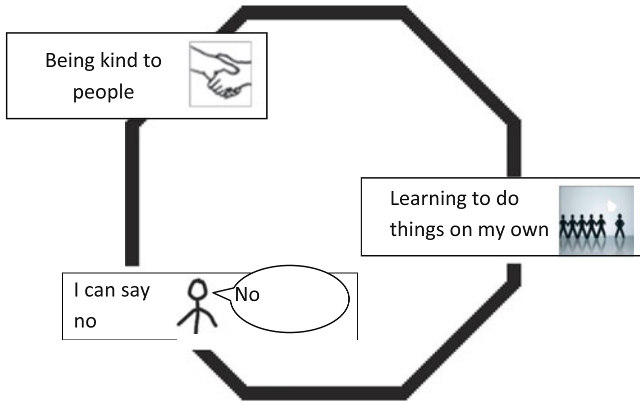

Fig. 22.3 Treatment targets for an intellectually disabled offender developed from the PROQ-ID

constructs as the original version. The foundation of the PROQ-ID within Relating Theory offers a positive approach to working with skill deficits and the identification of existing skills, while the presentation of the PROQ-ID in pictorial form enhances the development of a shared understanding of both difficulties and treatment targets for offenders with ID. Thus, although outcome data are not yet available, the PROQ-ID is an aid to treatment within forensic settings with three primary benefits; motivation, collaborative formulation, and the development of positive relating skills. In addition, the PROQ-ID can be readministered as men prepare to leave the treatment setting and changes in the PROQ-ID profile can be used to inform post-treatment reports.

The motivational aspect of the PROQ-ID comes from the basis of Relating Theory and a positive approach that recognises the presence of strengths in all styles of relating, even when an individual demonstrates a strong negative relating style within an area of the octagon. This positive approach offers a motivational aspect when working with people who have experienced negative relationships, particularly with those in positions of authority. Many people with ID and PD have experienced repeated rejection from services, ranging from schooling to psychiatric services to prison treatment programmes. These experiences are likely to resonate with early experiences of loss and difference where the individual

with ID has had to confront the tentative nature of their inclusion within various social systems. The PROQ-ID does not overcome these experiences of *disability*, but the positive nature of Relating Theory ensures that individual relating difficulties are located within a framework that also recognises *ability*.

Using the PROQ-ID also allows practitioners to develop a collaborative working alliance. For many people with ID and PD, their experience of others is often negative, being likely to have experienced early separation and rejection as well as multiple care placements. The administration of the PROQ-ID, the interpretation of the eight scales within the octagon, and the development of meaningful representations of the octagon, enable the practitioner to develop a therapeutic relationship that embodies positive relating styles. Clinicians are encouraged to model the positive aspects of each relating style.

A third benefit afforded by the PROQ-ID is the manner in which the focus can be turned into approach goals. One of the challenges facing clinicians working with individuals with ID and PD is how to understand the interplay of the intellectual difficulties with the interpersonal problems associated with PD, and how to disentangle the primary causal factors behind negative relating styles. Practitioners often view difficulties as arising from either the ID or the PD rather than appreciating the subtleties of the interaction. The PROQ-ID can support those with ID/PD to begin to understand how their relating styles may arise by having an explicit focus on a range of differing relating styles and on the range of assets and deficits found within each area of the octagon. By identifying areas of difficulty, the PROQ-ID enables clinicians to scrutinise the differing areas of relating that inhibit the development and maintenance of reciprocal social relationships.

In conclusion, adopting a tool that allows for this type of consideration would seem imperative when working with individuals who have enduring and complex difficulties with their relating styles. The adaptation of the PROQ-ID extends the benefits provided by Relating Theory and enables both clinicians and clients (in this case prisoners and patients) to build on their positive relating styles whilst also developing understanding and awareness of their more problematic patterns of interaction.

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23

Changes in Offenders' Interpersonal Relating Styles Following Treatment in Forensic Settings

Michelle Newberry

Introduction

Therapeutic Communities

Therapeutic communities (TCs) are based on the Maxwell Jones Henderson Hospital model of democratic therapeutic communities (Hobson and Shine 2000). TCs incorporate behavioural and social learning principles with the individual's experiences and perceptions as mechanisms in the process, and past circumstances and behaviour are explored in an attempt to understand negative attitudes and patterns of dysfunctional behaviour (De Leon 1994). Treatment addresses issues such as impulsive decision making, failure to control anger, substance misuse, and criminal thinking (Milton et al. 2006). The objectives of the TC have been described by Cullen (1994) as helping offenders to: (1) improve their self-confidence and sense of self-worth,

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_23

(2) develop positive relationships with the aim of developing greater consideration for the feelings and belongings of others, and (3) reduce their risk of reoffending.

Research has shown reductions in anti-authoritarian attitudes, hostility, psychoticism, and impulsivity, and improvements in self-esteem following treatment in prison TCs (e.g. Gunn and Robertson 1982; Lees et al. 1999; Newton 1998), and reductions in neuroticism (Dolan et al. 1992) and symptoms of borderline personality disorder (Dolan et al. 1997) in non-secure TCs (Chiesa and Fonagy 2000). However, little research has been conducted to evaluate how far TCs are effective in modifying maladaptive interpersonal tendencies or in promoting competence in relating as defined by Relating Theory.

Relating Theory

Relating Theory (Birtchnell 1993/1996) posits that humans strive to attain four principal relating objectives: upperness (relating downwards from a position of dominance) versus lowerness (relating upwards from a position of subservience), and closeness (seeking intimacy with others) versus distance (self-reliance). Although these objectives are described in terms of pairs of opposites, Relating Theory argues that each position, under certain circumstances, has advantages. These relating objectives can be represented graphically by two intersecting axes: an upper versus lower (vertical) axis, and a close versus distant (horizontal) axis. Intermediate positions which represent a blending of the positions to either side of them are inserted between the four polar positions to create a theoretical structure called the *Interpersonal Octagon* (Birtchnell 1994), each octant of which has a two-word name: upper neutral (UN), upper close (UC), neutral close (NC), lower close (LC), lower neutral (LN), lower distant (LD), neutral distant (ND), and upper distant (UD).

An important feature of Relating Theory is the clear distinction that is drawn between positive and negative relating (see Chaps. 1 and 2). The Person's Relating to Others Questionnaire (PROQ; Birtchnell and Evans

2004; Birtchnell et al. 1992, 2013) specifically measures negative relating and its eight scales correspond to the eight octants of the octagon.

The Relevance of Therapeutic Communities to Negative Relating

Research at Grendon prison TC in the UK revealed the prevalence of personality disorder (PD) to be 88 % (Shine and Newton 2000) and that 47 % of prisoners could be diagnosed as 'psychopathic' using the Psychopathy Checklist-Revised (Hare 1991; Hobson and Shine 1998). Given that PDs 'compromise deeply ingrained and enduring behavior patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations' (World Health Organisation 1992), it is of interest to explore whether individuals with different PDs may get 'stuck' in particular octants of the Interpersonal Octagon, as measured by the PROQ. Birtchnell (1997) found that the ten personality disorders specified in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 1994) can be placed within the octants of the octagon. In addition, scores on the Personality Diagnostic Questionnaire (Hyler 1994) correlate with PROQ scores among offenders in a prison therapeutic communities (PTC; Birtchnell and Shine 2000). What was not known however prior to the current study was whether offenders demonstrate linear reductions in maladaptive relating over the course of treatment in a TC.

The Current Study

This study builds upon research conducted by Birtchnell et al. (2009) which investigated whether the negative relating of offenders (as measured with the PROQ) reduced over the course of treatment in their respective TCs. Birtchnell et al. (2009) compared the negative relating of forensic patients/prisoners at different time intervals, but they did not determine whether there were *linear* reductions in negative relating over the course of treatment and the aim of the current study was to investigate this.

Method

Participants

Forensic Patients

Thirty-eight patients with a mean age of 29.47 (SD = 8.27, range 19–56) completed the PROQ2 at pre-admission, 3 months, and at 9 months during treatment in a medium secure unit (MSU). An MSU is specialist forensic service for individuals with a mental health problem who have been arrested, who are on remand or who have been to court and found guilty of a crime serious enough to warrant medium secure conditions. The MSU operates as a TC and treatment incorporates adapted cognitive behaviourally oriented treatment programmes that primarily address impulsive decision making, failure to control anger, substance misuse, and criminal thinking (see Milton et al. 2006).

Prisoners

One hundred and thirteen offenders with a mean age of 34.23 (SD = 7.9, range 21–62) completed the PROQ2 at admission, 9 months and 18 months during treatment in a PTC. The prisoners had been seconded from their prison of origin to receive treatment in a Category B PTC. Category B prisons in England and Wales are for offenders who require a high level of security in order to make any chance of escape very difficult (Prison Reform Trust 2012). Prisoners choose to enter the PTC and must have served at least 4 years of their sentence in a mainstream prison prior to admission. They must also meet certain admission criteria including that they have been out of high security conditions for at least 6 months, accept responsibility for their offence, have more than 18 months of their sentence left to serve, and have not self-harmed or had a positive drug test for at least 2 months prior to admission (Newberry 2010). Upon completion of treatment in the TC (typically after 18 months), prisoners are returned to the mainstream prison system to finish their sentence.

Measures

The PROQ has passed through three stages of development, and the most two recent versions, the PROQ2 (Birtchnell and Evans 2004) and the PROQ3 (Birtchnell et al. 2013) were used in the current study.

The Person's Relating to Others Questionnaire-Version 2

The Person's Relating to Others Questionnaire-Version 2 (PROQ2) has 96 items that assess relating in each of the 8 octants of the Interpersonal Octagon (see Fig. 1.1). There are 12 items per scale (10 of which are scored and 2 of which are included to relieve the overall negative tone of the questionnaire). Each item is rated on a 4-point scale (3 = 'Nearly always true' to 0 = 'Rarely true'). Thus the maximum score for each scale is 30. Total and scale scores are calculated using computer software which provides both numerical scores and a pictorial representation of scores shaded inside the octagon. There is factor-analytic support for most of the eight scales (Birtchnell and Evans 2004) and they have good internal reliabilities (Birtchnell et al. 2013).

The Person's Relating to Others Questionnaire Version 3

Its 48 items were selected from the PROQ2 items that had high loadings on only one factor, and most of their items were replaced to improve discriminant validity of the UC and LD scales. The Person's Relating to Others Questionnaire Version 3 (PROQ3) has 6 items per scale, 5 of which measure negative relating and are scored on the same 4-point scale (3 = 'Nearly always true' to 0 = 'Rarely true') to produce a maximum score of 15 for each scale. Its psychometric properties are acceptable; its factor-analytic structure has been supported, it shows positive and meaningful correlations with measures based upon the interpersonal circle, and Cronbach alpha coefficients of 0.70 or above have been found in four normative national samples (Birtchnell et al. 2013).

Procedure

The forensic patients had routinely completed the PROQ2 on admission and for the purposes of the study also after 3 and 9 months. Even though the shorter PROQ3 became available in 2001, for the sake of consistency, the longer PROQ2 continued to be used in the MSU. Data were collected from patients over an 8-year period. The prisoners had completed the PROQ3 on admission as part of a routine psychometric test battery, and, for the purposes of the study also after 9 and 18 months. Data were collected from prisoners over a 5-year period. For more information on data selection, see Birtchnell et al. (2009). It must be noted here that because the PROQ2 and PROQ3 were administered to the patients and prisoners, respectively, the mean scores of the samples are not directly comparable. Attrition is a common problem in treatment evaluation research (Hatcher et al. 2011) and the attrition rates for the forensic patient and prisoner samples of the current study are discussed in Birtchnell et al. (2009).

Data Analysis

One-way repeated measures ANOVAs were conducted to compare PROQ2/PROQ3 scores at different time intervals within the samples, and a trend analysis was conducted for each PROQ2/PROQ3 scale to determine whether negative relating reduced linearly over the course of treatment in the two forensic settings. Independent-sample *t*-tests were conducted to compare independent means.

Results

Changes in Negative Relating

For the forensic patients there was a significant difference between the three time periods on four of the eight PROQ2 scales (LC, LD, ND, and UD) as well as the total score, and the effect was linear (see Table 23.1).

Table 23.1 Changes in PROQ2 scores for forensic patients

PROQ2 scale	Pre-admission		3 Months		9 Months			
	M	SD	*M*	SD	*M*	SD	*F*	Linear trend (*F*)
UN	14.8	8.0	13.2	7.1	12.1	6.8	2.35	4.04
UC	15.9	8.3	15.6	7.3	15.3	6.5	0.81	1.69
NC	13.2	8.9	11.4	8.2	12.5	8.9	2.16	0.30
LC	18.0	8.7	14.4	7.4	13.9	8.1	5.68**	8.51**
LN	14.1	8.0	12.0	6.8	12.3	7.5	1.97	1.40
LD	13.3	7.8	10.4	7.3	10.2	6.7	2.94*	4.76*
ND	20.1	6.8	17.0	6.5	14.4	7.1	8.65**	15.37**
UD	14.0	8.3	13.5	7.0	11.0	6.4	3.84*	7.85**
Total	123.5	34.9	107.6	31.0	102.3	34.3	9.68**	9.78**

**p* < 0.05; ***p* < 0.01

Table 23.2 Changes in PROQ3 scores for prisoners

	Admission		9 Months		18 Months			
PROQ3 scale	*M*	SD	*M*	SD	*M*	SD	*F*	Linear trend (*F*)
UN	5.6	4.1	5.7	3.7	5.6	3.5	0.06	0.029
UC	4.8	4.2	3.3	3.7	2.6	3.3	19.91**	34.97**
NC	4.9	4.3	3.6	3.6	3.3	3.5	12.46**	18.52**
LC	7.9	4.4	6.5	4.5	5.6	3.7	17.10**	30.80**
LN	5.7	3.6	4.7	3.3	4.3	3.4	9.16**	14.65**
LD	6.1	3.9	5.0	3.1	5.1	3.2	6.49**	7.84**
ND	8.3	3.9	6.8	3.9	6.0	4.05	18.29**	32.75**
UD	7.1	4.4	6.3	3.7	6.4	3.5	4.45**	4.78*
Total	50.4	21.5	41.7	19.5	38.5	17.8	25.90**	41.20**

**p* < 0.05; ***p* < 0.01

Post hoc Sidak comparisons revealed that for ND, UD, and the total score there were significant differences between all three time points and for LC and LD there were significant differences between pre-admission and 3 months, and between pre-admission and 9 months.

For the prisoners there was a significant difference between the three time periods on seven of the eight PROQ3 scales (not UN) as well as the total score, and the effect was linear (see Table 23.2). Post hoc comparisons revealed that for LC there were significant differences between all time periods, whereas for five scales (UC, NC, LN, LD, ND) and the total score there were significant differences between admission and 9 months, and between admission and 18 months. For UD there was a significant difference only between admission and 9 months.

PROQ Scores of Forensic Patients/Prisoners Who Were Discharged Early Compared to Those Who Completed Treatment

Since attrition is a problem in treatment evaluation research, the PROQ scores of patients/prisoners who were discharged before the end of the treatment were compared with those who completed treatment. Patients who were discharged early had a significantly lower mean baseline LN score compared to patients who completed treatment (13.4 vs. 17.1, $t = 2.17$, $p < 0.05$). Prisoners who were discharged early had a significantly lower mean baseline LD score and a significantly higher UD score compared to prisoners who completed treatment (LD: 5.0 vs. 6.3, $t = -3.02$, $p < 0.01$ and UD: 8.1 vs. 7.0, $t = 2.04$, $p < 0.05$).

Discussion

Changes in Negative Relating

The forensic patients demonstrated linear change during the first 3 months of treatment on the LC (fear of rejection and disapproval) and LD (acquiescent, subservient, withdrawn) scales of the PROQ2. This suggests that patients became less likely to relate in negative lower ways quite quickly after treatment commenced. It is possible that treatment in a hospital setting may promote more positive forms of lower closeness (e.g. seeking care and protection) and lower distance (e.g. being obedient, loyal, and respectful). For the ND and UD scales and the total score, significant additional improvement occurred between 3 and 9 months; these are the scales relating to distance (ND reflects suspicious, uncommunicative, and self-reliant relating, whereas UD reflects sadistic, intimidating, and tyrannising relating), which indicates that the MSU was effective at reducing maladaptive distance over the full course of treatment rather than just the first 3 months, and suggests that patients presented their need for personal space and control in less intimidating ways as treatment progressed.

For the prisoners, significant linear improvement occurred during the first 9-month period on six of the PROQ3 scales (UC, NC, LN, LD, ND, UD) as well as the total score, although there was some continued

improvement during the second 9-month period for all scales (except UD) but it was significant only for LC.

Patterns of Reductions in Negative Relating for Forensic Patients and Prisoners

Although the aim of this study was not to compare the patients and prisoners (they were never comparable because different versions of the PROQ were used and the testing points were not equivalent), it might be interesting to describe similarities and differences in patterns of reductions on particular PROQ2/PROQ3 scales for the two samples over the course of treatment.

For both the patients and prisoners UN scores were relatively low compared to scores on the other scales. Interestingly, UN was the only scale on which the prisoners scored significantly lower than a non-offender community sample (see Birtchnell et al. 2009), which suggests that offenders may not perceive themselves as dominant as they really are or as people would expect them to be. The current finding that neither the patients nor the prisoners demonstrated any significant reduction on UN suggests that offenders who have a tendency to relate in a pompous, boastful, dominating, and insulting manner may be resistant to change. On the other hand, it is important to acknowledge that not all patients/prisoners started from the same baseline PROQ scores, and that for any given scale, considerable improvement can only be registered from a relatively high starting score.

Both samples demonstrated significant reductions on UD (sadistic, intimidating, and tyrannising relating) during a 9-month period in treatment. Unfortunately the patients were not tested again after 18 months so it is not known whether they would have continued to reduce this form of maladaptive relating. Prisoners were tested after 18 months but did not demonstrate any further significant reduction on UD. Both samples demonstrated significant reductions on ND (suspicious, uncommunicative, and self-reliant relating) across the entire duration of treatment. Given that TCs offer a ‘living learning’ environment (Campling 2001) where patients/prisoners live together to learn about and take responsibility for their behaviour it is not surprising that spending time in a TC promotes less distant interpersonal relations.

The final similarity between the patients and prisoners was that both demonstrated significant changes in overall negative relating across the full time in treatment, which indicates an overall improvement across various maladaptive areas of relating. However, because the current study investigated changes in negative relating among offenders in general it is not known whether different types of offender would show greater or less improvement in relating over the course of treatment. Newberry and Birtchnell (2011, see also Chap. 18) found that offenders convicted of particular types of offence could be differentiated on the basis of their PROQ3 scores on admission to the same PTC. For example, violent offenders were more intimidating, sadistic, and tyrannising, and sex offenders were more fearful of rejection and disapproval. Research is therefore being conducted (Newberry and Shuker submitted) to investigate whether TC treatment is more effective in reducing maladaptive relating among offenders convicted of particular offences.

There were some interesting differences between the samples. Whereas the patients demonstrated almost all of their reduction in lower close (LC) relating (fear of rejection and disapproval) over the first three months, the prisoners demonstrated continued reductions on this scale throughout the full 18 months of treatment. This suggests that some patients retained a sense of fear after the initial commencement of treatment. Such negative relating among patients is not surprising since many patients referred to this MSU have a personality disorder (Care Quality Commission 2014), and Birtchnell and Shine (2000) reported significant correlations between LC and all ten scales of the Personality Disorder Questionnaire-4 (Hyler 1994). Whilst the prisoners showed reductions in neutral close (NC: fear of separation and being alone) and upper close (UC: intrusive, restrictive, possessive) relating between admission and 9 months and between admission and 18 months, the patients did not show any significant reductions on these scales at all. Again, this suggests that the patients retained a tendency to be fearful of separation/being alone and to be intrusive, restrictive, and possessive, even on completion of treatment. These three closeness scales (LC, NC and UC) seem to differentiate most clearly between the patients and prisoners, prisoners demonstrating reductions in these domains but patients remaining resistant to change in these domains.

Unlike the prisoners who showed significant reductions in lower neutral (LN) relating (i.e. helpless, shunning responsibility, self-denigrating), the patients did not show any reduction on this scale at all. This seems to fit with the findings noted above concerning LC, NC, and UC; a person who is fearful of rejection or being alone is also likely to feel helpless and be self-denigrating. Together, these findings suggest that the patients were particularly resistant to change in the lower and closeness domains of the Interpersonal Octagon. This is not entirely surprising since a hospital setting (in contrast to a more punitive prison setting) may be more likely to engender a tendency for people to relate in lower (subservient) and close (dependent) ways.

The prisoners showed more significant reductions in negative relating overall (seven scales and the total score compared to four scales and the total score for the patients). Birtchnell and Shine (2000) used the PROQ2 to assess a different sample from the same PTC and found that their mean scores were also lower than those from patients from the same MSU, so it is reasonable to conclude that the patients have more negative relating tendencies than prisoners. This is not entirely unexpected since offenders in a PTC (who volunteer to go there and who must accept responsibility for their offending behaviour) do not necessarily have the kinds of interpersonal problems that offenders with mental health problems have, or perhaps they are less aware of them. Also, prison populations are more inclined than clinical populations to underreport psychopathology (Lees et al. 2006). However, this difference could be solely attributable to the fact that the prisoners were tested over a longer time span (admission to 18 months compared to pre-admission to 9 months for patients), meaning that prisoners had longer to reduce their maladaptive relating. The fact that prisoners demonstrated sustained improvement on some PROQ3 scales over 18 months suggests that it is desirable to keep prisoners in treatment for at least this long (Genders and Player 1995). In fact, Shuker and Newton (2008) observed that while mental health scores improve relatively early in treatment, significant improvement on criminogenic risk-related scales occurs only in those prisoners who remained in treatment for a year or more.

Relating Tendencies of Forensic Patients/Prisoners Who Completed Treatment Compared to Those Who Were Discharged Early

There was evidence in both treatment settings that reductions in negative relating on some scales of the PROQ2/PROQ3 were sustained. However, because TCs tend to promptly discharge prisoners/patients for non-compliance/non-engagement it is not known whether such clear linear reductions would be found if non-compliant patients/prisoners were retained in the samples at all of the time points. What is known is that the relating tendencies of patients and prisoners at baseline (pre-admission/admission, respectively) differed significantly on the LN, LD, and UD scales.

Specifically, patients who completed treatment scored lower on LN (i.e. were less helpless, shunning of responsibility, and self-denigrating) than those who were discharged early. This is not entirely unexpected since a common criterion for admission to a TC is acceptance of responsibility of one's behaviour. Secondly, prisoners who completed treatment scored higher on LD (i.e. were more acquiescent, subservient, and withdrawn) and lower on UD (i.e. were less sadistic, intimidating, and tyrannising) than those who were discharged early. This is not surprising since the lower scales of the PROQ are more associated with compliance and UD is more associated with an antisocial personality (Birtchnell and Shine 2000).

Limitations of the Study

It is important to consider that because the PROQ is a self-report measure of negative relating, patients/prisoners could 'fake good' their scores in an attempt to obtain sympathy or early release. Indeed, for the patients it was surprising that reductions in negative relating were registered so quickly, since Birtchnell (2002) found that the high PROQ2 scores of psychotherapy patients did not reduce significantly over a 9-month period and that scores sometimes did not improve even after several months of therapy. However, the sample in Birtchnell's study consisted of psychotherapy patients and not offenders. Newberry and Shuker (2012) also found that a different sample of prisoners in this TC had a ten-

dency to portray themselves in an exaggeratedly positive light, although this was not tested throughout the course of treatment. Nevertheless, the current findings must be treated with caution. It would be useful for future research to include a scale for examining social desirability bias and to determine whether changes recorded with the PROQ correspond with changes recorded with other psychometric measures and/or clinical observation.

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24

Further Directions for Research on Relating Theory

Argyroula Kalaitzaki, Michelle Newberry, and John Birtchnell

Introduction

This chapter is divided into two sections: the first refers to the measures that have been developed from Relating Theory and the second to the application of the theory and measures in clinical and forensic contexts. These parts are interwoven and inextricable; since measures comprise the means to conduct research, in a way, the development of a measure constitutes the application of the theory. For these reasons, this chapter will follow the same structure.

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3_24

Measures Developed from Relating Theory

Research on the Psychometric Properties of Relating/Interrelating Measures

A number of measures have derived from Relating Theory (see Part II of this volume), all of which are based either on the first relating measure, the Person's Relating to Others Questionnaire (PROQ), or the first interrelating measure, the Couple's Relating to Each Other Questionnaire (CREOQ). Some of them are shortened versions of already existing longer ones [e.g. the Person's Relating to Others Questionnaire Version 3 (PROQ3)], and others modifications [e.g. the Person's Relating to Others at Work Questionnaire (PROWQ)]. Their psychometric properties have been presented in relevant chapters (e.g. 3–11), yet further research should focus on addressing the drawbacks of the measures (such as the difficulty in distinguishing between the UN and UD items of versions of the PROQ3; see Chap. 4) and further refining these measures. Advanced statistical procedures are required, to determine the underlying structure and octagonal higher order of the newly developed measures [e.g. the shorter version of the Family Members Interrelating Questionnaire (FMIQ); see Chap. 7] or of other recent modifications [e.g. the PROWQ and the US as a Job Share Questionnaire (USJS); see Chap. 10] and to produce norms for diverse samples. It has, however, been proven that all measures subsequently derived from the original PROQ2 maintain robust psychometric properties, such as the PROQ3 (see Chap. 4). Once the reliability and validity of these instruments have been established, clinicians would be equipped with tools to estimate their clients' interpersonal difficulties in addition to their clinical experience and observation. These instruments may also assist therapists in planning therapeutic interventions.

The Translation of Relating/Interrelating Measures

The PROQ3 has been translated into four languages (Birtchnell et al. 2013) and applied in various samples, such as psychotherapy patients (Chaps. 13 and 14), offenders (e.g. Chaps. 18 and 22), sex offenders

(e.g. Chap. 17), non-offenders with psychopathic personality traits (e.g. Chap. 20), prison samples (e.g. Chaps. 18 and 23), and non-patients/student samples (Birtchnell et al. 2013; Kalaitzaki and Birtchnell 2014; Kalaitzaki et al. 2010). Not many instruments are available in languages other than English; the Person's Relating Interview (PRI) and Observation of Relating Behaviour (ORB) are available in Italian and Greek, the FMIQ, the CREOQ, the Person's Positive Relating to Others Questionnaire (PPROQ), and the Observed Person Relating to Others Questionnaire are available in Greek, and the Us as a Couple Questionnaire (US) is available in Greek and Dutch. Hopefully, the relating/interrelating measures will also be translated into other languages and their application will be expanded in diverse samples, various age groups and settings to spread their use.

Internet-Administered Versions of the Relating/Interrelating Measures

As we have rapidly moved to the age of information and communication technologies, a further advancement of the existing measures would be their establishment through the Internet and the investigation of whether the Internet-administered versions maintain the psychometric properties of the standard written versions. The advantages of the Internet-administered versions include, but are not limited to, recruitment of large numbers of participants not easily accessible otherwise, time-saving, ease of administration, and automated scoring, which makes the results readily available to the respondent (Gosling et al. 2004; Reips 2000). The Internet-administered version of the PROQ3 and its Greek, Dutch, and Italian translations are available upon request. They have been proven equivalent to the standard written forms (Kalaitzaki et al. 2015; see also Chaps. 3 and 4). It is hoped that other relating/interrelating measures will be also developed online in due course (e.g. CREOQ, FMIQ). Because the FMIQ derived from the CREOQ, which in turn derived from the PROQ3, it is anticipated that equivalent Internet-administered versions of these questionnaires can be readily produced. Since both the CREOQ and FMIQ are sets of questionnaires, each comprising four measures

to assess an interrelating dyad, administering the questionnaires via the Internet potentially entails the risk that some members may be unwilling to complete the questionnaires. Failure to collect complete data is likely to result in a distorted picture and bias the results. Undoubtedly, this would be a demanding enterprise.

Supplementing Self-Report Ratings of Relating/Interrelating with Ratings by Others

Although self-report measures are useful for capturing an individual's subjective experience, a major problem is the issue of validity, particularly construct validity (i.e. a measure's ability to measure what it has actually been devised to measure), which may be decreased for many reasons. Measures tend to rely on the respondent's honesty, their introspective ability to provide an accurate or nuanced response, their level of understanding and/or interpretation of particular questions, and response bias (Hoskin 2012; Jahedi and Méndez 2014). For instance, prisoners may be inclined either to present themselves in an exaggeratedly positive light in order to obtain early parole (see e.g. Davis et al. 2012) or to portray an overly negative impression of themselves in order to obtain a limited treatment placement (Newberry and Shuker 2012). People may also not be able to perceive their own relating difficulties objectively, due to severe relating or mental health problems. Considering these issues, PROQ3 scores may not necessarily be an accurate reflection of how respondents really relate to others, and research that relies solely on self-report ratings must be treated with caution, particularly when there are reasons to believe that an individual may respond in an untruthful manner.

For addressing issues of honesty and response bias (i.e. the tendency to minimise disclosure of socially undesirable behaviour), the Limited Disclosure Scale of the Personal And Relationships Profile (PRP) (Straus et al. 1999/2007) can be administered. In addition, supplementing self-report measures with observational ratings could provide a more accurate assessment. For this reason, the OPROQ and ORB (for individuals), the CREOQ (for couples), and the FMIQ (for families) have been developed (see Chaps. 9, 5, and 7 respectively) and compared with an individual's

self-ratings of his/her relating tendencies (see Chaps. 14 and 16). An advantage is that both partners/family members or other persons (e.g. members of a group) complete the measure and so the assessment of that person's relating/interrelating is more objective than if only one person were to judge his/her (inter)relating. Alternatively, self-report ratings could be complemented with interviews (Harris and Brown 2010), such as the PRI (see Chap. 9). The advantages of collecting data from various sources (the so-called 'multiple perspective approach') has been well documented (Cullerton-Sen and Crick 2005; Klonsky et al. 2002), as already suggested by Kalaitzaki in Chap. 7. Future research should address these potential drawbacks by comparing quantitative self-report ratings with observational ones, or even better with qualitative data, such as interviews.

Measuring Relating/Interrelating in Other Contexts

The lack of an instrument which identifies and assesses human relating/interrelating in work settings has been recognised and for this we (the editors) have welcomed the PROWQ and USJS to assess individuals' readiness to job share (see Chap. 10). Nowadays, organisations are concerned with the need to recruit, retain, and realise the full potential of their human resources, since poor relationships with co-workers and employers can impact negatively on employees' productivity within the organisation (Fitzgerald and Danner 2012; Smith 2013). Industrial organisational (I-O) psychologists are concerned with the study of individual or group attitudes and behaviour in the workplace. Having an instrument to assess and understand relating/interrelating in this context may be of use. For example, I-O psychologists could aim to improve the relating/interrelating inadequacies of employees in these areas, which could result in further improvements in their work satisfaction, productivity, health, and well-being. In line with this, two modifications of the PROQ and US have been developed to apply to the workplace with the purpose of assessing the relationships between co-workers, and results will be available soon (Tampakaki in press). Hopefully relating/interrelating research will be conducted in other contexts too.

Measuring the Positive Aspects of Relating/Interrelating

A gradual shift in therapeutic approaches has occurred over the past few decades, from the traditional ones that highlight deficits, shortcomings, and dysfunction to more postmodern approaches proposed by Positive Psychology that focus on the enhancement of clients' positive attributes, such as values, skills, strengths, and resources which may contribute to happiness and well-being (Seligman and Csikszentmihalyi 2000). For this reason, versions of the relating/interrelating instruments which assess positive relating may be useful. Kalaitzaki and Hammond (see Chap. 11) have already developed the PPROQ, which specifically focuses on an individual's positive relationships.

This shift towards Positive Psychology has also occurred in the field of marriage and family therapy (Murray and Forti 2009). For example, Solution-Focused Therapy suggests that positive changes occur through emphasising clients' strengths and resiliencies (Murray and Murray 2004). However, few empirically sound instruments exist to measure issues such as the support available in a couple's relationship (e.g. the Couples Resource Map Scales; Murray and Forti 2009), satisfaction within the relationship (e.g. the Relationship Assessment Scale; Hendrick 1988), the skills/competencies of those in the relationship (e.g. the Epstein Love Competencies Inventory; Epstein et al. 2013), or communication and conflict resolution (e.g. the PREPARE; Fowers and Olson 1986; the RELATE, Holman et al. 1994).

Strengths-based instruments for families are also limited. Those that do exist measure the positive aspects of family functioning (the Family Functioning Style Scale; Dunst et al. 1988), the adequacy of resources of both intrapersonal and interpersonal support in households with young children [the Family Resource Scale (FRS); Dunst and Leet 1987], protective factors that contribute to family resilience (the Inventory of Family Protective Factors; Gardner et al. 2008), empowerment in families whose children have emotional difficulties (Koren et al. 1992). A few others are available, such as the Family Inventory of Resources for Management (McCubbin et al. 1996), the Family Hardiness Index (McCubbin et al. 1986), and the FRS (Van Horn et al. 2001). In sum, to the authors'

knowledge no such instrument exists to assess positive interrelating between partners/couples or families across the eight states of relatedness posited by Relating Theory (Birtchnell 1993/1996). Therefore, the development of such measures is a priority. These might help improve couple/family therapy by evaluating change and therapy effectiveness, and ultimately help to improve many relationships. Based on the already existing measures of negative interrelating (i.e. the CREOQ and the FMIQ), they would be called the Couple's Positive Relating to Each Other Questionnaire and the Family's Member Positive Interrelating Questionnaire, respectively.

Clinical and Forensic Applications of Relating Theory and Its Associated Measures

Research on the Effectiveness of Relating Therapy

Unfortunately, the efficacy of Relating Therapy has not yet been determined. Research has been conducted with other modes of therapy (see Chap. 17) which has shown improvements in family members' interrelating despite them not being regularly involved in the patient's individual therapy and that the therapy had not been specifically targeted at ameliorating patients' (inter)relating difficulties. This was a limitation of the study, as recognised by Kalaitzaki et al. (2010), which precluded firm conclusions as to what led to the improvements. It would therefore be valuable for future studies to focus specifically on reducing interrelating deficiencies within the family, either through Relating Therapy or other modes of therapy, and to investigate whether any changes following therapy are sustained and for how long. Exemplary work is that of Nestoros (see Chap. 15) who has shown that acknowledging and working through stressful family interrelating resulted in the disappearance of schizophrenic symptoms without ever making the symptoms themselves the focus of the therapy.

Comparing the outcome of Relating Therapy, which specifically aims at improving relating/interrelating difficulties, with other forms of therapy which do not specifically focus on improving such difficulties would

be a worthwhile endeavour. In addition, further research needs to establish whether similar outcomes can be produced in diverse samples.

Incorporating Principles of Relating Therapy into Other Forms of Therapy

Although Relating Therapy may not be the model of choice for some therapists, incorporating the principles of Relating Theory into their theory and clinical practice could enhance their understanding, assessment, and interventions for treating the relating difficulties that their clients face. It is encouraging that clinicians with various theoretical backgrounds (e.g. psychoanalysis) have either applied Relating Theory and its associated measures in their clinical practice (e.g. Chap. 16) or gone beyond this and amalgamated their practice with principles from Relating Theory (e.g. *Synthetiki Psychotherapy*; see Chap. 15). Relating Therapy can be incorporated into diverse therapeutic models since it is a contemporary interpersonal approach which does not contradict other approaches, but rather complements them (Kalaitzaki and Nestoros 2006). We therefore encourage other theories to consider the principles of Relating Theory/Therapy. Comparing the outcomes and effectiveness of these models with those that apply solely the principles dictated by their orientation would be an interesting endeavour.

A Positive Psychology Approach

It would be interesting for Relating Therapy to align itself with the concepts and principles of Positive Psychology in order to streamline its theoretical background with current trends and developments. The efficacy of this new 'renovated' form of Relating Therapy could then be compared with the efficacy of traditional Relating Therapy which mainly focuses on negative relating. The therapist/counsellor, should he/she be familiar with the field of Positive Psychology, may work on two parallel levels: to assist clients/patients to recognise and overcome their relating deficiencies as well as to highlight their interpersonal strengths and competencies. Even if positive relating tendencies have been superseded by

negative ones, attention can be drawn to these more positive tendencies by depicting them graphically. The adapted version of the PROQ to Support Offenders with Intellectual Disability and Personality Disorder offers a positive approach to working with skills (see Chap. 22). Further attempts should be made in other fields too.

In recent years, the forensic psychology literature has begun to explore the value of positive strengths-based approaches for the rehabilitation of offenders, such as the Good Lives Model (Ward and Stewart 2003). This model of rehabilitation seeks to promote 'goods' and manage or reduce risks to achieve these goals (Ward and Langlands 2009). However, offenders need to develop the attitudes, values, skills, and resources necessary to develop a lifestyle that is meaningful and does not impinge upon other individuals (Ward and Langlands 2009). Understanding the ways in which offenders relate negatively to others (and how others perceive their relating behaviour) could be a crucial step forwards in this direction.

Internet Interventions/e-Therapy

The advancement of electronic communication-based technology over the past decade, such as the Internet and mobile device applications, has resulted in the rapid dissemination of Internet interventions to treat mental illness and to enhance well-being. Although e-therapy programmes for various mental health problems have been developed and appear to be delivering promising outcomes (e.g. Donkin et al. 2011; Loucas et al. 2014; Menovshchikov 2010) further research is encouraged to establish the effectiveness of e-therapy. An apparent next step would possibly be providing Relating Therapy through the Internet and to compare the effectiveness of online and offline Relating Therapy.

The Need for Methodologically Robust Studies

Methodologically robust studies in the field of therapeutic evaluation research are lacking; many report successful outcomes in clinical and forensic contexts but do not report the success rates for a control group, do not randomly allocate participants to the conditions, or do not match

treatment and control groups on important variables. For example, many forensic studies do not match offenders according to their risk of reoffending (see Looman et al. 2000) and potential extraneous/confounding variables are not controlled (see Polizzi et al. 1999). Despite the difficulties of conducting randomised control trials, in which the efficacy of the treatment under scrutiny for the treatment group is compared alongside a matched control group, and where subjects in these two conditions are randomised from the start, they are recommended by the authors. However, an additional problem exists with identifying 'treatment' and 'control' groups since many of those engaging in the treatment under study (patients, offenders) will have already taken part in some other form of treatment prior to the one under study, which may influence/bias the success of the current treatment.

Another limitation with therapeutic evaluation research is that studies often involve short follow-up periods. Although this is understandable since attrition is a problem among both psychotherapy patients (Beckham 1992; Roseborough et al. 2015) and prisoners (Hatcher et al. 2011; Olver and Wong 2013), research is needed to determine the longer-term benefits of therapeutic interventions in terms of ameliorating negative relating in these populations. For example, in Chap. 23 reductions in negative relating among offenders during treatment in a therapeutic community prison were shown; but did this lead to longer-term behavioural change? Studies must be conducted to track offenders' journeys through the prison system to release and beyond.

Providing Relating/Interrelating Feedback

Although providing feedback to respondents (e.g. clients, offenders) through the disclosure of their psychopathology scores has proven effective (e.g. Knaup et al. 2009), no studies to date have examined whether providing feedback on relating/interrelating could be similarly effective for therapy outcome. Research should also be conducted on the effectiveness of feedback effects in the area of relating/interrelating (often referred to as 'patient-focused research'; Lambert et al. 2001). Routinely tracking and disclosing clients' relating/interrelating could potentially

enhance the treatment outcome of Relating Therapy. To the respondents who are familiar with the basic concepts of Relating Theory (i.e. the eight states of relatedness), the graphic representation of the scores within the Interpersonal Octagon could facilitate recognition and understanding of their relating/interrelating deficiencies and strengths.

The Circumstances Under Which Relating/Interrelating Changes

Therapists can acknowledge significant moments in therapy when something important happens to shift a client's awareness, elicit powerful emotions, or when things fall perfectly into place (Mahrer et al. 1990). However, scant research exists, which dictates that in many cases there is a lack of agreement between therapists and clients over the turning points in therapy or the moments that are significant for the client and, therefore, research is needed to enlighten our understanding of these issues. For example, is there a profound moment that individuals become cognisant of their relating tendencies, how is their relating perceived by others or impacts upon others, or do they experience more subtle shifts in perception? Is awareness enough to change their relating behaviour or is there something else that influences the shift? People may simply make a conscious effort to alter the way they relate just by becoming aware of how they are perceived by others since most people want to be liked and respected (Baumeister 1982; Bergsieker et al. 2010), but others have no desire to change, even if they relate in the most negative of ways (e.g. see the words of an offender quoted in Chap. 20).

Conclusions

This chapter has highlighted the most important points drawn from research included in this volume. It does not intend to be an exhaustive enumeration of the further directions for research on Relating Theory, but an attempt to critically evaluate the studies and to inspire scholars to conduct future research in the field of Relating Theory. The application

of Relating Theory by the various contributing authors in diverse settings and from various cultural backgrounds and theoretical orientations may bring about further elaboration and modification of the theory. The theoretical background of Relating Theory permits the espousal of, or even amalgamation with, Positive Psychology; both a negative and positive octagon exist to describe and illustrate negative and positive relating tendencies. Relating Theory must seek to further understand positive forms of relating, including their origins and development, and their relation to the negative forms of relating. Hopefully, an updated version of Relating Theory will be published soon.

A clear conclusion which has arisen from our work on this book is that there is room to apply Relating Theory in other fields and contexts beyond the clinical and forensic ones encompassed. We therefore hope that researchers and academics will be inspired by the proposed research applications presented. Relating can be construed either as a dependent variable (e.g. how different variables influence relating) or as an independent variable (e.g. how relating affects other variables). Relating is a universal feature of all humans and for this, it will always be of interest to lay persons and scholars. The many contributors of this volume have demonstrated that Relating Theory not only has its own place in the relevant literature but that it continues to blossom and have ramifications for understanding human behaviour.

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J. Birtchnell et al. (eds.), *Relating Theory – Clinical and Forensic Applications*, DOI 10.1057/978-1-137-50459-3

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