The Intersession Report: Development of a Short Questionnaire for Couples Therapy

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Available online: 10 May 2010

To cite this article: Lee N. Johnson, Scott A. Ketring & Shayne R. Anderson (2010): The Intersession Report: Development of a Short Questionnaire for Couples Therapy, The American Journal of Family Therapy, 38:3, 266-276

To link to this article: http://dx.doi.org/10.1080/01926181003780142

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The Intersession Report: Development of a Short Questionnaire for Couples Therapy

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This article describes the Intersession Report, a short, easily administered nine-item questionnaire that clients complete at the beginning of each therapy session. This questionnaire was developed to enable clinicians and researchers to routinely collect standardized data on clients. Results showed that the Intersession Report has three subscales that represent Functioning, Symptoms, and Alliance. The subscales scores demonstrated multiple forms of validity and reliability. The Intersession Report provides clinicians a quick and easy way to assess clients. It also provides researchers information on clients who discontinue therapy and information that can be used in assessing attrition bias.

INTRODUCTION

Three questions can be asked to demonstrate that therapy works, “(a) Does it work under special, experimental conditions? (b) Does it work in practice? and (c) Is it working for this patient?” (Howard, Moras, Brill, Martinovich, & Lutz, 1996, p. 1059). A large proportion of the research in the field of...
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marriage and family therapy (MFT) has focused on the first two questions, demonstrating the efficacy and to a lesser extent the effectiveness of MFT. Efficacy and effectiveness research only demonstrate that treatments work in general. Of equal or greater importance to researchers and clinicians is determining whether treatment is working for individual clients. In order to answer this question, leading researchers have stated the necessity of valid and reliable instruments allowing clinicians and researchers to assess client improvement session-by-session (Howard et al., 1996; Pinsof & Wynne, 2000).

People frequently drop out of marital and family therapy (Allgood & Crane, 1991; Anderson, Attilano, Bergen, Russell, & Jurich, 1985; Bischoff & Sprenkle, 1993) leading to missing data which introduces a potential for attrition bias, and proves troublesome for analysis and interpretation of clinical data. Session-by-session assessment could reduce this problem by providing more data points. Attrition analysis would be more sophisticated, allowing researchers to compare participants at various time points using more information. Session-by-session data collection also assures that at least some termination data will be available for participants who do not keep scheduled appointments or who terminate without notice. Such an assessment will also enable researchers to answer questions about the process of change over the course of treatment using data analysis strategies that take into account multiple data points.

Questionnaires for assessing client progress on a session-by-session basis have been developed in individual therapy (Lutz, Lowry, Kopta, Einstein, & Howard, 2001). This paper presents the development of the Intersession Report (IR) a short, valid, and reliable instrument that can be used repeatedly over the course of treatment in couple and family therapy.

METHODS

Participants

Participants were \( N = 302 \) individuals who attended therapy as a couple at two marriage and family therapy clinics in the southeastern United States. Participants were recruited from all couples that presented for therapy. On average males were 31.5 (SD = 8.37) years old and females were 28.8 (SD = 7.07) years old. Participants had been in their current relationship for 6.2 (SD = 6.04) years, had one child, and reported their relationship as heterosexual. Most participants reported being Caucasian (male 82.8%; female 76.8%) and high school (male 29.8%; female 24.5%) or a bachelor’s degree (male 22.5%; female 27.8%) as their highest level of education. Household income was evenly distributed and ranged from under $5,000 to greater than $40,000. The average score on the Revised Dyadic Adjustment Scale (Busby, Christensen, Crane, & Larson, 1995) was 35.1 (SD = 7.74) for males and
34.2 (SD = 9.36) indicating that couples in this sample were experiencing relational distress.

Item Development

The IR is a nine-item self-report, Likert-type measure of client functioning completed by clients prior to each therapy session. The authors developed the questionnaire in three phases. First, six areas of interest were identified: emotional and mental health, relationship satisfaction, social role functioning, rating of progress to date, expected progress, and the therapy alliance. Individual items were then generated to operationalize and measure the areas of interest. These items were then presented to six MFT researchers/clinicians as well as doctoral and Master's level student therapists at two universities with COAMFTE accredited programs. The final questionnaire is presented in Appendix A.

Instruments

**Outcome Questionnaire 45.2 (OQ-45.2; Lambert et al., 1996)**

The OQ-45.2 is a 45-item, 5-point Likert-type questionnaire. The OQ-45.2 asks questions about clients’ subjective discomfort, personal relationships, and roles. The full scale has good test-retest reliability with coefficients ranging from $r = .78$ to $r = .84$ and internal consistency with coefficients ranging from $\alpha = .71$ to $\alpha = .93$. The authors also provide evidence of the concurrent validity of the OQ-45.2 (correlations with other measures range from .53 to .87). Internal consistency for this sample was $\alpha = .94$ for males and $\alpha = .91$ for females.

**Revised Dyadic Adjustment Scale (RDAS; Busby et al., 1995)**

The RDAS is a 14-item, self-report questionnaire to assess a couple’s adjustment to being in a committed relationship. (Crane, Middleton, & Bean, 2000) show that the RDAS is able to discriminate between distressed and nondistressed couples and report a cutoff score of 47, with lower scores indicating clinical distress. The authors report excellent reliability $\alpha = .90$. Internal consistency for this sample was $\alpha = .72$ for males and $\alpha = .78$ for females.

**Experiences in Close Relationships (ECR; Brennan, Clark, & Shaver, 1998)**

The ECR measures attachment in adult relationships on the two subscales of anxiety and avoidance. Each of the items is rated on a seven-point scale. The authors provide evidence of reliability and validity. Internal consistencies for this study were Anxiety $\alpha = .88$ for males and $\alpha = .75$ for females; Avoidance $\alpha = .81$ for males and $\alpha = .75$ for females.
COUPLE THERAPY ALLIANCE SCALE (CTAS; Pinsof, 1994; Pinsof & Catherall, 1986)

The CTAS is an instrument to assess client’s perceptions of their relationship with their therapist. The instrument contains 29 items rated on a seven-point scale. The authors report test-retest reliability $r = .79$. Others have also reported reliability of the CTAS $\alpha = .93$ (Heatherington & Friedlander, 1990). Internal consistency for this sample was $\alpha = .91$ for males and $\alpha = .75$ for females.

Procedures

Data were collected from two MFT clinics in the southeastern United States associated with COAMFTE accredited programs. This study was approved by the Human Subjects Board at both universities and client consent was given for participation. Prior to the first session of therapy, clients completed the OQ-45.2, RDAS, ECR, and provided demographic information. During the first session, clients were instructed to complete an IR prior to the second and each subsequent session and place it in a locked box in the clinic waiting room or give it to the clinic receptionist. Therapists did not collect the IR because it contained items assessing the therapy relationship. Following the directions on many therapy alliance measures, therapists were not shown those scores. By completing the IR prior to the session, responses would not be confounded with the proceedings of the therapy session. Reports completed after the session have the potential to be influence both positively and negatively by session events. Therapy was conducted at the discretion of the therapists. At the end of the fourth session, clients completed the OQ-45.2, RDAS, ECR, and CTAS. After responses to questions measuring the therapeutic alliance were removed, data from the IR and other instruments was returned to the therapist.

RESULTS

Preliminary Analysis

Attrition bias was assessed by determining if those who terminated at any point before the fifth session scored differently on intake information or were different on key demographic variables. Results of independent sample $t$-tests showed no significant differences between individuals who completed and did not complete an IR on either ECR subscale, the RDAS, or the OQ-45.2 for sessions two through five. Results also indicated that clients who terminated at any point before session five were not different on sex, race, income, and education from those who continued therapy. The results of
the evaluation of the IR will be presented in two sections. First, results from an exploratory factor analysis will be presented, followed by information on the reliability and validity of the IR.

Factor Analysis

To understand the underlying structure of the IR a factor analysis was conducted using data from session 2 (the first time participants completed the IR) with principle axis factoring using direct Oblimin rotation. We used a cutoff of .4 or greater to determine where items loaded. A three factor solution explained 66.3 percent of the variance (see Table 1). Factor 1 items represented Functioning and explained 31.1% of the variance, factor 2 represented Symptoms and explained 18.4% of the variance, and factor 3 represented the Alliance and explained 16.9% of the variance.

An unexpected finding was that each factor appeared to be measuring something unique. The correlation matrix among factors showed very low correlations between Symptoms and Functioning \( (r = -0.04) \) and between Symptoms and the Alliance \( (r = -0.04) \), with a moderate correlation between Functioning and Alliance \( (r = -0.29) \). Thus each subscale appears to be unique in the construct it is measuring. To examine the stability of the factor structure across time a second factor analysis was conducted for data collected at the fifth session. The results support a factor structure similar to the one obtained at session two.

Reliability and Validity

Chronbach’s alpha estimates ranged from a low of \( \alpha = 0.74 \) to \( \alpha = 0.90 \) (see Table 2). Convergent and discriminant validity was established by correlating the IR with the OQ-45.2, the RDAS, and the subscales of the ECR (see Tables 3 and 4). We expected the Functioning subscale of the IR to correlate positively

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Factor Loadings of Intersession Report Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item*</td>
<td>Functioning</td>
</tr>
<tr>
<td>Satisfaction with personal relationships</td>
<td>.736</td>
</tr>
<tr>
<td>Positive sentiment, support, and collaboration</td>
<td>.645</td>
</tr>
<tr>
<td>Ability to function at work, school, or home</td>
<td>.604</td>
</tr>
<tr>
<td>Progress toward therapy goals</td>
<td>.585</td>
</tr>
<tr>
<td>The likelihood of problems being resolved</td>
<td>.466</td>
</tr>
<tr>
<td>I feel nervous, anxious, or unsettled.</td>
<td>.020</td>
</tr>
<tr>
<td>I feel hopeless, depressed, or down.</td>
<td>-.022</td>
</tr>
<tr>
<td>My relationship with the therapist</td>
<td>-.028</td>
</tr>
<tr>
<td>The relationship between couple and therapist</td>
<td>.051</td>
</tr>
</tbody>
</table>

*Items are summarized to save space, for complete items see Appendix A.
TABLE 2 Reliability Coefficients of the Intersession Report Subscales

<table>
<thead>
<tr>
<th>Time</th>
<th>Functioning</th>
<th>Symptoms</th>
<th>Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 2</td>
<td>.74 (213)</td>
<td>.77 (226)</td>
<td>.90 (190)</td>
</tr>
<tr>
<td>Session 3</td>
<td>.85 (192)</td>
<td>.84 (195)</td>
<td>.86 (178)</td>
</tr>
<tr>
<td>Session 4</td>
<td>.85 (151)</td>
<td>.90 (153)</td>
<td>.88 (134)</td>
</tr>
<tr>
<td>Session 5</td>
<td>.86 (136)</td>
<td>.88 (138)</td>
<td>.88 (121)</td>
</tr>
</tbody>
</table>

with the RDAS and negatively with the OQ-45.2 and the anxiety subscale of the ECR. The Symptoms subscale was expected to show significant positive correlations with the OQ-45.2 and the Anxiety subscale of the ECR. Finally, we expected the Alliance subscale to be positively correlated with the CTAS.

As expected, Functioning was negatively correlated with the Anxiety subscale of the ECR and the OQ-45.2. The Functioning score was also positively correlated with RDAS. Contrary to our expectations, the Symptoms subscale was not correlated with OQ-45.2. However, this subscale was positively correlated with the RDAS. Symptoms scores were also correlated with the Avoidance subscale of the ECR. The absence of a relationship between the Anxiety subscale and Symptoms is not strange given that the Anxiety subscale is measuring anxiety related to attachment issues and not symptoms of anxiety and depression. The absence of a correlation between the OQ-45.2 and the Symptoms subscale was not expected and raised concerns about the validity of this factor; these concerns were addressed by looking at data from session four. The Alliance subscale of the IR was not correlated with the RDAS, or the ECR Anxiety and Avoidance subscales and only moderately correlated with the OQ, providing evidence of discriminant validity.

Results of correlational analyses from session four showed that the IR Alliance subscale score is correlated with the CTAS total score and was again not highly correlated with the other constructs. Thus it appears the two-item Alliance subscale is measuring some aspect alliance.

TABLE 3 Correlations Coefficients between Intersession Report From Session 2 and Intake

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Functioning</td>
<td>—</td>
<td>.27** (220)</td>
<td>—.09 (227)</td>
<td>—.05 (219)</td>
<td>—.26** (219)</td>
<td>.19** (212)</td>
<td>—.51** (207)</td>
</tr>
<tr>
<td>2. Symptoms</td>
<td>—.06 (220)</td>
<td>—</td>
<td>—.32** (219)</td>
<td>.00 (219)</td>
<td>.33** (212)</td>
<td>.09 (207)</td>
<td></td>
</tr>
<tr>
<td>3. Alliance</td>
<td>—.10 (212)</td>
<td>—.01 (212)</td>
<td>—</td>
<td>.13* (208)</td>
<td>—.15* (201)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Avoidance</td>
<td>—.15** (279)</td>
<td>—.50** (270)</td>
<td>.23** (259)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>5. Anxiety</td>
<td>—.14* (270)</td>
<td>.29** (259)</td>
<td>—.23** (253)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>6. RDAS</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—.14* (270)</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>7. OQ</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

Note: *p < .05, **p < .01, n in parentheses.
TABLE 4  Correlations Coefficients Between Intersession Report Other Variables From Session 4

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Functioning</td>
<td>—</td>
<td>—</td>
<td>—.17* (153)</td>
<td>—.07 (89)</td>
<td>—.47** (151)</td>
<td>—.42** (89)</td>
<td>—.24* (90)</td>
<td>—.44** (86)</td>
</tr>
<tr>
<td>2. Symptoms</td>
<td>—</td>
<td>—</td>
<td>—.53** (89)</td>
<td>—.14 (89)</td>
<td>.14 (89)</td>
<td>.41** (90)</td>
<td>.25** (86)</td>
<td>.49** (84)</td>
</tr>
<tr>
<td>3. Alliance</td>
<td>—</td>
<td>—</td>
<td>—.07 (88)</td>
<td>—.13 (88)</td>
<td>—.13 (88)</td>
<td>—.19* (89)</td>
<td>—.13 (85)</td>
<td>—.29** (83)</td>
</tr>
<tr>
<td>4. Avoidance</td>
<td>—</td>
<td>—</td>
<td>—.56** (112)</td>
<td>—.03 (103)</td>
<td>—.56** (112)</td>
<td>—.03 (103)</td>
<td>—.58** (102)</td>
<td>—.14 (102)</td>
</tr>
<tr>
<td>5. Anxiety</td>
<td>—</td>
<td>—</td>
<td>—.27** (112)</td>
<td>—.37** (103)</td>
<td>—.27** (112)</td>
<td>—.37** (103)</td>
<td>—.11 (105)</td>
<td>.45** (104)</td>
</tr>
<tr>
<td>6. RDAS total score</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>7. OQ total score</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>8. CTAS total</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

Note: *p < .05, **p < .01, n in parentheses.
Correlations of the Functioning subscale from session four showed similar results to session one correlations, further validating Factor I as a measure of Functioning. The correlations of the Symptoms subscale provided additional information on the validity of that factor. Using session four data the Symptoms subscale was significantly moderately correlated with the OQ-45.2 total score providing tentative support for the convergent validity of this subscale.

DISCUSSION

The purpose of this article was to describe the development of the Intersession Report (IR) and provide initial psychometric information of its validity and reliability. This assessment is a short questionnaire completed by clients at the beginning of every therapy session after the first. The assessment demonstrated promising results; it maintained strong internal consistency as well as tentative evidence for convergent and divergent validity. This study is a first step in developing a viable measure of assessing clients on a session-by-session basis.

Results of exploratory factor analyses and low correlations between the three subscales of the IR suggest it measures three distinct constructs, Functioning, Symptoms, and the therapeutic alliance. This factor structure was demonstrated at the second and fifth sessions, providing support for the stability of the factor structure across time. Evidence was found to demonstrate the reliability of the three subscales. Evidence was found that the Functioning subscale and the Alliance subscale are measuring some aspects of those constructs. Tentative support was found for the validity of the Symptoms subscale.

Implications

This short questionnaire is a quick way to obtain feedback on where clients are on a session-by-session basis. This is a necessary step in facilitating research that is focused on individual client progress (Howard et al., 1996; Pinsof & Wynne, 2000). The IR benefits clinicians and supervisors by providing information on clients at many points in therapy. The use of the IR can aid clinicians by giving them a reliable and valid client self-report to compare with their observational assessments on a weekly basis. This also gives data to supervisors and clinicians on cases that may not be progressing. Part of the training process of becoming a clinician is learning how to observationally assess client improvement. The IR provides supervisors a tool to help clinicians learn this skill.

The IR is helpful to researchers in that it allows them to collect data from many sessions to allow researchers to further examine couples’ progress and change. The IR also improves research by ensuring there is at least some
termination data from each couple. The use of the IR improves attrition analyses by giving information further in the course of therapy. Currently, one way of assessing attrition bias is to compare pretest scores of clients who dropout and remain in therapy. The IR will make possible the comparison of scores later in treatment and on a variety of variables in addition to demographic information. Despite the benefits of the IR, there are limitations to be considered when using this questionnaire.

Limitations & Future Research

The results should be generalized with some caution. Data for this study were collected at two marriage and family therapy training clinics in the southeastern United States, with the participants being predominantly heterosexual Caucasian couples. Further research needs to determine the generalizability of the factor structure of the IR and the reliability and validity of the questionnaire to other populations and settings.

The construct validity of this questionnaire needs more research. The current study found evidence of reliability and multiple types of validity, but additional replications are necessary to establish the construct validity of the IR. This is especially true of the Symptoms factor.

Future research needs to examine how sensitive the IR is at measuring change over time. One way of accomplishing this is by administering the IR to clients in therapy and a control group to establish differences in change rates between a group receiving therapeutic interventions and one not participating in therapy.

Research is also needed on a comparable measure established from the therapist’s perspective. This would allow data to be collected on a session-by-session basis from the clients and therapist’s perspective, thus increasing the amount of information available on a case-by-case basis. The authors have developed such a measure and are collecting data to establish the psychometric properties of that assessment.

REFERENCES


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**APPENDIX A: INTERSESSION REPORT**

Name: __________  Today’s Date: __________  Session Time: __________

Please circle the number that best represents your experiences.

1) **I feel nervous, anxious, or unsettled.**

<table>
<thead>
<tr>
<th>Almost never</th>
<th>Half the time</th>
<th>Almost all the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2) **I feel hopeless, depressed, or down.**

<table>
<thead>
<tr>
<th>Almost never</th>
<th>Half the time</th>
<th>Almost all the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3) I would rate my ability to function at work, school, or home:
   Very poor Similar to others Excellent
   1 2 3 4 5 6 7

4) Satisfaction with my personal relationships has been:
   Very poor About average Excellent
   1 2 3 4 5 6 7

5) I rate the positive sentiment, support, and collaboration in my life as:
   Very poor Similar to others Excellent
   1 2 3 4 5 6 7

6) I would rate progress toward therapy goals as:
   Very poor Moderate Excellent
   1 2 3 4 5 6 7

7) The likelihood of my problems being resolved is:
   Very low Not sure Very high
   1 2 3 4 5 6 7

Your responses to the next two questions will be removed prior to your therapist seeing this form:

8) My relationship with the therapist is:
   Very poor Moderate Excellent
   1 2 3 4 5 6 7

Answer Question 9 only if you are attending therapy with someone else:

9) I rate the relationship we as a couple or my whole family has with the therapist as:
   Very poor Moderate Excellent
   1 2 3 4 5 6 7