
The Therapeutic Realizations Scale—Revised (TRS-R): Psychometric Characteristics and Relationship to Treatment Process and Outcome



Gregory G. Kolden, Timothy J. Strauman,
Marci Gittleman, Jerry L. Halverson,
Erin Heerey, and Kristin L. Schneider

University of Wisconsin—Madison Medical School

Therapeutic realizations are one of five universal, session-level change processes explicated in the Generic Model of Psychotherapy. Realizations refer to session impacts, the moment-to-moment accomplishments that patients experience within sessions. This study establishes the psychometric characteristics and factor structure of a modified patient-rated measure of session-level effects, the Therapeutic Realization Scale—Revised (TRS-R). In addition, it shows the relationship of the TRS-R to treatment process and outcome from the perspective of both patients and therapists. The findings provide support for the TRS-R as a reliable and valid, multidimensional index of session-level treatment effects. © 2000 John Wiley & Sons, Inc. *J Clin Psychol* 56: 1207–1220, 2000.

Keywords: change processed; generic model of psychotherapy; session impacts; therapeutic realizations

The generic model of psychotherapy (Orlinsky, Grawe, & Parks, 1994; Orlinsky & Howard, 1986a, 1987) is a transtheoretical conceptual framework that posits five universal change processes: therapeutic contract, therapeutic operations, therapeutic bond, therapeutic

This article is a version of a paper presented in June 1995 by Marci Gittleman at the annual meeting of the Society for Psychotherapy Research, Vancouver, British Columbia, Canada.

This work was partially supported by research grants from the Graduate School of the University of Wisconsin, the Research and Development Committee of the Department of Psychiatry, and a Young Investigator Award from the National Alliance for Research on Schizophrenia and Depression (NARSAD) to Gregory G. Kolden. The authors are grateful for the helpful suggestions of the University of Wisconsin Depression Treatment Program Research Group and, as always, the mentorship and support of Ken Howard.

Correspondence concerning this article should be addressed to Gregory G. Kolden, Department of Psychiatry, University of Wisconsin—Madison, 6001 Research Park Blvd., Madison, WI 53719–1179.

openness/involvement, and therapeutic realizations. The present study focuses on the psychometric properties, factor structure, and construct validity of a scale that assesses therapeutic realizations, the Therapeutic Realizations Scale—Revised (TRS-R).

Therapeutic realizations, a session-level change process, involves the moment-to-moment accomplishments that patients experience within sessions. Examples of therapeutic realizations include unburdening, attainment of insight, problem clarification, encouragement, enhanced morale, and an increased sense of capacity to cope. Studies examining the role of session-level phenomena such as therapeutic realizations are important because they contribute to our understanding of how change occurs in psychotherapy. Moreover, previous change process research has consistently shown therapeutic realizations to be positively related to outcome (e.g., Greenberg & Webster, 1982; Kolden, 1988, 1996a; Kolden & Howard, 1992; Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon 1982; Sachs, 1983; see Orlinsky et al., 1994, for a review).

The generic model offers a conceptualization of outcome that follows a dynamic, evolving course that grows over the course of a therapy episode. Session-level change processes such as therapeutic realizations give rise to shorter-term micro-outcomes or immediate outcomes (e.g., session progress) which lead to intermediate outcomes (e.g., change over a few sessions) and longer-term macro-outcomes (longitudinal changes over a course of therapy, gains at follow-up). As such, therapeutic realizations are best considered a psychotherapy change process theoretically and empirically distinct from outcome.

The construct of therapeutic realizations is comparable to what others have referred to as session impacts (e.g., Elliott & Wexler, 1994; Mallinckrodt, 1994; Stiles et al., 1994). Both terms, therapeutic realizations and session impacts, refer to session-level effects of therapy for the patient. The two most important and frequently used measures of session-level therapy effects are the Session Evaluation Questionnaire (SEQ; Stiles, 1980; Stiles & Snow, 1984a, 1984b) and the Session Impacts Scale (SIS; Elliott, 1985; Elliott, James, Reimschuessel, Cislo, & Sack, 1985; Elliott & Wexler, 1994).

The SEQ is a global measure of impacts, emphasizing overall evaluations of sessions (i.e., depth and smoothness) and immediate emotional reactions to sessions (i.e., positivity and arousal). The factor structure and internal reliability of the SEQ are well established. Additionally, a variety of studies have shown depth and smoothness to vary independently and to be prominent in both patients' and therapists' ratings of sessions (Mintz, Luborsky, & Aurbach, 1971; Orlinsky & Howard, 1975, 1977, 1986a; Stiles & Snow, 1984b). Finally, the SEQ has been demonstrated to be associated meaningfully with patient and therapist characteristics, other therapy change processes, and outcome (see Stiles et al., 1994, for a review of these findings).

The SIS emerged from Elliott's work on significant therapy events (Elliott, 1985; Elliott et al., 1985). In contrast to the SEQ, the SIS assesses specific session content rather than the global emotional quality of sessions. Specific constructs measured include Helpful Impacts (e.g., Task Impacts, Relationship Impacts) and Hindering Impacts. The SIS has been shown to possess solid internal consistency, a stable factor structure, and excellent predictive validity. For example, the SIS has been shown to be associated with client ratings of session helpfulness and event helpfulness as well as therapist ratings of general session helpfulness (Elliott & Wexler, 1994).

The SIS and SEQ also have been studied concurrently. Positive correlations were found between SIS Helpful Impact Scales and SEQ depth and positivity (Elliott & Wexler, 1994). In addition, SEQ depth and smoothness were shown in another study to be positively related to SIS Understanding, Problem Solving, and Relationship indices (Stiles et al., 1994). Together, studies utilizing the SIS and the SEQ provide evidence that ses-

sion impacts can be reliably measured, are multidimensional in nature, and are positively related to other psychotherapy change processes as well as outcome.

Therapeutic Realizations Scale—Revised

The original Therapeutic Realizations Scale was derived from the Patient Satisfaction section of the Therapy Session Report (Orlinsky & Howard, 1966; see Orlinsky & Howard, 1986b, for a summary description of the evolution of this instrument). The generic model provided the guiding theoretical framework for the development of the Therapeutic Realizations Scale. Internal consistency for the Therapeutic Realizations Scale for patients' ratings of Session 3 was established as .86 (Kolden, 1991). In addition, acceptable test-retest reliability of .71 for the Therapeutic Realizations Scale between Sessions 3 and 7 was observed (Kolden & Howard, 1992).

In earlier work, the therapeutic-realizations construct was conceptualized as consisting of three components: Unburdening, Mastery-Insight, and Encouragement (Kolden, 1988, 1996b). These components were derived empirically via factor analysis (Howard & Orlinsky, 1987). Unburdening involves the emotional-cognitive process of telling one's story, ventilating, and clarifying what is most troublesome. It is important to clarify that Unburdening is not synonymous with catharsis; rather, it involves an emotional-cognitive sequence of sharing thoughts and feelings, and clarifying what is currently distressing and problematic. Unburdening does not involve unregulated release of pent-up feelings. Mastery-Insight captures two highly interconnected aspects of realization. Mastery reflects a sense of self-efficacy and the perception of an ability to cope and actively function to meet one's needs and goals. Insight signifies increased awareness and understanding of recent as well as remote (i.e., historical) determinants of behavior. Finally, Encouragement refers to the acquisition of enhanced morale, reassurance, and hopefulness. The significance of each of these impact constructs has been documented in several studies (see Elliott & James, 1989, for a review). Furthermore, previous work using the Therapeutic Realizations Scale has demonstrated that each construct is positively related to other early therapy processes as well as to outcome (Kolden, 1988, 1996b).

The Therapeutic Realizations Scale—Revised is the product of a recent modification and refinement of the Therapeutic Realizations Scale. The TRS-R has been incorporated in a modification of Orlinsky's and Howard's patient-rated Therapy Session Report (Orlinsky & Howard, 1966). The modified instrument is referred to as the Therapy Session Report—Generic Model, Patient version (TSR-GM-P; Kolden, 1993a). The TSR-GM-P is closely linked theoretically to the Generic Model of Psychotherapy. All 11 items of the original Therapeutic Realizations Scale from the TSR were retained, with six new items added to create the TRS-R (see Table 1; item numbers 58 to 63 are new). The new items were added to capture additional aspects of session-level therapy effects noted in a review of the change process literature (e.g., Elliott & James, 1989; Hill, Helms, Spiegel, & Tichenor, 1988; Stiles, 1980). It is important to note that therapeutic realizations constitute a patient experienced process. Thus, a therapist-rated version would be logically inconsistent with the theoretical underpinnings of this construct.

The TRS-R differs conceptually from both the SEQ and the SIS. Unlike the SEQ, but similar to the SIS, the TRS-R is content-specific. Also, unlike the SIS, the TRS-R does not include hindering impacts. This difference reflects the link between the TRS-R and the theoretical framework of the generic model of psychotherapy. The generic model does not incorporate impediments to change or hindering impacts, although these negative indicators for sessions effects are certainly interesting and potentially important contributors to understanding how change occurs in psychotherapy.

Table 1
Factor Loadings and Scale Items

Items	Obliquely Rotated Factor Loadings			
	I	II	III	IV
I. Remoralization				
*53. Confidence to try to do things differently.	.92			
*48. Hope: A feeling that things can work out.	.71			
*56. Better self control over my moods and actions.	.64			
*52. Reassurance and encouragement about how I'm doing.	.67			
*51. More understanding of reasons behind my behavior and feelings.	.51			
57. A more realistic evaluation of my thoughts, feelings, and actions.	.31	.18	.30	
II. Unburdening				
*47. A chance to let go and express feelings.		.98		
*49. A chance to talk about what was really troubling me.		.73		
*50. Relief from tensions or unpleasant feelings.		.56		
III. Past-Focused Insight				
*59. Increased awareness that reactions and behaviors toward someone now are similar to reactions and behaviors towards others in the past.			.88	
*58. Increased awareness that thoughts and/or feelings experienced now are similar to those in the past.			.86	
IV. Present-Focused Understanding				
*61. A chance to try out or practice a new skill or way of behaving.				.79
*55. Ideas for better ways of dealing with people and problems.				.62
54. More ability to feel feelings, to know what I really want.	.37			.47
*62. Education: Information about symptoms, problems, or people.				.52
63. A chance to reexperience and rework a troublesome experience.		.31		.33

*Items scored.

Previous work has examined propositions of the generic model that address therapeutic realizations in dynamic therapy (Kolden, 1991, 1996a, 1996b; Kolden & Howard, 1992). This work has shown realizations (as measured by the original Therapeutic Realizations Scale) to be associated with several other session-level change processes and outcome indices. These findings can be summarized as follows: (1) patient-rated therapeutic openness/involvement and therapeutic bond are positively associated with therapeutic realizations; (2) therapeutic realizations promote patient-rated session progress; (3) specifically, the realizations of Unburdening and Encouragement contribute to progress in Session 3, whereas Mastery-Insight contributes to progress in Session 7; and (4) therapeutic realizations do not contribute to variance in outcome above and beyond session progress.

The Present Study

The TRS-R was examined in a naturalistic study of psychotherapy delivered in a service setting providing clinical training in interpersonal, cognitive, and brief dynamic therapy. Session 3 patient and therapist ratings of session-level change processes were examined. The conceptual framework and prior empirical findings (outlined above) associated with the generic model of psychotherapy guided our investigation of the TRS-R. Three pri-

mary aims were pursued: (1) determining the internal consistency reliability of the TRS-R, (2) exploring the factor structure of TSR-R and the internal consistency reliability of the resulting factor scores, and (3) assessing the validity of the TRS-R by examining the relations of the global scale and factor-derived subscales with treatment process and outcome.

Method

Patients

The patient sample consisted of 95 adults who completed questionnaires following the third session of individual psychotherapy in the Outpatient Clinic of the University of Wisconsin (UW) Department of Psychiatry. Seventy-seven percent were female and 68% were between 18 and 34 years old. Ninety-three percent were white and slightly more than a third were married. The vast majority were employed (85%) and had attended at least some college (89%). This sample is approximately representative of the psychotherapy outpatient population, in which the modal patient is female, Caucasian, unmarried, highly educated, and employed (cf. Taube, Burns, & Kessler, 1984; Vessey & Howard, 1993).

All patients underwent a clinical screening interview where each was determined to be appropriate for individual psychotherapy. Participation in the research was voluntary, informed consent was obtained, and confidentiality of responses was ensured.

Therapists and Setting

The current study was conducted at the Outpatient Clinic of the Department of Psychiatry at UW Hospital and Clinics. This is a center for training in psychiatry and clinical psychology for the University of Wisconsin's Medical School. The outpatient clinic is intended to serve outpatients similar to those seen in the private practice of outpatient psychiatry.

At any time there are close to 50 potential therapists in the UW Outpatient Clinic. Most of these therapists are trainees—psychiatry residents as well as psychology predoctoral interns and postdoctoral fellows. Others are faculty members and a few are Master's-level clinicians (counseling psychology, social work, and nursing are represented in this latter group). Twenty-two therapists participated in the present study. The majority were trainees. Professionally, 45% were psychologists, 40% were psychiatrists, and 15% were social workers. Two-thirds of the therapists were female, 57% were married, and 93% were under 40 years of age. Seventy-one percent had experienced personal therapy. This therapist sample allows for a broad range of expertise, theoretical background, and patient participation, thus enhancing generalizability and external validity of our findings.

Therapy

The UW Psychiatry Outpatient Clinic offers training in three types of individual psychotherapy: interpersonal (IPT; Klerman, Weissman, Rounsaville, & Chevron, 1984); cognitive (CBT; Beck, Rush, Shaw, & Emery, 1979); and brief dynamic therapy (Luborsky, 1984; Strupp & Binder, 1984). All trainees are required to learn IPT and CBT, with training in brief dynamic therapy optional. Each case is conceptualized systematically from one of these three perspectives. Formal fidelity checks are not conducted; however, treatment is guided (at least in theory) by manuals. As such, this study represents a

quasi-naturalistic examination of early sessions of three kinds of therapy as delivered in a service setting providing clinical training.

Instruments

Therapy Session Report—Generic Model, Patient Version (TSR-GM-P). The TSR-GM-P is an 80-item instrument assessing the patient's experience in treatment sessions as well as short-term progress (Kolden, 1993b). The TSR-GM-P is an adaptation and elaboration of the Therapy Session Report—Patient Form (Orlinsky & Howard, 1966). The generic model of psychotherapy provided the theoretical framework for development of the process and outcome scales derived from the TSR-GM-P.

Five scales from the TSR-GM-P were used in this study: (1) Therapeutic Bond (15 items), (2) Therapeutic Openness/Involvement (6 items), (3) Therapeutic Realizations Scale—Revised (17 items), (4) Session Progress (4 items), and (5) Subjective Well-Being (4 items). Internal-consistency coefficients for these scales (as observed in the present study) ranged from acceptable to excellent: .91 for Therapeutic Bond, .61 for Therapeutic Openness/Involvement, .75 for Session Progress, and .83 for Subjective Well-Being (see results section for internal consistency of Therapeutic Realizations Scale—Revised).

Therapy Session Report—Generic Model, Therapist Version (TSR-GM-T). The TSR-GM-T is a 56-item instrument assessing the therapist's experience in therapy sessions and evaluation of short-term progress (Kolden, 1993c). Historically, the TSR-GM-T is an adaptation and elaboration of the Therapy Session Report—Therapist Form (Orlinsky & Howard, 1966) and the Therapeutic Procedures Inventory—Revised (Orlinsky, Lundy, Howard, Davidson, & O'Mahoney, 1987). The generic model of psychotherapy also provided the theoretical framework for the development of the process and outcome scales derived from the TSR-GM-T.

Seven scales from the TSR-GM-T were used in this study: (1) Therapeutic Bond (10 items), (2) Therapeutic Openness/Involvement (7 items), (3) Therapeutic Operations Scales: Prescriptive Interventions (6 items), (4) Exploratory: Past-Focused Interventions (5 items), (5) Exploratory: Experiential Interventions (4 items), (6) Session Progress (4 items), and (7) Patient's Well-Being (4 items). Internal-consistency coefficients for these scales (as observed in the present study) ranged from good to excellent: .78 for Therapeutic Bond, .74 for Therapeutic Openness/Involvement, .81 for Prescriptive Interventions, .73 for Exploratory: Past-Focused Interventions, .69 for Exploratory: Experiential Interventions, .80 for Session Progress, and .84 for Patient's Well-Being.

Results

TRS-R: Internal consistency

As noted in the methods section, the internal consistency for the TRS-R scale was determined to be .93 for the 16-item global scale in the present study (note that one item was deleted from this analysis; see explanation below). This is quite acceptable for this kind of reliability estimate.

Factor Structure of the TRS-R

A total of 95 TSM-GM-P Session 3 questionnaires were collected. Seventeen items from the Therapeutic Realizations Scale—Revised were available for analysis of the revised

instrument's factor structure. Item 60 ("Increased awareness that reactions to my therapist presently are similar to reactions to others now or in the past.") was dropped as less than 5% of respondents acknowledged experiencing this session effect, leaving 16 items. The correlation matrix of the 16 items, with squared multiple correlations in the major diagonal, was subjected to a principal-axis factor analysis with oblique rotation. An oblique rotation method was used, since we expected that different session impacts would be synergistic and therefore at least moderately interrelated. Realizations in any particular domain should influence and lead to realizations in other domains. For example, unburdening should lead to increased understanding, which in turn should lead to further unburdening and installation of hope.

This factor analysis resulted in a four-factor solution which accounted for a total of 61% of the intercorrelation variance. Inspection of the residuals as well as higher factor solutions indicated that the extraction of additional factors would be unstable. The four extracted (rotated) factors accounted for 19%, 15%, 13.8%, and 12.8% of the total variance, respectively.

In developing theoretically meaningful and clinically useful TRS-R subscales from the extracted factors, items were included in only one scale. An item was included in a scale if its loading on that factor was at least .43 (absolute value) and at least .20 greater than on two of the other three factors. Each scale score was calculated by summing the individual items loading on that scale. After inspection of the items comprising each factor, we arrived at the following descriptive labels: Remoralization (Factor I: 5 items); Unburdening (Factor II: 3 items); Past-Focused Insight (Factor III: 2 items); and Present-Focused Understanding (Factor IV: 3 items). All items and factor loadings are shown in Table 1. Items included in scoring of the scales are indicated by an asterisk.

Next, reliabilities were calculated for each of the scales using coefficient alpha. Resulting reliabilities for each of the subscales were as follows: Remoralization, $\alpha = .89$; Unburdening, $\alpha = .86$; Past-Focused Insight, $\alpha = .89$; and Present-Focused Understanding, $\alpha = .74$. The intercorrelations of the scales are shown in Table 2; they range from .36 to .66. While these scales are moderately intercorrelated as expected, it is important to note that the intercorrelations among the scales are well below the square roots of their reliabilities, indicating substantial unique variance.

Relation of TRS-R to Psychotherapy Process and Outcome

Table 3 summarizes the findings of correlational and regression analyses examining the relationship of the TRS-R and its subscales to patient- and therapist-rated process and outcome indices. Correlational analyses revealed that the TRS-R global scale score was

Table 2
Therapeutic Realizations Scale—Revised Subscale Intercorrelations

Scales	I	II	III	IV
I. Remoralization	(.89)			
II. Unburdening	.66	(.86)		
III. Past-Focused Insight	.51	.36	(.89)	
IV. Present-Focused Understanding	.59	.42	.41	(.74)

Entries on diagonal are coefficient alpha for subscales.

Table 3

Therapeutic Realizations Scale–Revised (TRS-R): Relationship to Treatment Process and Outcome

	Process Variables							
	Patient-Rated				Therapist-Rated			
	Therapeutic Bond (<i>N</i> = 94)		Therapeutic Openness/ Involvement (<i>N</i> = 94)		Therapeutic Bond (<i>N</i> = 76)		Therapeutic Openness/ Involvement (<i>N</i> = 77)	
	<i>r</i>	<i>r</i> ²	<i>r</i>	<i>r</i> ²	<i>r</i>	<i>r</i> ²	<i>r</i>	<i>r</i> ²
TRS-R Total	.58***	.34	.51***	.26	.45***	.20	.26*	.07
TRS-R Subscales	<i>R</i> ² = .41***		<i>R</i> ² = .30***		<i>R</i> ² = .21**		<i>R</i> ² = .12*	
	<i>r</i>	β ^a	<i>r</i>	β ^a	<i>r</i>	β ^a	<i>r</i>	β ^a
I. Remoralization	.56***	.30**	.48***	.24***	.45***	.38*	.29**	.28
II. Unburdening	.60***	.41***	.50***	.32**	.36***	.11	.28**	.16
III. Past-Focused Insight	.26**	-.05	.24**	-.03	.21*	-.04	.02	-.19
IV. Present-Focused Understanding	.35***	.03	.35***	.09	.29*	.04	.16	-.01
	Therapist Rated Operations							
	Prescriptive Interventions (<i>N</i> = 77)		Exploratory: Past-Focused (<i>N</i> = 77)		Exploratory: Experiential (<i>N</i> = 77)			
	<i>r</i>	<i>r</i> ²	<i>r</i>	<i>r</i> ²	<i>r</i>	<i>r</i> ²		
TRS-R Total	.25*	.06	.30**	.09	.08	.01		
TRS-R Subscales	<i>R</i> ² = .12*		<i>R</i> ² = .25***		<i>R</i> ² = .03			
	<i>r</i>	β ^a	<i>r</i>	β ^a	<i>r</i>	β ^a		
I. Remoralization	.19*	-.01	.25**	.19	.01			
II. Unburdening	.12	-.02	.07	-.18	.06			
III. Past-Focused Insight	.13	-.01	.47***	.49***	.10			
IV. Present-Focused Understanding	.35***	.36*	.12	-.12	.11			
	Outcome Variables							
	Patient-Rated				Therapist-Rated			
	Session Progress (<i>N</i> = 44)		Well-Being (<i>N</i> = 94)		Session Progress (<i>N</i> = 37)		Well-Being (<i>N</i> = 77)	
	<i>r</i>	<i>r</i> ²	<i>r</i>	<i>r</i> ²	<i>r</i>	<i>r</i> ²	<i>r</i>	<i>r</i> ²
TRS-R Total	.73***	.53	.37***	.14	.03	.00	.19	.04
TRS-R Subscales	<i>R</i> ² = .57***		<i>R</i> ² = .18**		<i>R</i> ² = .05		<i>R</i> ² = .08	
	<i>r</i>	β ^a	<i>r</i>	β ^a	<i>r</i>	β ^a	<i>r</i>	β ^a
I. Remoralization	.64***	.24	.36***	.32*	.04		.22*	
II. Unburdening	.71***	.49	.15	-.17	.05		.16	
III. Past-Focused Insight	.34**	-.03	.24**	.05	.11		.21*	
IV. Present-Focused Understanding	.49***	.15	.35***	.21	.09		.03	

p* < .05; *p* < .01; ****p* < .001.

^aStandardized Regression Coefficient.

positively related to both patient- and therapist-rated process measures of Therapeutic Bond and Therapeutic Openness/Involvement. It was also positively associated with two of the three therapist-rated operations: Prescriptive Interventions and Exploratory: Past-Focused Interventions. In terms of outcome indices, the global TRS-R score was related to patient-rated Session Progress and Subjective Well-Being. However, it was not associated with parallel therapist-rated measures of Session Progress and Well-Being.

Multiple regression analyses were conducted entering the TRS-R subscale scores as independent variables and psychotherapy process and outcome variables as dependent variables. This analytic strategy allows for comparison of the predictive power of the TRS-R global score versus its component subscales as a set. That is, we sought to examine the predictive validity of the underlying dimensions of therapeutic realization and whether they provide useful information beyond the TRS-R total score.

The TRS-R total score accounted for 34% ($p < .001$) of the variance in patient-rated Therapeutic Bond. In contrast, the four-factor-derived subscale scores as a set accounted for 41% ($p < .001$) with Remoralization ($\beta = .30, p < .01$) and Unburdening ($\beta = .41, p < .001$) accounting for significant portions of variance. For patient-rated Therapeutic Openness/Involvement, the TRS-R total score accounted for 26% ($p < .001$) of the variance, whereas the set of TRS-R subscale scores accounted for 30% ($p < .001$) with Unburdening ($\beta = .32, p < .01$) making the only statistically significant unique contribution.

The TRS-R total score accounted for 20% ($p < .001$) of the variance in therapist-rated Therapeutic Bond, whereas the subscale scores accounted for 21% ($p < .001$) with Remoralization ($\beta = .38, p < .05$) the only subscale significantly associated with that score. For therapist-rated Therapeutic Openness/Involvement, the TRS-R total score accounted for 7% ($p < .05$) of the variance, but the set of TRS-R subscale scores accounted for 12% ($p < .05$); none of the individual TRS-R subscale scores made a statistically significant unique contribution. Similarly, for therapist-rated Therapeutic Operations, the TRS-R total score accounted for 6% ($p < .05$) of the variance in Prescriptive Interventions whereas the subscale scores as a set accounted for 12% ($p < .05$); Present-Focused Understanding ($\beta = .36, p < .001$) was the only subscale accounting for unique variance. For Exploratory: Past-Focused Interventions, the TRS-R total score accounted for only 9% ($p < .01$) of the variance, whereas the set of TRS-R subscale scores accounted for 25% ($p < .001$) with Past-Focused Insight ($\beta = .49, p < .001$) making the only unique contribution. Neither the TRS-R total score nor the set of subscale scores accounted for significant portions of variance for Exploratory: Experiential Interventions in session three.

For patient-rated immediate outcome indices, the TRS-R total score accounted for 53% ($p < .001$) of the variance in Session Progress while the subscale scores as a set accounted for 57% ($p < .001$). Unburdening ($\beta = .49, p < .001$) was the only subscale accounting for unique variance. For patient-rated Subjective Well-Being, the TRS-R total score accounted for 14% ($p < .001$) of the variance, whereas the set of TRS-R subscale scores accounted for 18% ($p < .01$), with Remoralization ($\beta = .32, p < .05$) making the only unique contribution. For therapist-rated immediate outcome indices, neither the TRS-R total score nor the set of subscale scores accounted for significant portions of variance in Session Progress or Well-Being at session three.

Discussion

This study provides initial support for the TRS-R as a reliable and valid multidimensional index of session-level effects of psychotherapy. The TRS-R is comprised of four concep-

tually distinct, yet empirically interrelated, dimensions that are clinically interpretable and can be reliably measured. Moreover, these factors were shown to exhibit predictive as well as discriminant validity. The four factor-analytically derived components reflect the following descriptive content domains: Remoralization, Unburdening, Past-Focused Insight, and Present-Focused Understanding.

The Remoralization subscale is comprised of items that reflect a renewed sense of optimism and positive affectivity, as exemplified by the specific therapeutic impacts of confidence, hope, enhanced self-control, reassurance, and encouragement. The concept of remoralization derives from Frank's (1973; Frank & Frank, 1991) view that patients come to therapy because they are demoralized and therapists help by offering healing through persuasion, that is, by reassuring patients and convincing them to give up their hopelessness.

The Unburdening subscale captures the emotional-cognitive process of reflective self-expression, the experience of relief realized in interpersonal opportunities to verbalize troubling thoughts and feelings with a trusted listener. Unburdening is distinguishable from catharsis because it is a more emotionally regulated, cognitively mediated, and integrated process than the unmodulated discharge of affect connotated by the concept of catharsis.

Past-Focused Insight refers to a type of learning that occurs in psychotherapy characterized by the realization of connections between temporally remote experiences and present feelings, thoughts, actions, and ways of relating. Subscale items reflect the recognition and increased awareness of continuity or linkages between current and past experiences, intrapersonal as well as interpersonal.

Finally, Present-Focused Understanding involves the acquisition of new knowledge, skills, attitudes, and ways of coping. This type of learning is exemplified in items reflecting opportunities to gain practical information, learn and practice new behaviors, and develop alternative coping strategies.

The four factors of the TRS-R that emerged in the present study are conceptually consistent with three of the factors from the original Therapeutic Realizations Scale derived from the Patient Satisfaction section of the Therapy Session Report (Kolden, 1988, 1996b). Remoralization (Encouragement in the Therapeutic Realizations Scale) and Unburdening appeared to be underlying dimensions present in both scales. In addition, the Mastery-Insight subscale of the original Therapeutic Realizations Scale to some extent conceptually parallels the Present-Focused Understanding dimension of the revised version. The TRS-R goes beyond the original measure by differentiating between past-focused and present-focused learning that occurs in therapy sessions. Furthermore, examination of the correlation between Present-Focused Understanding and Past-Focused Insight in the TRS-R demonstrates that these two dimensions are not highly interrelated (i.e., $r = .41$).

The underlying factor structure of the TRS-R differs conceptually from the hierarchical structure of the Session Impacts Scale, in that it doesn't include hindering impacts and the Positive Impacts subdimensions of task impacts and relationship impacts are not distinguished. It should be noted, however, that the common positive aspects of session impact—i.e., task and relationship—are represented in the items comprising the factors of the TRS-R. Thus, the TRS-R offers a multidimensional measure of session-level therapy effects that is conceptually distinct from the Session Impacts Scale. The TRS-R and Session Impacts Scale (as well as the Session Evaluation Questionnaire) need to be examined concurrently to determine the extent to which each is of differential utility in furthering our understanding of session-level change processes in psychotherapy.

Overall, the findings demonstrated that the TRS-R was positively related to other aspects of psychotherapy process from the perspective of both patients and therapists. As

was observed in previous work, the TRS-R (a patient-rated process measure) was positively associated with patient-rated process measures of Therapeutic Bond and Therapeutic Openness/Involvement. The present study demonstrated that patient-rated realizations were also positively associated with therapist-rated bond and openness/involvement. Realizations occur in the context of strong therapy relationships and open participation in the therapy enterprise. Session 3 therapist-rated operations, another aspect of treatment process, were also positively related to TRS-R total scores. Thus, a greater frequency of therapist interventional activity in early sessions appears to be associated with a greater number of realizations. Overall, these findings are consistent with previous research examining associations between therapeutic realizations and other session-level psychotherapy processes (e.g., Elliott & James, 1989; Kolden, 1988, 1991, 1996a, 1996b; Kolden & Howard, 1992).

The TRS-R was positively related to patient-rated immediate outcome indices, but not to parallel therapist-rated measures. A greater number of session realizations was linked to both greater patient-rated progress in sessions and a greater degree of Subjective Well-Being. Although the correlation between the TRS-R and therapist-rated Patient's Well-Being approached statistical significance, its correlation with therapist-assessed Session Progress did not. The findings for the patient-rated immediate outcome indices are consistent with previous work showing a relationship between realizations and shorter-term outcome indices (e.g., Kolden, 1991, 1996a).

The findings for the therapist-rated indices appear to be similar to previous observations showing a lack of correspondence on outcome indices across measurement perspectives (i.e., patients, therapists, observers; Kazdin, 1994). The finding that patient reports of greater therapy benefits in sessions (therapeutic realizations) are unrelated to therapist evaluations of session progress and patient well-being could have many explanations. Therapeutic realizations, by definition, are private patient experiences; thus, as is found in many other literatures contrasting observers, therapists may merely be less-than-reliable judges of such an intrapersonal process. Furthermore, therapists may evaluate session progress and patient well-being according to different criteria and standards than patients. Additional studies of congruence/discrepancy between patient and clinician judgment processes will be required to come to a clearer understanding of these observations.

Overall, the findings from the present study provide solid evidence in support of the validity of the TRS-R global scale as a measure of session-level psychotherapy effects. The discussion that follows reviews evidence in support of the validity of the factor-derived TRS-R subscales and the multidimensionality of the realizations construct. For the multiple regression analyses with the set of subscale scores as independent predictors and process or outcome variables as dependent criterion, by simple tally the set of 4 TRS-R subscale scores accounted for greater portions of variance in eight of eight instances where the overall variance accounted for was statistically significant. The set of predictors also accounted for greater portions of variance in all three of the nonsignificant analyses. The difference in variance accounted for ranged from a trivial 1% for therapist-rated Therapeutic Bond to a sizeable 16% for Exploratory: Past-Focused Interventions.

The multiple regression data analytic strategy also allows for examination of unique associations between particular TRS-R subscales and the respective process and outcome indices. This was determined by examining the statistical significance of the standardized regression coefficients for each subscale variable when the overall R^2 for the set of factor-analytically derived scales was statistically significant.

Remoralization was uniquely associated with patient and therapist rated Therapeutic Bond. It also accounted for a unique portion of variance in patient-rated Subjective Well-Being. In addition, Remoralization was associated with a marginally significant contri-

bution for both patient- and therapist-rated Therapeutic Openness/Involvement. From our perspective, hopelessness is diminished and optimism is restored in the context of a warm, respectful, understanding collaborative relationship. Renewed morale in turn fosters a sense of well-being and healthiness. Thus, Remoralization can be seen as a relationship impact mediating the effect of interpersonal therapy processes on immediate outcomes such as well-being.

Unburdening accounted for unique portions of variance in patient-rated Therapeutic Bond, Therapeutic Openness/Involvement, and Session Progress. Again considering this association in terms of basic psychotherapy processes, nondefensive participation in a secure relationship promotes self-reflective expression and consideration of distressing experiences. In turn, when unburdening occurs in the therapeutic enterprise, the session is evaluated as helpful and progress is perceived. Hence, Unburdening can be viewed as another mediator of relationship effects on more immediate therapy outcome.

Patient-rated Past-Focused Insight was uniquely associated with the therapist-rated operation of Exploratory: Past-Focused Interventions, whereas patient-rated Present-Focused Understanding was uniquely related to the therapist-rated operation of Prescriptive Interventions. Within the present sample, patients reported experiencing task-congruent impacts consistent with the specific types of interventions reported to be offered by therapists. Past-focused exploratory intervention efforts lead to insights linking past and present experience. Similarly, present-focused directive interventions help to foster understanding of the current situation. This pattern of findings provides noteworthy evidence for the discriminant validity of the two realizations scales associated with task-related impacts. That is, despite their degree of intercorrelation, they were discriminantly associated with different, theoretically relevant realizations as independently reported by patients. Clinically, it is indeed reassuring to know that patients seem to be receiving what therapists report they are delivering.

Across the analyses reported, it appears that the TRS-R (both as a global scale and in terms of its factor structure) is a valuable addition to the set of instruments available for psychotherapy session impact research. Naturally, our conclusions must be considered in light of limitations inherent in the present work. It is important to bear in mind that the process and outcome measures consisted of the patients' and therapists' reports of session events and that in this study there was no independent confirmation of these perceptions. However, the change processes examined in this study are highly phenomenological in nature, and experiential variables such as these are likely to be best captured by patient and therapist self-report. In addition, this was a naturalistic study involving three brands of therapy as delivered in a training clinic; the therapy did not explicitly follow a manual, although manuals were used didactically as part of the training program. While naturalistic designs maximize generalizability and external validity, limits to generalizability were introduced in this work by the delivery of disparate therapies without manuals in a training clinic. Most importantly, although we interpret our findings within a theory-based model of reciprocal causality between patient and therapist, we acknowledge that the correlational analyses reported above cannot be considered evidence for causal associations among variables. Nonetheless, we offer these preliminary interpretations based on the overall fit between the present findings and the conceptual and empirical literature from which the TRS-R emerged.

References

- Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.

- Elliott, R. (1985). Helpful and nonhelpful events in brief counseling interviews: An empirical taxonomy. *Journal of Counseling Psychology*, 32, 307–322.
- Elliott, R., James, E., Reimschuessel, C., Cislo, D., & Sack, N. (1985). Significant events and the analysis of immediate therapeutic impacts. *Psychotherapy*, 22, 620–630.
- Elliott, R., & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review*, 9, 443–467.
- Elliott, R., & Wexler, M. M. (1994). Measuring the impact of sessions in process-experiential therapy of depression: The Session Impacts Scale. *Journal of Counseling Psychology*, 41, 166–174.
- Frank, J.D. (1973). *Persuasion and healing: A comparative study of psychotherapy* (Rev. ed.). Baltimore: Johns Hopkins University Press.
- Frank, J.D., & Frank, J.B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd. ed.). Baltimore: Johns Hopkins University Press.
- Greenberg, L.S., & Webster, M.C. (1982). Resolving decisional conflict by Gestalt two-chair dialogue: Relating process to outcome. *Journal of Counseling Psychology*, 29, 468–477.
- Hill, C.E., Helms, J.E., Spiegel, S.B., & Tichenor, V. (1988). Development of a system for categorizing client reactions to therapist interventions. *Journal of Counseling Psychology*, 35, 27–36.
- Howard, K.I., & Orlinsky, D.E. (1987). [Therapy session report first-level factor scores]. Unpublished raw data.
- Kazdin, A.E. (1994). Methodology, design, and evaluation in psychotherapy research. In A.E. Bergin & S.L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 19–71). New York: Wiley.
- Klerman, G.L., Weissman, M.M., Rounsaville, B.J., & Chevron, E.S. (1984). *Interpersonal psychotherapy of depression*. New York: Basic Books.
- Kolden, G.G. (1988). Process and outcome in psychotherapy: An empirical examination of Orlinsky and Howard's generic model of psychotherapy. *Dissertation Abstracts International*, 49, 1945B.
- Kolden, G.G. (1991). The generic model of psychotherapy: An empirical investigation of patterns of process and outcome relationships. *Psychotherapy Research*, 1 (1), 62–73.
- Kolden, G.G. (1993a). *Therapy Session Report—Generic Model, Patient version*. Madison, WI: University of Wisconsin—Madison.
- Kolden, G.G. (1993b). *Therapy Session Report—Generic Model, Therapist version*. Madison, WI: University of Wisconsin—Madison.
- Kolden, G.G. (1996a). Change in early sessions of dynamic therapy: Universal processes and the generic model of psychotherapy. *Journal of Consulting and Clinical Psychology*, 64, 489–496.
- Kolden, G.G. (1996b). Effective microprocesses in early sessions of dynamic psychotherapy. *Journal of Psychotherapy Practice and Research*, 5, 122–31.
- Kolden, G.G., & Howard, K.I. (1992). An empirical test of the generic model of psychotherapy. *The Journal of Psychotherapy Practice and Research*, 1, 225–236.
- Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment*. New York: Basic Books.
- Mallinckrodt, B. (1994). Session impact in counseling process research: Comment on Elliott and Wexler (1994) and Stiles et al. (1994). *Journal of Counseling Psychology*, 41, 186–190.
- Mintz, J., Luborsky, A., & Aurbach, A.H. (1971). Dimensions of psychotherapy: A factor analytic study of ratings of psychotherapy sessions. *Journal of Consulting and Clinical Psychology*, 36, 106–120.
- Morgan, R., Luborsky, L., Crits-Christoph, P., Curtis, H., & Solomon, J. (1982). Predicting the outcomes of psychotherapy by the Penn Helping Alliance Rating Method. *Archives of General Psychiatry*, 39, 397–402.
- Orlinsky, D.E., Grawe, K., & Parks, B.K. (1994). Process and outcome in psychotherapy—Noch

- einmal. In A.E. Bergin & S.L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270–376). New York: Wiley.
- Orlinsky, D.E., & Howard, K.I. (1966). *Therapy Session Report, Forms P and T*. Chicago: Institute of Juvenile Research.
- Orlinsky, D.E., & Howard, K.I. (1975). *Varieties of psychotherapeutic experience: Multivariate analyses of patients' and therapists' reports*. New York: Teachers College Press.
- Orlinsky, D.E., & Howard, K.I. (1977). The therapist's experience of psychotherapy. In A.S. Gurman & A.M. Razin (Eds.), *Effective psychotherapy: A handbook of research* (pp. 566–590). Elmsford, NY: Pergamon Press.
- Orlinsky, D.E., & Howard, K.I. (1986a). Process and outcome in psychotherapy. In S.L. Garfield & A.E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed.). New York: Wiley.
- Orlinsky, D.E., & Howard, K.I. (1986b). The psychological interior of psychotherapy: Explorations with the therapy session reports. In L.S. Greenberg & W.M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook*. New York: Guilford Press.
- Orlinsky, D.E., & Howard, K.I. (1987). A generic model of psychotherapy. *Journal of Integrative and Eclectic Psychotherapy*, 6, 6–27.
- Orlinsky, D.E., Lundy, M., Howard, K.I., Davidson, C.V., & O'Mahoney, M.T. (1987). *Therapeutic Procedures Inventory—Revised*. Chicago, IL: Northwestern University.
- Sachs, J.S. (1983). Negative factors in brief psychotherapy: An empirical assessment. *Journal of Consulting and Clinical Psychology*, 51, 557–564.
- Stiles, W.B. (1980). Measurement of the impact of psychotherapy sessions. *Journal of Clinical Psychology*, 23, 311–312.
- Stiles, W.B., Reynolds, S., Hardy, G.E., Rees, A., Barkham, M., & Shapiro, D.A. (1994). Evaluation and description of psychotherapy sessions by clients using the Session Evaluation Questionnaire and the Session Impacts Scale. *Journal of Counseling Psychology*, 41, 175–185.
- Stiles, W.B., & Snow, J.S. (1984a). Counseling session impact as viewed by novice counselors and their clients. *Journal of Counseling Psychology*, 31, 3–12.
- Stiles, W.B., & Snow, J.S. (1984b). Dimensions of psychotherapy session impact across sessions and across clients. *British Journal of Clinical Psychology*, 23, 59–63.
- Strupp, H.H., & Binder, J.L. (1984). *Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy*. New York: Basic Books
- Taube, C.A., Burns, B.J., & Kessler, L. (1984). Patients of psychiatrists and psychologists in office-based practice: 1980. *American Psychologist*, 39, 1435–1447.
- Vessey, J.T., & Howard, K.I. (1993). Who seeks psychotherapy? *Psychotherapy*, 30, 546–553.