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EMPIRICAL PAPER

Measuring change in relating and interrelating during the early stages of psychotherapy: Comparison with a nonpatients' sample

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Abstract
The study examined whether the relative short time period of two months of individual psychotherapy improved patients' psychiatric symptoms, their negative relating (i.e. destructive and undesirable interpersonal attitudes and behavior to others) and their negative interrelating (i.e. destructive and undesirable relationship with their partners). A sample of 60 outpatients, reportedly suffering mainly from a mood or anxiety disorder, were compared with a sample of 48 nonpatients and their partners, over a comparable time span. It was shown that the patients' psychopathology scores dropped significantly. Significant changes in some relating and interrelating scores also occurred, even though the therapy had not specifically addressed these issues. Unexpectedly, the partners demonstrated some degree of deterioration both in their relating and their interrelating scores.

Keywords: couple relationship/interrelating; psychotherapy; relating theory; psychiatric outpatients; the short version of the Couple's Relating to Each Other Questionnaires; the short version of the Person's relating to others Questionnaire

Introduction

There is a well-established literature showing that patients suffering mainly from anxiety or depression have improved after five to eight sessions of cognitive behavioral or interpersonal therapy (Haas, Hill, Lambert, & Morrell, 2002; Hayes et al., 2007; Lutz et al., 2013). For several decades now, psychotherapists have been interested in the impact that individual psychotherapy has upon the client's significant others, particularly the client's marital partner (Fox, 1968; Hafner, 1979; Kniskern & Gurman, 1985). Studies have revealed different reactions from the partners. Significant others may have conflicting feelings about their partners' therapy, ranging from acknowledging improvement in communication within their relationship, being more empathic and open, being pleased that the client was benefiting from therapy, to feeling blame and inadequacy and being excluded from the therapist–patient relationship or annoyance by, and resentment of the client's changes (Brody & Farber, 1989; Hafner, 1979; Hunsley & Lee, 1995). There is also evidence that patient's psychotherapy of different modalities can be threatening to couple's relationships (Colson, Lewis, & Horwitz, 1985; Kohl, 1962; Milton & Hafner, 1979; Zeitner, 2003) and may have potentially negative effects on significant others (Ackerman, 1958; Koch & Ingram, 1985; Zeitner, 2003).

On the other hand, a large body of research has documented that individually oriented therapies can be effective for both the partner and the couple's relationship (e.g., Brody & Farber, 1989; Lefebvre & Hunsley, 1994), particularly to those with higher levels of pretherapy marital satisfaction (Milton & Hafner, 1979) and may also have positive repercussions, spreading extensively toward members of the extended family (Roberts, 1996). It has also been shown that

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individual psychotherapy brings about marked improvements on the majority of the indices of negative relating (Birtchnell, Hammond, Horn, De Jong, & Kalaitzaki, 2013) and negative interrelating with family members (e.g., parents–patients) who had not been involved in the patient's therapy (Kalaitzaki, Birtchnell, & Nestoros, 2010). Such improvement occurred after the first three months of individual psychotherapy, and it had been sustained by the end of therapy, which was about one year later (mean number of sessions: 41.3). Improvement, as it applies to the measures of relating and interrelating, implies a shift from negative relating to positive relating (as will be defined in the next paragraph).

Birtchnell's (1993/1996) relating theory is relevant to this study and for this reason, it will be briefly summarized. It defines relating as a person's attitude and behavior toward other people or one particular person, and interrelating as the relating which takes place between two specified people. Interrelating is both each person's relating behavior toward the other and each person's view of the other's relating behavior toward him/her. Birtchnell proposed that relating occurs across two primary axes: a horizontal one concerning becoming close (referred to as Neutral Close or NC to indicate relating purely from this pole) versus becoming distant (referred to as Neutral Distant or ND); and a vertical one concerning relating from above downwards (e.g., dominance, control; Upper Neutral or UN) versus relating from below upward (e.g., submission, shunning responsibility; Lower Neutral or LN). The four intermediate positions of upper close (UC), upper distant (UD), lower close (LC), and lower distant (LD) have been inserted between the four polar positions to create a theoretical structure that is called the interpersonal octagon. Relating theory assumes that positive relating is constructive, advantageous, and desirable, whilst negative relating is destructive, disadvantageous, and undesirable to the person being related to. Thus, positive relating is the condition of relating confidently, effectively, respectfully, considerately, and inoffensively toward another person in each one of the eight positions of the octagon, whereas negative relating is a person's lack of competence to relate positively to other(s) or a troubled relating behavior. More specific, negative relating is an anxious, self-centered, inconsiderate, clumsy, or awkward relating behavior toward another person (Birtchnell, 1993/1996), which may result in a unidirectional or bidirectional dissatisfying relationship between the two relaters. Typical examples of positive and negative features of relating in each octant of the octagon are presented in Figure 1. This paper is concerned predominantly with the negative forms of each position.

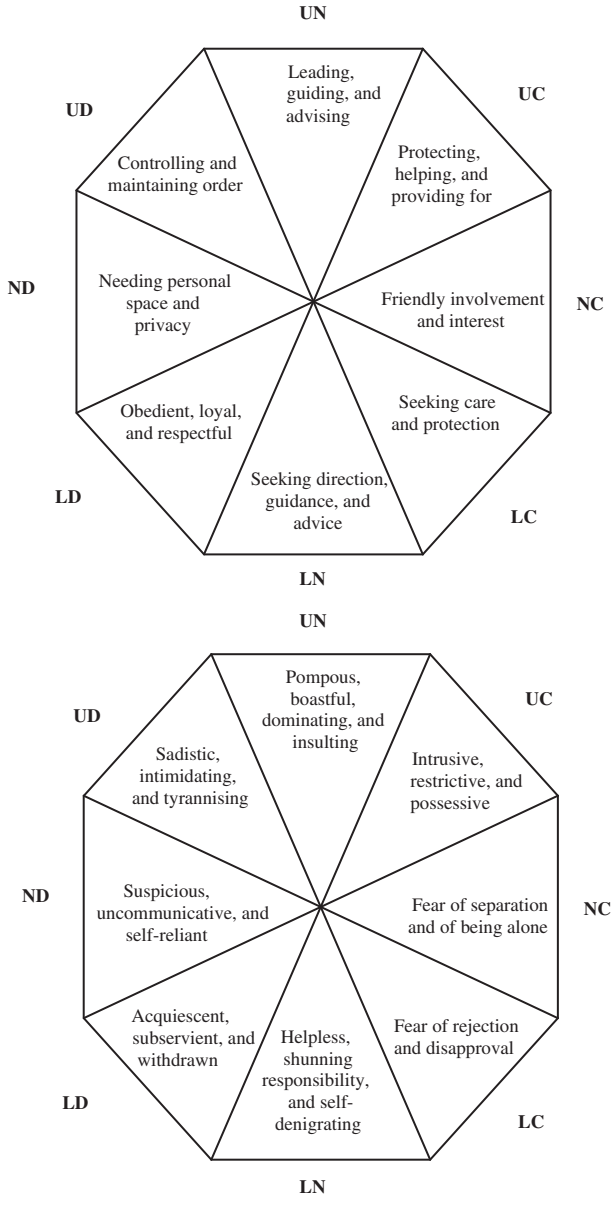

Figure 1. Examples of positive (upper diagram) and negative (lower diagram) forms of relating for each octant. The initials are abbreviations for the full names of the octants given in the text. Note: UN, upper neutral; UC, upper close; NC, neutral close; LC, lower close; LN, lower neutral; LD, lower distant; ND, neutral distant; UD, upper distant.

Comparing Relating Theory with Interpersonal Theory

A comparison between Birtchnell's relating theory and Leary's (1957) interpersonal theory has been provided in detail elsewhere (Birtchnell, 1994, 2014). While Leary considered that adaptive and maladaptive relating are quantitative different (and for this they are represented in a continuum), Birtchnell considers that they are qualitative different (and for this there is both a positive and a negative octagon). While 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. Thus, a person is allowed to relate from either pole, even the seemingly opposite ones, such as when, for instance, someone experiences problems with both closeness and distance (i.e., desperately clinging to his/her partner, while also being uncommunicative). Whereas Leary's circle requires the statistical procedure that is called ipsatisation, in order to correct for the high positive correlation between scales, Birtchnell's octagon does not. Where Leary's theory considers interpersonal behavior to be a way of alleviating anxiety, Birtchnell's theory considers relating to be a normal interaction between people. Where Leary's Interpersonal Checklist (ICL) has half adaptive and half maladaptive items, Birtchnell's basic instrument, the Person's Relating to Others Questionnaire (PROQ3), measures only negative relating. The most widely used circle-based measure, the circumplex version of the Inventory of Interpersonal Problems (IIP-C; Alden, Wiggins, & Pincus, 1990), resembles the PROQ3 (Birtchnell, 2014). Personality disorders have been more successfully classified within Birtchnell's theory than within interpersonal circle (Birtchnell & Shine, 2000).

A computer-generated graphic representation of a person's dysfunctional relating in the form of the shaded areas of the octants of an octagon is an important feature of relating theory. Thus, at a glance, the therapist can obtain a clear picture of the patient's dysfunctional relating. An important feature of relating theory is its application to both relating and being related to (i.e., interrelating). Although the benefits of considering for each partner both the self-ratings and partner-ratings have been recognized by other authors (e.g., Busby & Gardner, 2008; Watson, Hubbard, & Wiese, 2000), to the authors' knowledge there is no such other measure of interpersonal relating.

The aim of the present study was to examine the possible interpersonal effects of a brief period of individual psychotherapy for both the couple and each partner separately. It specifically examined the question of whether the first two months of therapy of 60 Greek psychotherapy outpatients had had the effect of improving their own and their partners' relating to others. It also measured their (in-between) interrelating. Only one member had been the recipient of therapy and neither relating nor interrelating difficulties may had been specifically addressed during the course of therapy. The patients were compared with a control sample of 48 nonpatients and their partners, over a comparable time span. It was expected that, even over as short a period as two months, (i) the patients' psychiatric symptoms would have dropped significantly; (ii) the patients' negative relating and interrelating would have changed to some extent; (iii) the partners' negative relating and interrelating may also have changed to some extent because the partners would have had close involvement with the patients. Change in negative relating and interrelating was expected to have been more marked than that of the members of the control group (neither of whom had received psychotherapy).

Method

Participants

Patients and their partners. The initial sample comprised 79 Greek patients and their partners. Based on exclusion criteria (i.e., high rate of missing responses, omission of either partner to return questionnaires, or premature termination of therapy), a sample of 60 Greek psychotherapy patients (18 men, 30% and 42 women, 70%) and their partners had finally been recruited from the private practices of 10 psychotherapists. The patients' and their partners' age was around 18–24 (33.3% and 30.0%, respectively; range for both: 18–49). Based on the demographics, 23% of the patients reportedly suffered from a mood disorder (mainly dysthymia or depression), 44% reportedly had an anxiety disorder (mainly panic attacks), but 33% admitted to no previously diagnosed psychiatric disorder (though they reportedly suffered stress, agitation, and various other symptoms). The therapists' formal diagnostic criteria were not available to the investigators. Of the partners, none had admitted to being currently suffering from a psychiatric disorder. The couples were mostly married (53.3%) or in a committed relationship (46.7%), which was described as a constant one (79.3%).

Nonpatients and their partners. The nonpatient couples were recruited using the snowball/chain-sampling technique, for which questionnaires were handed out to senior authors' relations and students. A few couples were also recruited by the parents of the children attending an elementary school. Initially, 100 Greek couples were approached. Eighty-seven of them agreed to participate. Based on the aforementioned exclusion criteria, finally 48 Greek nonpatient couples were used as a control group (27 men, 56.3% and 21 women, 43.8%). For making patients and nonpatients comparable, one member of the nonpatients' couple was randomly assigned as the "index case" and the other the "partner." The index cases' and their partners' age

were around 18–24 (37.3% and 43.8%, respectively; range for both: 18–59). None of the index cases or their partners reported currently suffering from a psychiatric disorder. The couples were either married (43.8%) or in a committed relationship (56.2%), which was described as a constant one in all cases.

Comparability of the samples. In both samples, all couples turned out to be heterosexuals. All couples were in the same relationship at Time point Two of the study. Significantly more patients than nonpatients had a higher degree diploma (college, university, or masters' degree: 65.4% vs. 43.8%; $\chi^2_{(6)} = 41.05$, $p < .001$), a full-time paid job (60.0% vs. 37.5%; $\chi^2_{(4)} = 10.800$, $p < .029$), and reportedly a good yearly income (52.6% vs. 47.4%; $\chi^2_{(4)} = 11.33$, $p < .023$).

Therapists. This was a convenience sample, comprising of seven psychologists and three psychiatrists (69% females; mean age: 38 years), who agreed to participate from the 20 therapists that were initially approached. Their mean level of experience practicing psychotherapy was 6.8 years ($SD = 2.9$) and 20% of them had a master's or doctoral degree.

Therapy. Individual therapy sessions, typically lasting 50 minutes, were held weekly. The treatment plan, techniques, and therapy duration depended on the salient orientation practiced, which reportedly was humanistic (47%), psychoanalytic/psychodynamic (28%), or behavioral/CBT (21%). The therapy may not have been specifically directed toward the patients' relationship with their partners. The average sessions between the two time points was 7.65 ($SD = 0.67$, range 6–9 sessions).

The Measures

Psychopathology measure. The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) is a self-report rating scale of 14 items for measuring anxiety and depression (seven items for each subscale). The responses range from 0–3. The maximum score for each subscale is 21 and for the total questionnaire is 42. The Greek translation has shown good psychometric properties (Michopoulos et al., 2008). In the present study, Cronbach alphas were all above .80. It was used in this study with permission.

Relating and interrelating measures. *The short version of the Person's Relating to Others Questionnaire (PROQ3).* The PROQ3 (Birtchnell et al., 2013) a computer-scored questionnaire, was designed to measure only negative (i.e., maladaptive or deficient) relating. Its 48 self-rating items are allocated to eight scales, which correspond to the eight octants of the interpersonal octagon (Birtchnell, 1993/1996, 1994). Of its 48 items, eight are positive (one for each scale), and though they do not contribute to the score, they have been included in order to reduce the negative tone of the questionnaire. The responses are given on a 4-point Likert scale, ranging from 0–3. The maximum score for each subscale is 15 and for the complete questionnaire is 120. The higher the score, the more maladaptive is the relating. Good psychometric properties have been demonstrated for both the English and Greek versions (Birtchnell

Table I. The range of Cronbach alphas and the mean inter-scale correlations, using Pearson's product moment correlation coefficient, is presented for the PROQ3, OPROQ3, and CREOQ measures, for both the patients and nonpatients, and their partners.

		Croncbach alphas[a]		Interscale correlations[b]			
				Index case		Partner	
		Index case	Partner	Adjacent octants	Rest octants	Adjacent octants	Rest octants
PROQ3	Patients	.55–.87	.64–.82	0.37	0.16	0.22	0.10
	Nonpatients	.65–.85	.55–.79	0.43	0.18	0.30	0.09
OPROQ3	Patients		.59–.86			0.31	0.06
	Non-patients	.55–.87	.54–.83	0.40	0.29	0.43	0.14
CREOQ (Self-rating)	Patients	.53–.78	.57–.83	0.40	0.30	0.31	0.08
	Non-patients	.57–.84	.63–.76	0.20	0.10	0.39	0.24
CREOQ (Other rating)	Patients	.57–.89	.64–.77	0.37	0.20	0.34	0.21
	Nonpatients	.57–.81	.75–.81	0.26	−0.04	0.42	0.20

Note. [a]The internal consistency of the scales was calculated with the Cronbach alpha coefficients. The range of the coefficients is presented here.
[b]Interscale correlation matrices for the eight scales of each questionnaire were generated, for both the nonpatients and the patients, and their partners. The mean of the correlations is presented here. Consistent with the expectation (Birtchnell et al., 2006), the mean of the correlations between the polar scales (neutral close, NC; neutral distant, ND; upper neutral, UN; and lower neutral, LN) and the adjoining intermediate ones (e.g., upper close, UC) should be higher than the mean of the correlations of the remaining scales.

et al., 2013). In the present study, the Greek version was used, the psychometric properties of which are presented in Table I. It can be downloaded from http://www.johnbirtchnell.co.uk.

The short version of the Observed Person's Relating to Others Questionnaire (OPROQ3). The OPROQ3 is essentially an other-rating version of the PROQ3, with which one person can rate the negative relating of another. The item structure and scoring instructions are identical to the PROQ3, with the I-statements being changed to he/she-statements. It was used in the present study in order to take into account the partners' reports of the patients and nonpatients' (index cases') negative relating. The psychometric properties of the OPROQ3 are presented in Table I.

The short version of the Couple's Relating to Each Other Questionnaires (CREOQ3). The CREOQ3 was designed to measure only negative interrelating. It is half the length of the original 96-items CREOQ (Birtchnell, 2001; Birtchnell, Voortman, Dejong, & Gordon, 2006). In its name, it has been assigned the "3" in order to make it comparable with the PROQ3. There never was a CREOQ2. The CREOQ3 comprises a self-relating measure (how the person considers that he/she relates to the other) and a partner-rating measure (how he/she considers that the other relates to him/her) for each of the two partners. The items for the two self-rating questionnaires and for the two partner-rating questionnaires differ only in terms of the gender. The item structure and scoring instructions of each questionnaire are identical to the PROQ3. The higher the score, the more maladaptive is the interrelating. Good psychometric properties have been reported for the longer version (CREOQ), in both the English (Birtchnell et al., 2006) and Greek versions (Kalaitzaki, Birtchnell, & Nestoros, 2009). The CREOQ3 can be downloaded from http://www.johnbirtchnell.co.uk. Table I presents Cronbach alphas coefficients and inter-scale correlations for both the patients and nonpatients, and their partners, in all the relating (i.e., PROQ3 and OPROQ3) and interrelating (CREOQ3) measures used in this study.

Procedure/Data Collection

On admission to each therapist's private practice, the patients were informed of the purpose of the study and of their rights (i.e., anonymity, confidentially, and voluntary participation). These points were also printed on the cover page of the questionnaire, which functioned as an informed consent. Agreeing to participate, they were given two questionnaires for them and their partners to complete as soon as they got home. Partners' version of the questionnaire also contained the OPROQ3 for them to rate the patients' negative relating to others. The completed questionnaires were placed in a sealed envelope, which was delivered by hand by the patient to the therapist. The same procedure was carried out after two months. An assistant to the senior author kept a check on the times when the sets of questionnaires were to be completed and supervised their collection. The senior author was responsible for administering the questionnaires to the nonpatients, reminding the participants to return them, and collecting the questionnaires. Both partners completed the OPROQ3 so that no suspiciousness or no mistrust was raised by any partner.

Analyses

The central issue was to know what the persons' view of the change of their relating and interrelating was. The individualized use of dyadic information concerning change in one member can prove to be misleading because of the inherent interdependence of the data sources (Kenny, Kashy, & Cook, 2006). The interdependence between persons and partners was taken into account by applying a multilevel mixed model to the data (Campbell & Kashy, 2002; Kenny & Cook, 1999). Initially, indices of change were calculated for each person over the two-month period by using the simple Reliable Change Index (RCI) for every PROQ3 and CREOQ3 scale score. The RCI was calculated by dividing the difference between pretest and posttest score by the corrected standard error of measurement derived from the test–retest reliabilities (Christensen & Mendoza, 1986): $RCI = \frac{x1-x2}{SDiff}$, where RCI = Reliable change index, $x1$ = pretest score (time 1), $x2$ = posttest score (time 2), and SDiff = Standard error of difference between two test scores. The *SDiff* was estimated using the formula: $SDiff = \sqrt{2(SE)^2}$. The Standard Error (SE) was estimated as: $SE = \sigma\sqrt{1 - r_{tt}}$, where σ is the standard deviation of the score from the first administration and r_{tt} is the estimate of test–retest reliability. Data were then arranged in dyads (patient and partner). For the patients, the unit of analysis was the patients' PROQ3 or CREOQ3 scores, namely, the patients' self-rating and the partners' other-rating (rating of the patients). For the partners, the unit of analysis was the partners' PROQ3 or CREOQ3 scores, namely, the partners' self-rating and the patients' rating of their partners. The RCI for each scale was entered as a multiple outcome measure. A Mixed Model analysis was then carried out for each scale for both the patients and their partners' PROQ3 and CREOQ3, in which membership of a dyad was used

as the random effect and "Group" was entered as fixed effect. Because the data are in *z*-score form, the effects reported represent standard deviations. All statistical analyses were conducted with IBM SPSS 20.0 (Nie, Hull, & Bent, 2011).

Results

It was examined whether there was evidence that the patients had improved after two months more than the nonpatients either symptomatically or in terms of their negative relating or negative interrelating.

Did the Patients' Psychopathology Symptoms Change?

The patients' anxiety and depression scores dropped significantly after two months of therapy (Anxiety: 11.5 vs. 9.1, $t_{(59)} = 4.24$, $p = .000$; Depression: 8.8 vs. 7.9, $t_{(59)} = 2.33$, $p = .023$). There was also a significant drop in the partners' anxiety scores (4.5 vs. 4.0, $t_{(57)} = 2.39$, $p = .020$), but not in their depression scores (4.2 vs. 4.7, $t_{(57)} = 1.69$, $p = .097$). Fewer changes occurred in the nonpatients' sample. Only nonpatients' anxiety scores dropped significantly from .1–.2 (6.2 vs. 4.9, $t_{(41)} = 2.80$, $p = .008$).

Did the Patients' Negative Relating to Others (PROQ3) and Negative Interrelating with Their Partners (CREOQ3) Change?

The results of the multilevel mixed model for the PROQ3 and CREOQ3, for the patients and their partners are summarized in Tables II and III, respectively. The results demonstrated a small number of statistically significant effect sizes. From Table II, it is clear that the majority of the PROQ3 scale scores dropped, suggesting that patients manifested less negative relating, though not all differences were statistically significant. The patients and the nonpatients groups significantly differed only on UN and NC, suggesting patients' amelioration on these scales. This effect was also apparent for the CREOQ3; statistically significant differences were shown only for the UN and UD scales, suggesting patients' improvement on these certain scales. This was consistent with the expectation that, if the therapy was being successful, the patient's reported marital quality would also show an improvement (e.g., Hunsley & Lee, 1995).

Did the Artners' Corresponding Scale Scores Change?

Although the partners were not involved in the patients' psychotherapy, the partners' negative relating

Table II. Multilevel analysis on patients change, taking the dyadic effects into account.

	Fixed effects		Random effects		
PROQ3 scales	Intercept	Group	Intercept	Residual	AIC
UN	0.45 (0.30)	−0.37* (0.15)	−0.15 (0.11)	−0.83 (0.12)	599.65
UC	−0.90 (0.34)	0.32 (0.17)	−0.37 (0.10)	−0.62 (0.08)	578.96
NC	0.23 (0.28)	−0.38* (0.14)	0.00 (0.00)	−0.97 (0.09)	600.31
LC	−0.21 (0.32)	0.08 (0.16)	−0.29 (0.12)	−0.72 (0.11)	601.23
LN	0.27 (0.29)	−0.04 (0.14)	−0.08 (0.11)	−0.91 (0.13)	606.71
LD	−0.70* (0.31)	−0.10 (0.16)	−0.29 (0.10)	−0.66 (0.09)	584.00
ND	−0.13 (0.33)	−0.08 (0.16)	−0.31 (0.11)	−0.70 (0.10)	598.96
UD	−0.75* (0.29)	0.06 (0.14)	−0.07 (0.09)	−0.89 (0.12)	598.58
Total	−0.37 (0.34)	−0.06 (0.17)	−0.44 (0.12)	−0.59 (0.09)	592.14
CREOQ3 scales					
UN	0.45 (0.30)	−0.61* (0.17)	−0.16 (0.11)	−1.26 (0.17)	696.31
UC	1.08 (0.41)	−0.52 (0.21)	−0.19 (0.19)	−1.81 (0.25)	768.50
NC	0.46 (0.51)	−0.28 (0.26)	−1.16 (0.24)	−1.00 (0.13)	748.73
LC	−0.09 (0.14)	0.08 (0.15)	−0.21 (0.09)	−0.67 (0.09)	586.88
LN	−0.55 (0.31)	0.02 (0.16)	−0.09 (0.11)	−1.08 (0.15)	654.95
LD	−0.26 (0.27)	−0.07 (0.14)	−0.19 (0.07)	−0.59 (0.08)	528.31
ND	0.07 (0.27)	0.14 (0.14)	−0.24 (0.07)	−0.45 (0.06)	530.44
UD	1.05* (0.28)	−0.43* (0.14)	−0.15 (0.09)	−0.75 (0.10)	593.18
Total	0.69 (0.43)	−0.35 (0.22)	−0.80 (0.17)	−0.73 (0.10)	677.91

Note. PROQ3 = the short version of the Person's Relating to Others Questionnaire; CREOQ3 = the short version of the Couple's Relating to Each Other Questionnaires.
UN, upper neutral; UC, upper close; NC, neutral close; LC, lower close; LN, lower neutral; LD, lower distant; ND, neutral distant; UD, supper distant.
Standard errors of the estimates are presented in the parentheses.
Fixed effects manifesting statistical significance at the 1% level are highlighted by an asterisk.
A negative sign indicates amelioration and a positive sign indicates deterioration, as the concept assessed is "negative relating" or "negative interrelating."

Table III. Multilevel analysis on partners change, taking the dyadic effects into account.

	Fixed effects		Random effects		
PROQ3 scales	Intercept	Group	Intercept	Residual	AIC
UN	−0.10 (0.31)	−0.25 (0.16)	0.00 (0.00)	0.99 (0.11)	449.45
UC	0.24 (0.32)	−0.22 (0.17)	0.19 (0.11)	0.80 (0.13)	447.93
NC	−0.56 (0.31)	0.11 (0.17)	0.00 (0.00)	0.99 (0.11)	448.91
LC	0.22 (0.32)	−0.11 (0.17)	0.05 (0.17)	0.96 (0.19)	452.25
LN	−0.64 (0.34)	0.22 (0.18)	0.44 (0.12)	0.52 (0.12)	433.22
LD	−0.77* (0.30)	0.48* (0.17)	0.04 (0.18)	0.91 (0.20)	441.85
ND	0.75* (0.30)	−0.15 (0.17)	0.00 (0.00)	0.97 (0.11)	445.11
UD	−0.05 (0.33)	−0.11 (0.18)	0.24 (0.14)	0.77 (0.15)	449.41
Total	−0.25 (0.32)	0.02 (0.17)	0.11 (0.11)	0.89 (0.14)	449.99
CREOQ3 scales					
UN	−0.33 (0.29)	0.21 (0.15)	0.09 (0.09)	0.90 (0.12)	621.39
UC	−0.41 (0.27)	0.26 (0.14)	0.00 (0.00)	0.98 (0.09)	618.86
NC	0.05 (0.29)	−0.29 (0.15)	0.10 (0.09)	0.88 (0.12)	617.54
LC	−0.61* (0.27)	0.05 (0.14)	0.00 (0.00)	0.97 (0.09)	615.88
LN	−0.13 (0.32)	0.04 (0.16)	0.28 (0.10)	0.73 (0.09)	614.22
LD	0.74* (0.30)	0.13 (0.15)	0.17 (0.09)	0.76 (0.10)	595.38
ND	−0.36 (0.30)	−0.12 (0.15)	0.21 (0.09)	0.76 (0.10)	610.48
UD	−0.84* (0.30)	0.62* (0.15)	0.26 (0.09)	0.66 (0.09)	594.02
Total	−0.60 (0.30)	0.27 (0.15)	0.21 (0.09)	0.77 (0.10)	611.47

Note. PROQ3 = the short version of the Person's Relating to Others Questionnaire; CREOQ3 = the short version of the Couple's Relating to Each Other Questionnaires.
UN, upper neutral; UC, upper close; NC, neutral close; LC, lower close; LN, lower neutral; LD, lower distant; ND, neutral distant; UD, upper distant.
Standard errors of the estimates are presented in the parentheses.
Fixed effects manifesting statistical significance at the 1% level are highlighted by an asterisk.
A negative sign indicates amelioration and a positive sign indicates deterioration, as the concept assessed is "negative relating" or "negative interrelating."

and interrelating were also expected to change to some extent, as an effect of their close involvement with the patients. As can be seen in Table III, the drops were less marked for the partners than for the patients, and unexpectedly, there had been some deterioration in the partners' PROQ3 and CREOQ3 scores. In particular, the partners' scores in the PROQ3 scale LD and in the CREOQ3 scale UD had got worse.

Discussion

In line with previous findings (Birtchnell et al., 2013; Kalaitzaki et al., 2009), the PROQ3 showed adequate internal consistency and discriminant validity in respect of the comparison of the patients with the nonpatients' scores, similarly the CREOQ3. It was reassuring that the OPROQ3, a further modification of the PROQ3, which concerned the person's view of the partner's relating to others, was in line with the aforementioned results. Higher interrater reliability was shown for the nonpatients' PROQ3 and the patients' CREOQ3. Healthy persons may assess their relating to others more accurately than unhealthy ones. Healthy couples may disagree in their views of the other in respect of the situational characteristics of their relationship (Fincham, Beach, & Baucom, 1987), whereas unhealthy couples may assimilate themselves to each other, and thus, agree in their views of the other. Higher test–retest coefficients were also shown for the nonpatients compared to the patients, which may manifest rather than poor reliability of the measures, high sensitivity to capture/detect real changes. However, further research is required on the psychometric properties of the instruments.

Patients' Change at the Early Stages of Psychotherapy

The examination of the possible change in the patients' psychiatric symptoms and in their negative relating to others over the relatively short period of two months of therapy was an important feature of this study. In line with previous findings (Haas et al., 2002; Kalaitzaki et al., 2010), improvements in patients' psychopathology occurred at an early stage of psychotherapy. As might have been expected, improvement also occurred in the patients' relating to others (PROQ3) scores, though it was significant on only two scales. What is perhaps striking is that such change can occur even after only a relatively short period of psychotherapy. It would be a possibility though, that when a person's psychiatric

condition improves, his/her view of his/her relating may be more positive, though the opposite might also be so: a negatively relating person might be more prone to become depressed or judge his/her psychiatric condition more pessimistically, than a positively relating person.

The study also examined whether the patients' reportedly negative interrelating with their partners, who had not been involved in the therapy, had changed after only two months of therapy, particularly as it may not have been specifically directed toward the couple's relationship. Thus, it was reassuring to find that two of the patients' self-rating CREOQ3 scales improved significantly. The study suggested that both relating and interrelating can be changed over the course of psychotherapy, even though the therapist may not have focused attention specifically upon the relating or interrelating process.

Partners' Change over the Course of Patients' Therapy

Though the patients' partners' psychopathology scores were within the range of normality (Crawford, Henry, Crombie, & Taylor, 2001; Snaith, 2003), their anxiety scores dropped further after two months of patients' therapy. Therefore, the patients' therapy seems to have had a positive effect upon their partners, suggesting that changing the level of psychopathology in one partner, has a positive impact upon the functioning of the other partner may occur.

However, the amelioration of the patients' interpersonal difficulties would seem to have created a disturbance in their relationship with their partners: partners' interrelating with the patients (CREOQ) deteriorated in nearly all scales, though significantly on only one. A similar pattern was observed for the partners' relating to others (PROQ3). This is consistent with previous findings (e.g., Colson et al., 1985; Zeitner, 2003) and may suggest that the patients' change was unwelcomed by their partners. Significant others may even resist or sabotage, either consciously or unconsciously, their partner's therapy (Hurvitz, 1967; Kohl, 1962), or they may themselves simply find it difficult to cope with the new relating and interrelating patterns expressed by the partners. The partners may be unwilling to abandon their own well-established relating patterns, and/or they may feel uncomfortable, insecure, or even incompetent in attaining new forms of relating in order to relate competently with the treated patients. Patients' progress could also have triggered off the partners' rivalry, thus feeling "left behind" while their partner is progressing. This may explain why our findings do not add up to those by Kalaitzaki et al. (2010); in this study, the most marked improvements concerned the interrelating between the patients and their parents, namely, a presumed "supportive" relationship, which was not the case in the present study. Another explanation may be that the patient may not be the more disturbed (Kohl, 1962). It is possible that the less-disturbed partner has been the first to seek treatment. Perhaps the patients' difficulties are closely intertwined with their partners' (Zeitner, 2003). However, we could not know whether partners' deterioration was temporary. It may be that the partners need time to cope and adjust to the patients' newly acquired positive relating patterns. Intermediate assessments over the course of therapy would have probably addressed this issue,

In short, any therapy that has an impact on an individual may subsequently have an impact on their partner. This study suggested that even a short period of individual psychotherapy may be beneficial in ameliorating patients' negative relating to others and their interrelating difficulties with their partners, but it may also impact negatively upon their partners' relating and interrelating.

It was a disadvantage that the study was based upon the specific psychotherapists' willingness to recruit the patients and their partners. The nonpatients' sample was a convenience one and rather sociodemiographically disadvantaged compared with the patients' sample. A randomized study would have been preferable in avoiding bias. The high attrition rate for the nonpatients' sample limits the generalization of the findings. It should be noted that the random residual effect was markedly high in all cases, which suggests that the dyads were not generally operating as homogenous sources of information. We do not know whether preexisting marital conflict or other factors may have been confounding (Hunsley & Lee, 1995). In all likelihood, the possible effects of individual therapy on the couple may have been underestimated; the couples that declined to participate are likely to have been the most dysfunctional ones. We also do not know whether the positive relating may have changed. Had the samples been larger, if the patients' sample had been more homogeneous in terms of their psychopathology symptoms, and if the patients suffered more severe symptoms, the results may have been different.

Future research might address the issues of when exactly change occurs by adding intermediate assessments over the course of therapy. It would be an interesting exercise to persuade a group of psychotherapists to focus on recognizing their patients' relating and/or interrelating difficulties and then to direct the therapy toward modifying these difficulties. Should this be the target of the therapy more marked improvements would seem to be likely to

occur. The findings of this study have important implications. The questionnaires proposed in this study could be valuable tools in assessing the patients and their partners' relating and interrelating difficulties during therapy. Frequently monitoring any potential change and offering feedback to the patients and the therapists on patients' progress may have positive impact on the therapy outcome (e.g., Carlier et al., 2012; Knaup, Koesters, Schoefer, Becker, & Puschner, 2009). The therapist should be aware of the possible negative repercussions patients' therapy may have upon those close to the patient, namely, their partners (who are not involved in the therapy) and in their relationship. As Garfield (2004) points out, "problems may occur in individual therapy when the therapist is unaware of the impact of the therapeutic alliance on the patient's relationships outside therapy" (p. 460). Offering the partners the possibility to receive information on the patients' treatment could be effective in the level of prevention. Had deleterious effects on significant others been detected, a possible remedial action might have been to also invite the partners to be involved occasionally in the therapy (Carveth & Hantman, 2002; Garfield, 2004), and—should they consent—change the therapy format or simultaneously conduct individual therapy for them (Kalaitzaki & Nestoros, 2006). Despite the proliferation of systems' thinking, addressing the individual rather than the couple may also be advantageous. Should the therapist be aware of the possible ramifications that the patients' individual psychotherapy may have upon their partners and in their relationship, then he/she could target the therapy to benefit both.

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