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Chapter I

Review of the Literature

History of PTSD

The idea that humans who are exposed to stressful events can develop negative psychological reactions, as well as experience physical effects, appears logical to most people (Briere, 1998). However, systematic empirical research into this idea only began within the last several decades. Historical accounts of humanity's attempt to understand or explain the effects of trauma exposure reveal a long and shifting process (Everly, 1995; Parson, 1988; Wilson, 1995). The physical effects of trauma are typically obvious and easily described. However, the psychological reactions can be subtle, slow to develop, and range from temporary stress reactions to the development of persistent and intractable posttraumatic stress disorder (PTSD). Review of historical documents provides a record of the wide variety of traumas that have been observed and recorded (Everly & Lating, 1995; Freedy & Hobfoll, 1995; Herman, 1992). Military historians, such as John Fortescue, have documented the more subtle psychological effects of trauma as well (Parson, 1988). Sources of trauma can include natural disasters, technological catastrophes, violent crime and assaults, accidents, terrorism, and military combat (Everly & Lating, 1995; Freedy & Hobfoll, 1995; Herman, 1992).
Natural disasters include tragedies such as earthquakes, hurricanes, tornadoes, avalanches, fires, and volcanoes. Information gathered following various natural disasters, including earthquakes, found prevalence rates of PTSD in the adult population ranging from 1.0 to 12.3% (Fairbank, Ebert, & Costello, 2000). The 1988 Armenian earthquake was particularly devastating and yielded PTSD rates of 87% after 1.5 years and 73% after 4.5 years (Tural et al., 2004). Technological catastrophes are also a common source of traumatic stress. These catastrophes include events such as the Buffalo Creek dam collapse, the Chernobyl nuclear accident, the Bhopal India gas leak, and the Three Mile Island nuclear spill. From 1900 to 1986, it is estimated there were more than 2400 natural and technological catastrophes affecting 1.4 billion people and killing 42 million (Green & Solomon, 1995).

The history of documenting stress reactions to violent crimes and assaults can be traced back to Freud’s early work in describing hysteria among his female patients. He originally stated that these women developed their hysteria as a result of childhood sexual abuse. However, he later modified the causal mechanism of hysteria to a more politically acceptable formulation and stated that hysteria was the byproduct of patients’ imagined childhood sexual abuse (Beall, 1997). The idea that sexual imposition and/or assault are traumatic is now well accepted. Recent studies show that fears of violent crime and sexual assault represent the most significant trauma concerns for most people (Hanson, Kilpatrick, Falsetti, & Resnick, 1995).

While trauma sources such as natural or man-made disasters and personal assault have evoked discussion and documentation of human distress throughout
history, by far the most common context of trauma study and discussion has been military combat. The response to combat stress is found in many ancient texts. Herodotus described the psychological responses to war as early as the 6th century B.C.E. (Everly, 1995; Parson, 1988). During the Napoleonic war, one general was reported being so disturbed from battle that he could not sleep and was constantly distressed. He concluded by stating that he would retire from the military as a result of his anguish (Everly). United States Civil War military histories described PTSD-like trauma symptoms and termed the disorder “Da Costa’s Syndrome” (National Center for PTSD [NCPTSD], 2006a). Over the years, military trauma reactions have been described by a variety of terms including battle fatigue, shell shock, soldier’s heart, physioneurosis, gross stress reaction, and combat fatigue. The use of such numerous terms served to slow progress in understanding stress disorders and further complicated characterization (Everly; Friedman, 1995; Rattler/Firebird Association, 2005). The persistent and often delayed onset of trauma response symptoms also made understanding the stress syndrome more difficult. For example, many Holocaust survivors, World War II combat Veterans, and prisoners of war (POWs) endorsed trauma symptomatology and stated their symptoms persisted for numerous years following their trauma (Freedy & Donkervoet, 1995). One study found that 71% of World War II POWs continued to experience some level of trauma symptoms 40 years after their release (Kluznik, Speed, Van Valkenburg, & Magraw, 1986).

Further complicating an understanding of the trauma syndrome is the fact that most people witnessing distressing events do not develop diagnosable traumatic disorders (Bonanno, Galea, Bucciarelli, & Vlahov, 2006). However, current research
demonstrates that the likelihood of PTSD increases with repeated exposures (Bonanno et al.). Recent studies (Bonanno et al.; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) estimate that most people report experiencing at least one potentially traumatic event (PTE) during their lifetime, including physical assault, sexual attack, or a potentially deadly accident. Thus, with increasing numbers of opportunities for traumatic events to impact both the civilian and military populations, understanding trauma becomes increasingly important. Without adequate trauma diagnosis and effective targeted treatment, the quality of life for all segments of society will suffer.

**Diagnostic Criteria**

During the time of the American involvement in the Vietnam War (1959-1975), the characterization, assessment, and treatment of serious traumatic symptoms were undertaken in earnest. During this epoch, many returning Veterans arrived at Veteran Administration Hospitals describing severe stress symptoms, often coexisting with other psychological difficulties such as substance abuse (Mulligan, 2004). As these Veterans sought psychological and psychiatric services, it became clear that existing diagnostic categories did not fully capture the symptoms and functional impairment being displayed by these young men. As a result, efforts were undertaken to formally characterize and describe this population, with the outcome being the PTSD diagnosis. The disorder was first formally defined in 1980 in the American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders – Third Edition (DSM-III) (APA, 1980).

Posttraumatic stress disorder (PTSD) is a constellation of diagnosable, persistent, traumatic-reaction symptoms. These symptoms coalesce into three
clusters, each named for its common core: re-experiencing, avoidance, and arousal (APA, 2000). The re-experiencing response involves repetitive dreams, memories or feelings that were present during the trauma itself. The avoidance response results in the sufferer staying away from various activities, persons, or places which trigger memories of the trauma and which evoke feelings of detachment, estrangement, and diminished interest in life. Lastly, the arousal response is revealed through disturbed sleep patterns, concentration difficulties, irritability, and increased startle response (APA).

While not everyone exposed to a traumatic event will develop PTSD, about 8% of men and 20% of women do develop diagnosable PTSD following a trauma experience. Within the subgroup of individuals who do develop PTSD, it is estimated that 30% will develop the disorder's chronic form, which can last years and is often treatment resistant (Ford, Fisher, & Larson, 1997; NCPTSD, 2006b).

While PTSD is clearly not limited to military trauma, it remains frequently reported among military personnel (Ford, Fisher, & Larson, 1997). At this time, with the United States' ongoing Iraqi and Afghani military conflicts, several PTSD researchers, Raymond M. Scurfield and John P. Wilson, believe that not all cases are new but are recurrence of PTSD symptoms among Vietnam Veterans secondary to exposure (via media) to a current conflict (R.M. Scurfield, personal communication, September 8, 2007; Wilson, 1995). As a result, a burgeoning stream of military personnel have been requesting PTSD services at Veterans Administration (VA) facilities since soon after the onset and press coverage of these recent military actions - a pattern that is expected to last for the foreseeable future due to the ongoing nature
of these wars (Boston University, School of Public Health [BUSPH], 2005; BUSPH, 2006a; BUSPH, 2006b; Johnson et al., 2007; U.S. Government Accountability Office [USGAO], 2005).

A recent General Accounting Office (GAO) report raised questions about the readiness of the VA to deal with the potentially large influx of Veterans in need of PTSD treatment (USGAO, 2005). In addition, a Defense Department report indicated that “35% of Iraqi, 21% of Afghani, and 24% of Veterans who served elsewhere” are currently seeking mental health services as a result of their active military service, including a significant number for PTSD (Hoge, Auchterlonie, & Milliken, 2006, p. 1023). Added to these new cases are the Veterans from earlier wars who are experiencing renewed PTSD symptoms. The Department of Veterans Affairs reported receiving more than 20,000 new requests during 2006 for PTSD treatment (Goldstein, 2006). This represents a rapidly expanding number of Veterans and puts pressure on the VA as these Veterans request PTSD services. In order to adequately deal with this increased demand, developing ways to provide the most cost effective and coordinated assessments, treatments, and follow-up services are viewed as imperative (Ford, 1996; Ford, 1997; Johnson, et al., 1996; Johnson, et al., 2007).

Elements of this coordinated approach include focus on early detection through Critical Incident Stress Debriefing (CISD) of specific traumatic events and psychological debriefing (PD) upon exit from the war zone (Litz & Gray, 2004; Litz, Gray, Bryant, & Adler, 2002; C. Newtown, personal communication, September 29, 2006). Efforts also consist of education of Veterans and their families regarding the symptoms of traumatic stress by VA clinicians, the Department of Veterans Affairs,
and the National Center for PTSD (National Center for Post-Traumatic Stress Disorder & Walter Reed Army Medical Center, 2004). Veterans are urged to seek services if their symptoms align with traumatic stress reactions. These efforts have resulted in earlier evaluations for PTSD, targeted short-term treatment approaches, and community-based group services (Adams, Ford, & Dailey, 2004; Ford, Fisher, & Larson, 1997).

**Treatment Models**

The treatment of PTSD has included a variety of approaches in the 27 years since the disorder's formal characterization. Relaxation training and biofeedback have been used to treat PTSD symptoms and reduce physiological responses but they are not supported by controlled studies. Pharmacological agents are also often included in most PTSD treatment regimens because of the psychobiological symptoms of depression, anxiety, aggression, impulsivity, irritability, dissociative symptoms, and sleep disturbances (Friedman, Davidson, Mellman, & Southwick, 2000; NCPTSD, 2006a; NCPTSD, 2006b). Varying numbers and types of research studies have been conducted for the psychological treatment of PTSD including psychodynamic psychotherapy, hypnotherapy, eye movement desensitization and reprocessing (EMDR), prolonged exposure (PE), and various behavioral interventions (Rothbaum, Meadows, Resick, & Foy, 2000). Research in the past has focused on PTSD and the related symptoms such as depression, low self-esteem, and anxiety. Perhaps some of the unexplained variance in treatment outcome studies could be accounted for by variables more commonly found in alternative theoretical models.
The psychodynamic psychotherapy model for PTSD focuses on the unconscious of the PTSD victim, and is most effectively delivered within the context of a robust therapeutic relationship stressing safety and honesty (Khousam, Ghafoori, & Hierholzer, 2005; Kudler, Blank, & Krupnick, 2000). Psychodynamic theory conceptualizes the PTSD response as resulting from damage to the mental adaptation apparatus and involving a fundamental structural psychic impairment (Solomon & Shalev, 1995). This impairment results in a shift from the healthy, ego-based strategy of maintaining homeostasis to a maladaptive approach for attaining internal equilibrium through “repetition compulsion” manifested in repeated and endless reiterations of the trauma (Solomon & Shalev, p. 253). Within this formulation, the repetition process signals surrender by the psychic apparatus to the trauma and because the trauma cannot be completely integrated or understood, this leads to limitations in the ability to access or describe inner affective life and feelings (Krystal, 1978; Solomon & Shalev). Psychodynamic psychotherapy for PTSD attempts to reengage a more normal adaptation mechanism through making the unconscious meaning of the trauma conscious in a safe and honest environment (Kudler, Blank, Krupnick, 2000).

EMDR has been used for trauma treatment since its description in 1995 (Chemtob, Tolin, van der Kolk, & Pitman, 2000). The technique was detected serendipitously by Dr. Francine Shapiro when she noticed a decrease in her negative reaction to unpleasant thoughts as her eyes tracked back and forth during a walk. She termed this process “eye movement desensitization” (EMD) and later added the component of “reprocessing” in order to encourage change in the subject. She
accomplished this “change” through identifying and rehearsing positive cognitions during therapy. EMDR involves several components: self-assessment of the intensity of the negative reaction(s); a “letting go” of the negative reactions following the eye movement experience; and, permitting the emergence of positive cognitions related to the trauma. EMDR is theorized to provide relief due to what Shapiro termed the “accelerated information processing” model. This model hypothesizes that: trauma interferes with the normal psychological and biological processes of adaptation; self-healing is inherent in all people and merely needs reactivating at times; negative self thoughts are often associated with trauma events, and; the number of EMDR treatments must be matched to the number of traumatic events. Overall, EMDR has been found to be more efficacious than wait-list, routine care, and active-treatment controls. However, EMDR’s overall efficacy may be limited to treatment of single-event, civilian trauma rather than multiple-event, chronic military trauma (Chemtob et al.).

Cognitive Behavior Therapy (CBT) approaches to PTSD have been found to be particularly effective. CBT approaches often include multiple components such as psychoeducation, trauma exposure, cognitive restructuring, assertiveness training, and anxiety management via relaxation techniques (Harvey, Bryant, & Tarrier, 2003). The psychoeducational component of CBT provides a rationale for treatment, normalizes the patient’s trauma experience, and helps the patient develop a framework in which to understand the trauma experience. The exposure component assists the patient in constructing an accurate narrative of the trauma through vivid imagining of all relevant physical and sensory details. Cognitive restructuring is the
mechanism for teaching patients to explore and evaluate evidence for their negative automatic thoughts and beliefs regarding their trauma experience. Assertiveness training allows for the development of responses that tend to inhibit the development of fear through being able to talk about their trauma, to ask for help, and to correct misinformation. Finally, anxiety management teaches skills for overcoming the fears and minimizing the patient’s arousal levels through increased levels of awareness and techniques that minimize physiological responses (Harvey, et al.).

Prolonged Exposure (PE) typically involves confronting the anxiety provoking stimuli without relaxation or anxiety-reduction techniques until the anxiety level begins to diminish and desensitization occurs (Rothbaum, Meadows, Resick, & Foy, 2000). The application of PE to the treatment of PTSD has consistently been found to be methodologically sound in studies with Vietnam Veterans and sexual assault victims. The PE treatment process consists of the development of an anxiety hierarchy and in treatment the patient is exposed to increasing levels of anxiety-producing experiences within that hierarchy. PE postulates that through this continuing confrontation of the frightening stimuli, the patient will eventually experience a lowered anxiety level. PE is considered one of the standard PTSD treatment approaches and has been subject to multiple well controlled studies. PE has been found effective compared to wait-list or supportive counseling in Veterans, female-assault survivors, and mixed trauma victims (Rothbaum et al.).

Another form of CBT is Cognitive Processing Therapy (CPT) which incorporates information processing theory to create a treatment focused on the individual with PTSD and related symptoms (Resick & Schnicke, 1992; Resick &
Schnicke, 1996). Information processing theory helps describe how information is processed (Resick & Schnicke, 1996). This processing allows humans to not be overwhelmed by the vast amount of information they are daily exposed to. One way that information is organized is through the use of schemata, which are groupings of information, which allow information to be understood, encoded, and remembered. The schemata therefore direct the person’s expectations, interpretations, and memory searches. Another important aspect of schemata trauma processing, is the person’s reaction when their personal experience exposes them to information that is discrepant with previously encoded schemata. In this situation, the person’s sense of self and the world is challenged or disrupted and the person is left with an unprocessed event. Their adjustment, or maladjustment, is then the result of the meaning they ascribe to the event in light of their schemata (i.e. the beliefs used to determine their response) (Resick & Schnicke, 1996).

CPT includes three components; an introduction / education phase describing the connection between thoughts and feelings; a writing phase where a detailed description of the traumatic event is developed by the patient using as much sensory detail as possible with the identification of stuck points related to the trauma, and; a challenging phase where stuck points are addressed using worksheets targeting disruptions in the areas of safety, trust, power, control, esteem, and intimacy as related to the meaning of the traumatic event (Resick & Schnicke, 1992). Although it should be noted that a recent study by Resick (in press) suggests that it is not necessary to perform the written narrative to have an equally effective outcome. Cognitive Processing Therapy was originally developed as a treatment for women
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with PTSD resulting from rape (Resick & Schnicke, 1992). This therapy lasted for 12 weeks and was provided in either a group or individual format. The therapy was based upon the premise that female rape victims had reactions that often were inconsistent with their prior beliefs and this mismatch precluded them from integrating the rape event. As a result of these prior beliefs, rape victims were thought to change the event (i.e. assimilate it) in order to make it fit with their preexisting schema. An example of assimilation would be, “Because he did not hurt me, it was not really a rape” (Chard, Weaver, & Resick, 1997, p. 33). If the victim were thought to be able to accommodate the event (i.e. alter their pre-existing belief), then they are said to have integrated the experience. An example of accommodation which can result in integration would be to change their belief of “Good things happen to good people” to “Bad things may happen to good people” (Chard, Weaver, & Resick, 1997, p. 34).

CPT has been shown to be an effective, empirically based, short-term, cost-effective treatment modality for the treatment of PTSD in rape victims and it is especially useful given the current managed care environment. The treatment has also been successfully adapted for use with female childhood sexual abuse survivors (Chard, 2005) and with male and female combat Veterans suffering from PTSD (Monson et al., 2006; Resick, Nishith, Weaver, Astin, & Feuer, 2002). While still early, encouraging results have been seen using CPT with the military PTSD population. Monson, et al., 2006, found that a sample of 60 (54 men and 6 women) Veterans experienced reductions in chronic PTSD symptoms and improvements in
co-occurring depressive and generalized anxiety symptoms when compared to a wait-list condition.

CPT follows a short-term, manualized treatment regimen consisting of an ordered set of modules. Therapy often has patients elicit memories of their trauma experience(s) and then directly confront conflicts and maladaptive prior beliefs that were activated by the trauma. Using this CPT approach the Veteran modifies existing beliefs into new adaptive ones through exposure to alternative, new, incompatible information (i.e. accommodation) (Resick & Schnicke, 1992). Assessment of a patient’s willingness to engage in this CPT is conducted through evaluation using structured interviews and psychometric instruments. These evaluations are performed at the start, middle, and at the end of treatment. Such assessments are useful in planning and can be especially helpful if a patient is having difficulty engaging in CPT activities or is using avoidant coping behaviors. Avoidant coping is usually associated with low levels of intrusion of thoughts and re-experiencing. When avoidant coping is present, it can lead to increased resistance during therapy. In such instances, the therapist needs to help the client focus upon their trauma feelings and emotions (Chard, Resick, & Wertz, 1999). The efficacy of various PTSD psychotherapies has been found to provide varying levels of relief to patients.

**Treatment Efficacy**

Three meta-analyses of various PTSD psychotherapies have demonstrated improvements in psychological health and decrease in symptoms for various populations (Bisson et al., 2007; Bradley, Greene, Russ, Dutra, & Westen, 2005; Sherman, 1998). Bisson et al., studied 38 randomized, controlled studies which
compared trauma-focused cognitive-behavioural therapy (TFCBT), EMDR, stress management, group cognitive behavioural therapies, wait-list, and usual care in patients 16 years or older, with PTSD symptoms for at least three months, and at least 70% of a study's participants carried a PTSD diagnosis from all sources of trauma. Overall, TFCBT and EMDR were found to be superior to stress management and other therapies, and stress management was found to be superior to other therapies including pharmacological interventions (Bisson et al.).

Bradley et al. (2005) conducted a meta-analysis of psychotherapy for PTSD which consisted of 26 studies, published between 1980 and 2003, with adult patients receiving a specific psychotherapy for PTSD versus a control condition, an alternative psychotherapeutic treatment or a combination of two or more of these treatments. There were 44 treatment conditions including 13 exposure-based, five cognitive behavioral therapies other than exposure, nine cognitive behavior and exposure, 10 EMDR, and seven other therapeutic types. Overall, Bradley et al. found that exposure and other cognitive behavioral therapy approaches, as well as EMDR, are highly effective in the treatment of PTSD symptoms and 40-70% of patients who met PTSD criteria initially no longer met PTSD criteria after brief treatment. However, whether these gains were sustained beyond 6-12 months was not known. Also the exclusion of various patients from these studies, including substance abusers, limited generalizability of the results.

Sherman (1998) also conducted a meta-analysis of 17 PTSD studies using flooding, systematic desensitization, EMDR, CBT, or psychodynamic therapy, wait-list, or no treatment control with a total of 690 participants who met PTSD criteria
according to DSM-III, DSM-III-R, and DSM-IV. Various traumatic events were associated with the development of the PTSD (i.e. combat, rape, assault, other violent crimes, motor vehicle accidents, child abuse, and traumatic loss of a loved one). The effect size was calculated to be significant with a $d = .52, r = .25$ for the impact of psychotherapy on PTSD and psychiatric symptomatology immediately after treatment and at follow-up $d = .64, r = .31$. Specific PTSD target symptoms, as well as general psychological symptoms, had significant effect sizes at post-treatment: intrusion, $d = .62, r = .30$; avoidance, $d = .79, r = .37$; hyperarousal, $d = .58, r = .28$; anxiety, $d = .53, r = .26$, and; depression, $d = .55, r = .27$. These target symptoms maintained their effect sizes at follow-up as well with effect sizes ranging from .65 for depression to .97 for intrusion.

**Relationship**

No matter what psychotherapeutic approach to the treatment of PTSD is utilized, the process of therapy itself is an interpersonal one involving a therapist and patient. Treatment may therefore be dependent upon the quality of the therapist–patient relationship (Puschner, Bauer, Horowitz, & Kordy, 2005). This connection is known variously as the “helping alliance,” “working alliance,” or “therapeutic alliance” and has been identified as an important determinant in therapy outcome (Puschner et al., p. 416). Studies have concluded that the therapeutic alliance is a significant predictor of outcome and treatment success (Horvath & Symonds, 1991; Puschner, et al.). Factors believed related to the formation of an effective therapeutic alliance include: demographic variables, pretreatment motivation and expectations, pretreatment symptoms, and pretreatment interpersonal functioning (Puschner et al.).
Among demographic variables found to be of importance are gender and education. Women have been found more able to form positive relationships with their therapists than men (Marmar, Weiss, & Gaston, 1989). Patients with more education have tended to engage more effectively with therapists in psychotherapy, hypothesized as due to their increased familiarity, and resulting comfort, with the process (Marmar et al.). Greater pretreatment motivation and more positive expectations have also been found to result in an improved therapeutic alliance, likely because the patient is optimistic about the therapy process (Gibson et al., 2003; Joyce & Piper, 1998; Marmar et al.). However, in general it is thought that the more severe the pretreatment symptoms, the less positive the resulting therapeutic relationship will be because of patient impairment (Eaton, Abeles, & Gutfreund, 1988). Finally, the patient’s interpersonal functioning, i.e., interpersonal relationships, degree of social adjustment, level of social support, and attachment capacity, has been identified as key in the formation of the therapeutic alliance (Puschner et al.). Of these elements, attachment capacity appears central to the formation of the therapeutic alliance (Gaston, Marmar, Thompson, & Gallagher, 1988; Mallinkrodt, 1991; Mallinkrodt, Coble, & Gantt, 1995; Moras & Strupp, 1982; Piper et al., 1991; Puschner et al.). A useful construct for understanding a patient’s attachment capacity is object relations (OR). Object relations refers to an individual’s lifelong pattern of relationships. Within the object relations framework, the patient – therapist relationship becomes the focus for exploring the patient’s process of relating to others (Scharff & Scharff, 2005). Object relations has been recognized as a robust predictor in the formation of
the therapeutic alliance and has been linked to positive treatment outcomes (Joyce & Piper, 1998; Piper et al., 1991; Piper, Joyce, McCallum, & Azim, 1998).

The Complexity of Trauma Reactions

A complicating factor in treating military PTSD is that relatively few “pure” cases exist. Studies have shown that between 80 – 98% of PTSD Veterans meet lifetime diagnostic criteria for another psychiatric disorder (Bollinger, Riggs, Blake, & Ruzek, 2000; Connor et al., 2001; Herman, 1992; Kimble, Riggs, & Keane, 1998; Lasiuk & Hegadoren, 2006). High comorbidity often signals a chronic form of PTSD (Bollinger et al.). Estimates are that nearly one-third of those diagnosed with PTSD develop a chronic form; among chronic sufferers who do improve, many continue to experience significant symptoms although they no longer meet full diagnostic criteria for PTSD (Tarrier, Liversidge, & Gregg, 2006; Tarrier & Sommerfield, 2004). Among PTSD diagnosed Veterans, the most common Axis I disorders appear to be generalized anxiety disorder, alcohol abuse, and major depression (Bollinger, et al.; Lasiuk & Hegadoren). PTSD is also highly comorbid with Axis II psychopathology (Bollinger, et al.). While the importance of understanding this connection is clear, the study of PTSD and Axis II comorbidity has been limited by several factors. First is fear that studying the relationship between personality and PTSD may create a blame-the-victim attitude. Second, is a general lack of understanding how PTSD and personality interact. Lastly, inconsistent research designs -- often with very small and ill-defined participant pools -- have been used in many Axis II /PTSD studies (Kamen, 2001). Nonetheless, despite these research barriers, Axis II disorders have consistently been found to be over-represented in PTSD populations. One of the most
recent and robust empirical studies determined a 75% comorbidity rate of at least one personality disorder with PTSD; other studies have found rates of approximately 33% (Bollinger, et al.; Faustman & White, 1989). Bollinger et al. also determined that 50% of their sample of PTSD patients met diagnostic criteria for two or more personality disorders. The most common were Avoidant (47.2%), Paranoid (46.2%), Obsessive-Compulsive (28.3%), and Antisocial (15.1%). These categories are somewhat different than those of earlier studies, which typically found elevated Borderline personality rates as well (Bollinger, et al.). Bollinger's study also supports the theory that personality disorders reinforce the characteristics found in PTSD itself. For example, personality disorders and PTSD share such characteristics as avoiding experiences that remind the patient of their trauma, pervasive mistrust of others and situations, and preoccupation with control and perfectionism (Bollinger, et al.).

When PTSD becomes chronic, its effects are often extreme and involve difficulties with affect regulation, consciousness, bodily functions, as well as psychosocial impairment (Ford, Fisher, & Larson, 1997). Chronic PTSD is also associated with repeated psychiatric hospitalizations, increased homelessness, divorce, job instability, anger management problems, and substance abuse difficulties (Ford et al.). These impairments are similar to those seen in severe personality disorders and suggest that personality patterns may prolong PTSD symptoms and impede recovery much more severely than comorbid Axis I disorders (Shea, et al., 2004; Shea & Yen, 2003). Therefore, the association between PTSD features and certain core personality attributes suggests that Axis II comorbidity may be at the heart of intractable PTSD and its associated treatment failure (Bollinger, Riggs,
Object Relations

Object relations had its beginning with Freud when he introduced the term “object” to describe the location where drive energy gratification, libido, takes place. He stated that for the infant, this “object” is initially experienced internally because the child looks within itself for satisfaction of its needs. Freud described this as “primary narcissism.” With time, the child grows to realize that there is an external object of satisfaction, the breast. However, when the child recognizes that this external object is not always available; the focus then turns inward once again. At this stage, the child embarks on a developmental trajectory where libidinal satisfaction is attached to various internal objects in distinct phases, i.e., oral to anal to phallic to genital. Freud hypothesized that the infant connects caregivers to each of these phases and forms internalized psychic structures associated with each stage. These psychic structures provide aid and comfort to the child when they experience conflict. Thus, Freud’s focus was on the development of internal psychic structures, which he postulated were always present but varied in degree and sophistication from arrested development to full, normal functioning (Scharff & Scharff, 2000).

Fairbairn reformulated Freud’s description of object from an intrapsychic orientation to one concerning relationship (Scharff & Scharff, 2005). Through his work with abused children, traumatized military personnel, and mentally ill patients, he came to believe that object relations, or the expectations one holds about others and the world, were formed within the infant/parent relationship and then were
reenacted in other important relationships, including the therapeutic one. The reenactment process is a constantly evolving series of interactions and of relationship experiences that ultimately constitute personality (Greenberg & Mitchell, 1983).

Researchers have described persons possessing more highly developed levels of object relations as able to maintain a positive working relationship with a therapist even when confronted by stressors during therapy and, thereby, ultimately achieving positive treatment outcomes. In contrast, researchers have hypothesized that individuals with impaired object relations usually form poor working alliances with their therapists, display little tolerance for the stresses of the therapeutic encounter, and demonstrate poor treatment outcomes (Hull, Clarkin, & Kakuma, 1993).

Parson (1988) further contributed to understanding the role of object relations capacity in treatment response when he described the impact of extreme stress upon the self. Working with Veterans from the Vietnam era, he described how self structures were assaulted in combat and then again through traumatic homecoming experiences. He argued that the extreme stress seen in some combat Veterans is best characterized as a “ruinous experience of the self” (Parson, p. 261). He further argued that this type of damage must be repaired as part of treatment effectiveness.

**PTSD and Object Relations**

Drawing on the connection between characterological integrity and treatment outcome, Ford et al. (1997) suggested that treatment resistant PTSD patients could be identified not by the amount of expressed PTSD symptoms, but through their relational capacity -- as assessed via object relations. He found that when patients were classified as having low levels of object relations, they failed to show
improvement in self-reported symptoms and adjustment. On the other hand, when patients were classified as having moderate levels of object relations, they reported improvement in both symptoms and adjustment. Thus, Ford et al. concluded that object relations was a robust predictor of treatment outcome in his sample. However, the generalizability of his findings is unknown as, to date, there have been no large scale studies looking at object relations development or patterns in PTSD patients and the normative patterns of object relations in those diagnosed with combat-related PTSD are unknown.

Taking Ford’s findings a step further, assessment of object relations may be helpful in triaging patients into appropriate treatments, with those exhibiting lower levels being first exposed to reparative therapies before engaging in targeted PTSD treatment. To be used in this manner, assessment of object relations needs to be efficient as well as psychometrically sound. However, to date, determination of object relations typically has involved extensive and detailed clinical interviews. For example, in Ford’s (1997) study object relations ratings were produced by three clinicians each conducting a laborious 60- to 90- minute structured psychosocial interview, which was first consolidated into a single score and then dichotomized into Low and Moderate categories of object relations. This level of effort makes determination of object relations a research exercise and not useful in routine screening for treatment matching.

Other approaches to assess the object relations construct through the years have often employed projective measures, which have provided information and a basis for understanding a person’s intrapsychic representation of themselves and
others. These assessments have variously used aspects of the Rorschach, Thematic Apperception Test, early memory measures, parental representations, various portions of the MMPI or WAIS-R, or dream analysis (Blatt, Brenneis, Schimek, & Glick, 1976; Segal, Westen, Lohr, & Silk, 1993; Stricker & Gooen-Piels, 2004; Stricker & Healey, 1990; Thompson, 1986; Trimboli & Kilgore, 1983; Westen, 1991; Westen, Lohr, Silk, Gold, & Kerber, 1990). While providing useful information, these assessment strategies require considerable time and expertise and are, again, most appropriate for research settings and not for routine screening.

Less involved assessment approaches are needed if object relations is to be useful within the context of current treatment needs. A technique must have demonstrated reliability and validity, as well as ease of administration. Identification and use of such an assessment instrument could streamline the object relations assessment process and facilitate the study of object relations’ capacity to identify those patients ready to effectively engage in and make use of well-validated PTSD treatments such as cognitive processing therapy. This project will validate the effectiveness of one such instrument – the Bell Object Relations and Reality Testing Inventory (BORRTI) (Bell, 1995).

The current study has two goals: 1) to determine normative patterns for object relations as assessed by the BORRTI in combat PTSD patients and if/how object relations varies between inpatient and outpatient PTSD samples, and; 2) examine if CPT treatment outcome is related to the quality of object relations within an inpatient sample. It is important to note that the focus of this study is not on the efficacy of the CPT treatment. CPT has been well validated (Chard, Weaver, & Resick, 1997;

Rather, the focus is on the role of patients' object relations capacity to make use of the treatment. It is expected that lower levels of object relations will be related to less treatment response and this relationship will be mediated by attachment capacity.
Chapter II

Rationale and Hypotheses

The purposes of this study are: 1) to establish object relations norms for both inpatient and outpatient PTSD-diagnosed Veterans and; 2) to assess the relationship between object relations profiles and both the therapeutic alliance and the capacity to utilize treatment in an inpatient sample. Object relations theory posits that a person’s internalized images of self and significant others can range from primitive to highly developed and are related to a person’s ability to self regulate and interpersonally engage during psychosocial encounters such as psychotherapy (Ford, Fisher, & Larson, 1997). A person with more highly developed object relations capacity is able to get along with others and to “tolerate stressors in the therapeutic process and maintain a positive working alliance” which are associated with improved treatment outcomes (Ford et al., p. 547). Patients with more primitive object relations capacity tend to struggle with interpersonal encounters, often form more tenuous therapeutic alliances and show less effective treatment outcomes. The measurement of object relations capacity can be a laborious and time consuming process. The Bell Object Relations and Reality Testing Inventory (BORRTI) represents an easy to administer, brief (90 true/false questions) inventory that is a reliable and valid instrument useful in measuring a client’s level of object relations (Huprich & Greenberg, 2003). The BORRTI has been found to have excellent discrimination among groups of Axis II,
Borderline and Other, Axis I, Mixed (disorders with psychotic and affective features), Affective disorder, Schizophrenia, and College and University Students and community active adults (Bell, 1995). At present no studies have established norms for PTSD patients using the BORRTI.

Goal 1 of this research is to gather normative data for the BORRTI from residential and outpatient PTSD diagnosed military Veterans who are seeking treatment at a local Veterans Administration Hospital.

Goal 2 of this research is to evaluate whether object relations, as measured using the BORRTI instrument, is related to therapist attachment (as measured by The Patient Characteristics Questionnaire) and treatment outcome in a group of residential combat Veterans who are being treated with Cognitive Processing Therapy (CPT). CPT is an empirically validated, manualized treatment program that can be used in either group or individual settings and utilizes “elements of Beck’s Cognitive Behavior Therapy with procedures derived from information processing theories” (Chard, Resick, & Wertz, 1999, p. 37).

**Study Goal 1**

No specific hypotheses will be tested regarding patterns of Object Relations and Reality Testing (RT) in PTSD patients. Rather, the purpose is to describe overall Object Relations patterns in PTSD diagnosed Veterans and identify any similarities and differences that may exist between residential and outpatient groups.

**Study Goal 2**

The general hypothesis to be tested is that impaired object relations can predict treatment outcome, and that the relationship between object relations and Outcome is
mediated by attachment capacity. As such, it is expected that higher scores (reflecting more impairment) on each BORRTI Object Relations subscale will be associated with lower scores on the Patient Characteristics Questionnaire (reflecting attachment difficulty), and with higher Clinician Administered PTSD (CAPS) scores at end of treatment (reflecting more PTSD symptoms and poorer treatment outcome).

Specifically, the following hypotheses are offered:

1a.) Higher scores on the Object Relations subscale of Alienation (ALN) will predict lower therapist attachment scores and higher end-of-treatment CAPS scores.

1b.) Higher scores on the Object Relations subscale of Insecure Attachment (IA) will predict lower therapist attachment scores and higher end-of-treatment CAPS scores.

1c.) Higher scores on the Object Relations subscale of Egocentricity (EGC) will predict lower therapist attachment scores and higher end-of-treatment CAPS scores.

1d.) Higher scores on the Object Relations subscale of Social Incompetence (SI) will predict lower therapist attachment scores and higher end-of-treatment CAPS scores.
Chapter III

Method

Participants

This study will include 200 male Veterans (100 residential, 100 outpatients) between the ages of 18 and 90 from the residential and outpatient programs of the PTSD and Anxiety Disorders Clinic at the Cincinnati, Ohio, Veterans Administration (VA) Hospital – Domiciliary, located in Ft. Thomas, Kentucky. These patients must meet the following admission criteria: current diagnosis of PTSD or subthreshold (based upon assessment and not service connection); no evidence of psychosis; 60 days abstinence from alcohol and other substances; no legal issues requiring the Veteran to be absent during any portion of the seven-week program; no Veteran can be a registered sex offender due to Criminal Sexual Conduct Laws and the facility’s proximity to schools and day care centers; must be referred by a clinician (PTSD Residential Program, 2006).

CPT treatment for residential Veteran PTSD patients is performed using a 7 week, 13 session (2-3 group or individual sessions per week) model. Residential patients also engage in 25 hours of group sessions addressing topics such as anger management, assertiveness training, communication, health issues, self-defeating behaviors and distress tolerance (Intake Coordinator, PTSD Residential Program, VHACIN Ft. Thomas Domiciliary, personal communication, July 6, 2007). At no
time during the group sessions do participants share the specifics of their individual trauma. This policy avoids traumatizing the other participants (Chard, Resick, & Wertz, 1999). In the outpatient format, Veterans are provided 12 individual CPT sessions usually conducted 1 session per week (K. M. Chard, personal communication, August 4, 2006).

The study will also include a staff of psychologists, psychology interns, psychology practicum students, and nurses who provide Cognitive Processing Therapy to PTSD residential patients.

**Study Description**

Study Goal 1 -- the establishment of PTSD norms on the Bell Object Relations and Reality Testing Inventory (BORRTI) -- will occur for the period required to secure at least 200 total completed BORRTI instruments from Veterans diagnosed with PTSD (100 residential and 100 outpatient). Data collection for outpatients is estimated to take approximately 28 weeks based on the number of intake assessments conducted during the year 2006. In 2006, 191 diagnostic intake interviews were conducted. It should be noted that this is a conservative time estimate as in early 2007 the VA psychologist staffing levels were increased to accommodate greater patient flow. Data collection for the residential participants is estimated to require 15 months. This is based on 2006 data. The Residential Rehabilitation Program (PRRP) admits cohorts of 12 men every 7 weeks and has run at full capacity for the past two years. Based on this patient flow, nine cohorts will be required to reach the target N of 100. It is anticipated that dropout rates for the
residential sample will be minimal and comparable to the 5 participants who left the program during 2006.

Study Goal 2 -- the relationship of object relations to therapist attachment and capacity to benefit from PTSD treatment -- will use the 100 PRRP residential participants recruited during Study Goal 1.

The target sample size was selected based on the power required to adequately test the hypotheses articulated in Goal 2. A minimum sample of 83 is required to detect a moderate effect size (Cohen, 1992). To ensure this level of detection, a sample size of 100 participants was selected for the residential group. In order to ensure that the normative data is maximally representative of PTSD diagnosed Veterans, the outpatient sample size of 100 was chosen.

Data collection for both Goals 1 and 2 will begin at the point that approval is provided by the IRBs of the Cincinnati Veterans Administration Medical Center, the University of Cincinnati, and Xavier University.

Measures

Primary Outcome Measure.

Clinician Administered PTSD Scale (CAPS).

The Clinician Administered PTSD Scale - Week version (CAPS) is a structured clinical interview instrument developed to assess the presence and severity of symptoms of PTSD. The CAPS was created to provide a comprehensive, psychometrically sound interview and is currently the accepted standard for assessing traumatic stress. The CAPS was originally developed in 1989 and has been revised
three times (1990, 1994, and 1998). The 1998 revision is identical to the past versions except it uses a one-week rather than one-month time frame.

The CAPS assesses PTSD diagnostic criteria as outlined in the DMS-IV. Its administration consists of a series of questions that assess the frequency and severity of 17 PTSD symptoms. Summary scale scores for the PTSD symptoms of re-experiencing (DSM – IV Criterion B), avoidance and numbing (DSM – IV Criterion C), and hyperarousal (DSM – IV Criterion D) are computed. These three scales are then summed to provide a total PTSD severity score (Blanchard, et al., 1995).

The CAPS is a psychometrically sound instrument. Studies have shown good test-retest reliability (kappa ranging from .89 to 1.00) and high interrater reliability scores, ranging from .86-.87 for frequency, .86-.92 for intensity, and .92 for overall severity. Other PTSD measures correlate well with the CAPS including the Mississippi Scale for Combat Related PTSD (r = .97) (Keane, Caddell, & Taylor, 1988), the PTSD subscale (PK) of the Minnesota Multiphasic Inventory (r = .82) (Keane, Malloy, & Fairbank, 1984), and the Combat Exposure Scale with a Pearson product-moment statistic, r = .25, p<.0001 (Keane et al., 1988).

**Primary Predictor Measure.**

*Bell Object Relations and Reality Testing Inventory (BORRTI).*

The Bell Object Relations and Reality Testing Inventory (BORRTI) is a 90 statement true – false paper and pencil inventory designed to test ego functioning in an efficient manner. There are 45 statements related to object relations and 45 statements related to reality testing. The BORRTI is intended for use with individuals 18 years and older. There are four subscales generated for Object Relations:
Alienation Subscale (sample item: I may withdraw and not speak to anyone for weeks at a time), Insecure Attachment Subscale (sample item: It is hard for me to get close to anyone), Egocentricity Subscale (sample item: Exercising power over other people is a secret pleasure of mine), and Social Incompetence Subscale (sample item: Others frequently try to humiliate me). Three subscales are generated for Reality Testing: Reality Distortion, Uncertainty of Perception, and Hallucinations and Delusions (Bell, 1995).

Internal consistencies for each subscale have been found to be adequate to good. Cronbach's alpha and Spearman split-half reliability estimates are as follows: Alienation (.90 and .90); Insecure Attachment (.82 and .81); Egocentricity (.78 and .78); Social Incompetence (.79 and .82); Reality Distortion (.87 and .85); Uncertainty of Perception (.82 and .77), and; Hallucinations and Delusions (.85 and .83). The BORRTI has shown test-retest reliability across all subscales from .58 to .90 over four weeks and from .63 to .81 over 13 weeks in a mixed diagnoses sample. The test-retest reliability over 26 weeks for a Schizophrenic sample ranged from .58 to .78 (Bell, 1995). For Goal II of this study (prediction of treatment utilization), the four Object Relations scales will be used. The Reality Testing data will be collected and used for Goal I (establishment of norms) only.

Secondary Prediction Measures.

Structured Clinical Interview for Axis I Disorders (SCID I).

The Structured Clinical Interview for Axis I Disorders (SCID I) is a semistructured interview that identifies DSM-IV Axis I disorders (APA, 1994). It can be used with both psychiatric and general medical patients and uses language
appropriate for patients 18 years or older. The SCID I is used by both clinicians and researchers. The SCID-I covers all subcategories within the diagnostic areas of Mood Disorders, Anxiety Disorders, Psychotic Disorders, Substance Use Disorders, Somatoform Disorders, Eating Disorders, and Adjustment Disorders. Administration typically takes from 60-90 minutes. Patients answer questions about symptoms reflective of the diagnostic areas and the clinician rates the response on a four point scale (\( ? = \) Inadequate information to code the criterion as 1, 2, or 3; where 1 = Absent or False; 2 = Subthreshold; 3 = Threshold or True). Examples of SCID-I questions are: What was your energy like? (Tired all the time? Nearly every day?); Do periods of [Depressed Mood] mostly seem to happen at the same time of the year, like fall or winter?, and; Do you think that you were more afraid of (Phobic Activity) than you should have been (or than made sense)? The interview results are reviewed again in summary form before a final determination is made regarding the presence of a disorder. For this study, one point will be assigned for the presence of each disorder and the sum of all disorders will used to create a single variable ranging from 0 to 14.

Since the SCID-I is dependent upon the clinical judgment of the interviewer, the kappa statistic is typically used as a reliability estimate. Studies have produced kappas in the range of .70 to 1.00 by using either joint or videotaped interviews, thereby removing some of the variability in observation (Strakowski, Keck, McElroy, Lonczak, & West, 1995; Stukenberg, Dura, & Kiecolt-Glaser, 1990).
Chart Review.

A review of the electronic medical record will be performed for each patient in this study to obtain demographic information and presence of Axis II psychopathology.

Structured Clinical Interview for DSM-IV Axis II Personality Questionnaire (SCID-II-PQ).

The SCID-II Personality Questionnaire (SCID-II PQ) is a 119-item true/false assessment of personality functioning covering the 11 DSM-IV (APA, 1994) Personality Disorders, including Personality Disorder Not Otherwise Specified (NOS). The SCID-II PQ was developed to be used in conjunction with the SCID-II Clinical Interview as a screening tool to shorten the time required by the clinician to administer the SCID-II. The SCID-II PQ typically takes about 20 minutes and was designed to identify areas requiring in-depth examination through the full Clinical Interview. Studies have shown that endorsed items hold considerable information but denied items have limited utility due to very low rates of false negatives (Ekselius, Lindstrom, von Knorring, Bodlund, & Kullgren, 1994; Jacobsberg, Perry, & Frances, 1995). The questions within the SCID-II-PQ are grouped by personality disorder. The presence of a disorder is determined by exceeding an empirically derived threshold score. The SCID-II is normed for adults (18+ years of age). Examples of questions from the Dependent and Passive scales of the SCID-II Personality Questionnaire are respectively: Do you usually feel uncomfortable when you are by yourself? Are you often grumpy and likely to get into arguments?
Although the SCID-II Personality Questionnaire was not designed to be used as a stand-alone instrument, its threshold scores have an overall kappa of agreement with the SCID-II interview of 0.78 (Jacobsberg, Perry, & Frances, 1995). It has also been found to display reasonable internal consistency coefficients, ranging from .76 for the avoidant and borderline scales to .33 for the schizoid scale (Jacobsberg et al.). For this study, the SCID II-PQ will be used to obtain an estimate of overall AXIS-II comorbidity. The obtained scores will be collapsed into a single continuous variable (range 0 – 11), reflecting the total number of disorders which reached diagnostic threshold.

*The Patient Characteristics Questionnaire.*

The Patient Characteristics Questionnaire (Appendix A) has been specifically created for this study. It is intended to capture the therapist’s experience of the patient’s ability to connect during therapy as compared to the therapists’ experience of other clients. Thus, the scores have an ipsative nature and the client’s attachment capacity per se is not being quantified. The questionnaire consists of six statements that the therapist rates using a five point Likert-type scale (1 = Much Less to 5 = Much More). Example statements are: Compared to my other patients, this patient displayed a demanding and manipulative attitude toward me, and; Compared to my other patients, I felt connected with this patient.

**Procedure**

In order to assure that ethical guidelines are followed, this research proposal will be submitted to the Institutional Review Boards of Xavier University, the University of Cincinnati, and the R&D Committee of the Cincinnati Veterans
Administration Medical Center (VAMC). Data collection will commence when these approvals have been secured. Upon admission to either the residential or outpatient PTSD programs at the Cincinnati Veterans Administration, Ft. Thomas Domiciliary PTSD and Anxiety Clinic, each Veteran will be given an informed consent form to read and sign. We have been advised by the Cincinnati VA and the University of Cincinnati IRB’s to use a consolidated (i.e. Residential and Outpatient) Informed Consent Form to simplify this part of the process. This written consent form will be explained verbally and the participant will then be given the opportunity to ask any questions they may have regarding the specifics of the consent form or this research study. Each therapist providing the Cognitive Processing Therapy, will also be given an informed consent to read and sign at the initiation of the study.

For Study Goal 1, all residential and outpatients in this study will be asked to complete the BORRTI as an additional instrument during the routine clinic intake process. For residential participants this will be during one of the early group meetings and for outpatients, this will be during one of the first three CPT sessions. Intake currently consists of the following assessments: Clinician Administered PTSD Scale – 2 (CAPS); PTSD Checklist Modified (PCL-M); Structured Clinical Interview for Axis I Disorders (SCID I); Structured Clinical Interview for Axis II Disorders – Personality Questionnaire (SCID-II-PQ); Posttraumatic Stress Cognition Inventory; Beck Depression Inventory (BDI-II), and; Pittsburgh Sleep Quality Inventory. Only Veterans who meet the CAPS criterion for PTSD -- a score of 45 or greater -- (Weathers, Ruscio, & Keane, 1999) are admitted to the clinic. The BORRTI
instruments collected from these patients will form the basis of the BORRTI normative data for PTSD outpatients.

For Study Goal 2, all residential participants will be followed during their standard treatment at the PTSD clinic. Standard treatment is comprised of 13 sessions of group and individual intense Cognitive Processing Therapy, in addition to various group psychoeducational therapy sessions on the topics of Anger Management, Sleep Management, Assertiveness, Distress Tolerance, Interpersonal Effectiveness, Mindfulness, Communication Training, and Health Issues. At the end of treatment, the participants' therapists will complete the Patient Characteristics Questionnaire. All participants will be administered an end-of-treatment CAPS in keeping with standard procedures.
Chapter IV

Proposed Analyses

Study Goal 1: Our attempt is to determine normative object relations patterns for treatment-seeking PTSD diagnosed Veterans and to describe the similarities and differences present in residential and outpatient populations using the Bell Object Relations and Reality Testing Inventory. We have no predictions regarding patterns or profiles.

Study Goal 2: Prior to any analysis, all variables will be examined for normalcy and transformed as needed. In addition to the variables of theoretical interest, the following demographic variables will be collected: age, history of substance abuse, educational level, employment status, marital status, service era, PTSD service connection, and therapist.

Hypothesis 1: The general hypothesis of this study is that impaired Object Relations can predict treatment resistance / failure to make improvement, and that this relationship is mediated by attachment capacity. As such, it is expected that higher scores (reflecting more impairment) on Object Relations subscales of the BORRTI will be associated with attachment difficulty, and with failure to make treatment gains.

Regression will be used to test all hypotheses.
For all analyses, the Outcome Variable (OV) will be total end-of-treatment CAPS score. Poor outcome is operationally defined as higher CAPS score (higher scores reflect more PTSD symptoms and lower treatment gains). The mediational variable of attachment capacity will be operationally defined as the Patient Characteristics Questionnaire total score (higher scores reflect greater attachment ability as rated by the therapist). The baseline CAPS score will be entered as a control variable on the first step of all analysis.

To test the general hypothesis, the following strategy will be followed:

1) Tests of the relationship of each Object Relations subscale of the BORRTI (the Predictor Variable [PV] in this study) to end-of-treatment CAPS score will be conducted. Any subscale that fails to show a significant relationship to outcome will cease to be further analyzed.

2) The mediational properties of Attachment capacity (Patient Characteristics Questionnaire Total Score) on CAPS total score will be tested for all retained BORRTI scales.

3) A combined prediction model containing only significant BORRTI subscales will be identified using iterative removal.

4) The incremental validity and unique predictive power of the retained BORRTI scales for outcome will be tested by controlling for the influence of demographic and other theoretical variables (i.e. Axis I and Axis II comorbidity).

The following specific null hypotheses will be tested:
1a.) Higher score on the Object Relations subscale of Alienation (ALN) will be unrelated to Patient Characteristics Questionnaire score and end-of-treatment CAPS score. This hypothesis will be tested using regression. The PV will be the Alienation subscale score from the BORRTI.

If a significant result is obtained, a multiple regression will test for the mediational effects of attachment by entering ALN on the first step following control variables, and the Patient Characteristics Questionnaire score on the next step. Mediation will be determined to be present if the relationship between the ALN and CAPS goes away once attachment is introduced in the model.

1b.) Higher score on the Object Relations subscale of Insecure Attachment (IA) will be unrelated to Patient Characteristics Questionnaire score and end-of-treatment CAPS score. This hypothesis will be tested using regression. The PV will be Insecure Attachment subscale score from the BORRTI.

If a significant result is obtained, a multiple regression will test for the mediational effects of attachment by entering IA on the first step following control variables, and Patient Characteristics Questionnaire score on the second step. Mediation will be determined to be present if the relationship between the IA and CAPS goes away once attachment is introduced into the model.

1c.) Higher score on the Object Relations subscale of Egocentricity (EGC) will be unrelated to Patient Characteristics Questionnaire score and end-of-treatment CAPS score.
This hypothesis will be tested using regression. The PV will be Egocentricity subscale score from the BORRTI.

If a significant result is obtained, a multiple regression will test for the mediational effects of attachment by entering EGC on the first step following control variables, and Patient Characteristics Questionnaire score on the second step. Mediation will be determined to be present if the relationship between the EGC and CAPS goes away once attachment is introduced into the model.

1d.) Higher score on the Object Relations subscale of Social Incompetence (SI) will be unrelated to Patient Characteristics Questionnaire score and end-of-treatment CAPS score.

This hypothesis will be tested using regression. The PV will be Social Incompetence subscale score from the BORRTI.

If a significant result is obtained, a multiple regression will test for the mediational effects of attachment by entering SI on the first step following control variables, and Patient Characteristics Questionnaire score on the second step. Mediation will be determined to be present if the relationship between the SI and CAPS goes away once attachment is introduced into the model.

1e.) Once the BORRTI subscales that are significantly related to outcome have been identified, they will be used to create a combined model containing only significant elements. This model will be created by entering all significant BORRTI scales on the same step and then removing each non-significant element in an iterative manner until only the significant predictors remain.
Lastly, the incremental validity of the identified BORRTI scales will be tested through multiple regression by building a regression model where significant demographic variables and comorbid psychopathology (i.e. presence of Axis I and Axis II disorders) will be entered prior to the BORRTI scales. Incremental validity will be judged to be present for any BORRTI scale that continues to show a significant relation to outcome once the influence of comorbid psychopathology and demographic variables have been taken into account.
References


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Appendix A

Clinician-Administered PTSD Scale for DSM-IV (CAPS)
Clinician-Administered PTSD Scale for DSM-IV (One Week Version) is available from the National Center for Posttraumatic Stress Disorder, Behavioral Science Division-Boston VA Medical Center and Neurosciences Division-West Haven VA Medical Center.
Appendix B

Bell Object Relations and Reality Testing Inventory (BORRTI)
The Bell Object Relations and Reality Testing Inventory (BORRTI) is available for purchase from Western Psychological Service, 12031 Wilshire Boulevard, Los Angeles, California 90025-1251.
Appendix C

The Structured Clinical Interview for Axis I Disorders (SCID I)
The Structured Clinical Interview for Axis I Disorders (SCID I) is available from Biometrics Research Department at Columbia University, 1051 Riverside Drive – Unit 60, New York, NY 10032.
Appendix D

The Structured Clinical Interview for DSM-IV Axis II Personality Questionnaire
(SCID-II PQ)
Appendix E

The Patient Characteristic Questionnaire (PCQ)
Client

The Patient Characteristics Questionnaire
Please provide your professional evaluation regarding your experience in working with this patient across the following domains.

1. Compared to my other patients, this patient displayed the ability to form relationships with me.
   Much Less | Less | Neutral | More | Much More

2. Compared to my other patients, this patient displayed fear, shyness, and anxiety in their interactions with me.
   Much Less | Less | Neutral | More | Much More

3. Compared to my other patients, this patient displayed trust and confidence in their interactions with me.
   Much Less | Less | Neutral | More | Much More

4. Compared to my other patients, this patient displayed a demanding and manipulative attitude toward me.
   Much Less | Less | Neutral | More | Much More

5. Compared to my other patients, this patient displayed the tendency to withdraw from me and to adopt an antisocial attitude.
   Much Less | Less | Neutral | More | Much More

6. Compared to my other patients, I felt connected with this patient.
   Much Less | Less | Neutral | More | Much More

7. Any other comments concerning your work with this patient that are noteworthy or striking.
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________

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Chapter V

Abstract

The current study had two goals: determine norms for the Bell Object Relations and Reality Testing Inventory (BORRTI) and evaluate object relations as a predictor of treatment response to Cognitive Processing Therapy (CPT) among Veterans with posttraumatic stress disorder (PTSD). Norms were derived with a sample of 163 (87 residential and 76 outpatient) male PTSD-diagnosed Veterans from a Veterans Administration PTSD clinic. Overall, the Veterans displayed a distinct pattern of object relations impairment compared with normative data for community and pathological populations (Borderline, Schizophrenia, Affective). The relationship between object relations and treatment response was assessed in the 87 residential Veteran subsample. Contrary to predictions, no relationship was found between the level of object relations and treatment outcome.
Dissertation

An Investigation of Trauma and PTSD

Research has confirmed that people find it logical to think that when humans are exposed to traumatic events they may develop negative psychological and physical effects (Briere, 1998). However, systematic empirical research into the effects of trauma only began within the last several decades (Briere, 1998). The physical effects of trauma are typically obvious and easily described while the psychological reactions are often subtle, slow to develop, and range from temporary stress reactions to the development of persistent and intractable posttraumatic stress symptoms. In addition, sources of trauma are varied and range from natural disasters, technological catastrophes, violent crimes and assaults, transportation accidents, terrorism attacks and abuse to military combat (Everly & Lating, 1995; Freedy & Hobfoll, 1995; Herman, 1992). Another important consideration is that recent epidemiological studies and meta-analyses have found that most people admit to experiencing at least one potentially traumatic event (PTE) during their lifetime, thereby making trauma a common life experience (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Ozer, Best, Lipsey, & Weiss, 2003).

Trauma and PTSD

A complication in the study of the trauma syndrome is the fact that most people exposed to a traumatic event do not develop a diagnosable traumatic disorder. For example, 65.1% of a large sample of New York areas residents \((N=2,752)\) displayed resilience (none or only one symptom of trauma) 6 months following the September 11th attacks (Bonanno, Galea, Bucciarelli, & Vlahov, 2006). However, repeated trauma...
exposure significantly decreases resilience and is associated with increased trauma-spectrum diagnoses (Bonanno, 2004). The risk for repeated exposure to PTE’s is especially high among those serving in the military, particularly at this present time with various active American engagements occurring in several combat theatres. As is true with civilian populations, the majority of Veterans exposed to a single PTE do not go on to develop PTSD. However, current estimates indicate that due to increasing exposure to PTE’s, 35% of returning Veterans will likely ultimately meet criteria for PTSD (Atkinson, Guetz, & Wein, 2009).

Diagnostic Criteria

Even though PTSD has been observed and described since the early history of warfare, the diagnostic criteria were only formalized in 1980. During the time of the American involvement in the Vietnam War (1959-1975), the characterization, assessment, and treatment of serious traumatic symptoms were undertaken in earnest because of the number of returning Veterans presenting at Veteran Administration Hospitals describing severe stress symptoms, often coexistent with substance abuse (Mulligan, 2004). As these Veterans sought psychological and psychiatric services, it became clear that existing diagnostic categories did not fully describe their symptoms and functional impairments. Efforts to formally characterize and describe this population culminated in a new diagnosis -- posttraumatic stress disorder (PTSD) -- first introduced in the 1980 American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders – Third Edition (DSM-III) (APA).

Posttraumatic stress disorder (PTSD) is defined as a constellation of diagnosable, persistent, traumatic-reaction symptoms which coalesce into three clusters, each named
for its common core element: re-experiencing, avoidance, and arousal (APA, 2000). The re-experiencing response involves repetitive dreams, memories or feelings associated with the traumatic experience. The avoidance response involves staying away from various activities, persons, or places which trigger memories of the trauma and which evoke feelings of detachment, estrangement, and diminished interest in life. Lastly, the arousal response involves disturbed sleep patterns, concentration difficulties, irritability, and an increased startle response (APA, 2000).

While most people exposed to a traumatic event will not develop PTSD, about 8% of combat-exposed male Veterans will, with an estimated 30% of this group developing the disorder’s chronic form which can last for years and has often been described as treatment resistant (Ford, Fisher, & Larson, 1997). Obviously, while PTSD is clearly not limited to military trauma, it is frequently reported among military personnel (Ford et al., 1997). At this time, with the United States’ ongoing Iraqi and Afghani military conflicts, not only are many new cases of PTSD developing but reactivation of quiescent PTSD symptoms among Vietnam Veterans secondary to the current media coverage has been observed (St. George, 2006). As a result, a burgeoning stream of military personnel are requesting PTSD services at Veterans Administration (VA) facilities, establishing a pattern which is expected to last for the foreseeable future (“PTSD among,” 2005; “U.S. said,” 2006; “Mental health,” 2006; Johnson et al., 2007; U.S. Government Accountability Office [USGAO], 2005). General Accounting Office (GAO) reports and the recent Atkinson study raise warnings about the readiness of the VA to deal with the potentially large influx of Veterans in need of PTSD treatment as the current engagements continue (Atkinson, Guetz, & Wein, 2009; USGAO, 2005). For example,
the Department of Veterans Affairs reported receiving more than 20,000 new requests for PTSD treatment during 2006 alone (Goldstein, 2006). This situation creates a rapidly expanding number of Veterans with PTSD symptoms and puts additional pressure on the VA to provide timely treatment. In order to adequately deal with this increased demand, developing efficient ways to provide the most cost effective and coordinated assessments, treatments, and follow-up services are viewed as imperatives (Ford, 1996; Ford, 1997; Johnson et al., 1996; Johnson et al., 2007).

**Treatment Models**

The treatment of PTSD has included a variety of approaches since the disorder's formal characterization in 1980. While studies of psychotherapeutic interventions have found support for psychodynamic psychotherapy, hypnotherapy, and eye movement desensitization and reprocessing (EMDR) as treatment modalities (Rothbaum, Meadows, Resick, & Foy, 2000), prolonged exposure (PE) and cognitive behavioral models have been identified as the most effective treatments (Foà et al., 1999; Foà, Keane, & Friedman, 2000).

The application of prolonged exposure (PE) for the treatment of PTSD has consistently been found to be efficacious across trauma populations and is considered the gold standard of PTSD treatment approaches (Rothbaum et al., 2000). PE is based on conditioning principles and uses an anxiety hierarchy to extinguish the anxiety response. Cognitive Behavior Therapy approaches to PTSD add cognitive elements, such as psychoeducation, cognitive restructuring and assertiveness training, to exposure techniques (Harvey, Bryant, & Tarrier, 2003). A particularly efficacious variant is Cognitive Processing Therapy (CPT), which incorporates findings from information
processing theory (Resick & Schnicke, 1992; Resick & Schnicke, 1996). CPT was first developed to treat sexual trauma victims but has subsequently been adapted for use with military PTSD populations. Results of studies in military trauma populations have shown it to be an effective, empirically supported, short-term, cost-effective treatment modality (Cox, 2008; Monson, et al., 2006; Plouffe, 2007; Schulz, Huber, & Resick, 2006).

**Relationship and Object Relations**

No matter what psychotherapeutic approach is used to treat PTSD, the process of therapy itself is an interpersonal one involving a therapist and patient. The quality of the therapist–patient relationship has been shown to be a “nonspecific” factor in treatment outcome and to influence progress across various treatment modalities (Puschner, Bauer, Horowitz, & Kordy, 2005). This relationship -- variously known as the “helping alliance,” “working alliance,” or “therapeutic alliance” -- has been identified as a moderate determinant in therapy outcome and success across treatment approaches (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Puschner et al., p. 416). Such findings have led some theorists to place a primary emphasis on relationship. For example, Herman (1992) argued that trauma recovery can only occur in the framework of relationship and that through restored relationship the survivor of trauma can be healed. She theorized that the process of healing is one of empowering the trauma survivor to assume responsibility for his or her own cure and its maintenance. Therefore, Herman stated that both therapist and patient must equally attend to the relationship in order to nurture and maintain it as an authentic collaborative effort.

Research investigating factors associated with the formation of a solid therapeutic relationship has shown that the social and interpersonal skills that the patient possesses
The pre-treatment are of vital importance. For example, in a sample of 60 elderly depressed patients treated using various therapeutic approaches, Gaston et al. (1988) found that greater family social support was associated with higher levels of patient commitment to therapy and that the level of patient defensiveness was negatively associated with their working capacity in treatment. Along with a variety of demographic features such as gender, age and education, Puschener et al. highlighted that the level of, or capacity for, attachment was predictive of the quality of the therapeutic alliance (2005). Attachment theorists have suggested that the capacity to form relational bonds dates back to early childhood experiences. Strupp theorized that the ability of the client to “benefit from what the therapist has to offer” is based largely upon the client’s early childhood experiences and is an important factor in whether a productive therapeutic alliance is formed (1974, pp. 251-252). Similarly, Mallinckrodt et al. (1995), studying adult attachment capacity and working alliance in a sample of 76 women obtaining therapy in a variety of university settings and community agencies, found that the level of parental bonding they recalled accounted for 23% of the variance in therapy alliance ratings. Additionally, the clients’ self-assessment of their ability to form adult attachments was a good indicator of their ability to form a working alliance with their therapist and accounted for 14% of the variance in the alliance ratings.

A potentially useful construct for understanding how early relationships may affect a patient’s attachment capacity is object relations. Object relations articulates how early primary relationships (e.g., mother – child) can be key to the development of current relationships, the nature and direction of psychological growth, and what template or pattern is used by the client to interpret the world (Piper et al., 2002). Object relations
has been defined as "a person's internal enduring tendency to establish certain types of relationships" (Piper et al., 2002, p 81). Object relations therefore refers to an individual's lifelong pattern of relationships. Within the object relations theoretical framework, the patient – therapist relationship becomes the focus for exploring the patient's process of relating to others (Scharff & Scharff, 2005). Object relations has been recognized as a robust predictor in the formation of the therapeutic alliance and has been linked to positive treatment outcomes. For example, Piper et al. (2002) summarized findings from three clinical trials they conducted between 1977 to 1998. In these studies object relations was measured via standardized clinical interview and patients were classified into one of five developmental levels: primitive, searching, controlling, triangular, and mature. Level of object relations was assessed for three time periods – childhood, adolescence, and adulthood. Piper found that quality of object relations was related to the clients' capacity to tolerate the psychic stressors evoked during therapy. For example, in a sample of 64 psychiatric outpatients receiving short-term, dynamic therapy, higher levels of object relations were associated with higher patient ratings of the therapeutic alliance, more improvement on outcome measures such as general symptomatology and fewer therapeutic problems compared to those patients with lower quality of object relations, who displayed less improvement and more dysfunction. Further work by Piper et al. (2004) replicated these findings in a sample of 72 psychiatric outpatients, classified as either high or low quality of object relations, who received interpretive therapy, suggesting that the importance of object relations may be independent of therapeutic modality. Results from this trial found that the more developed the quality of object relations was, the greater the therapeutic alliance and the
more favorable the treatment outcomes were in both individual and group psychotherapy settings. Other recent studies which have corroborated the importance of object relations for therapy outcome include Van et al. (2008), who determined, using a sample of 81 clinically depressed outpatients, that higher baseline object relations functioning was associated with better treatment response as measured by the Hamilton Depression Rating Scale compared to those with lower levels of object relations functioning.

The Complexity of Trauma Reactions

Another complicating factor in treating military PTSD trauma is that relatively few “pure” cases exist. Studies have shown that between 80 – 98% of PTSD Veterans meet lifetime diagnostic criteria for another psychiatric disorder, with up to 100% of chronic PTSD patients being comorbid for at least one other Axis I or Axis II psychiatric disorder. Axis I conditions include mood, anxiety and substance-use disorders (Bollinger, Riggs, Blake, & Ruzek, 2000; Connor et al., 2001; Herman, 1992; Kimble, Riggs, & Keane, 1998; Lasiuk & Hegadoren, 2006). In one sample of 107 PTSD-diagnosed Veterans, the most common comorbid Axis II personality disorders were Avoidant (47.2%), Paranoid (46.2%), Obsessive-Compulsive (28.3%), and Antisocial (15.1%) (Bollinger et al., 2000). This study supported the theory that personality disorders reinforce the characteristics found in PTSD itself. For example, personality disorders and PTSD share characteristics such as avoiding experiences that remind the patient of their trauma, pervasive mistrust of others and situations, and preoccupation with control and perfectionism.

As previously noted, when PTSD becomes chronic, its effects are often extreme and involve difficulties with affect regulation, consciousness, bodily functions, as well as...
psychosocial impairment, repeated psychiatric hospitalizations, increased homelessness, divorce, job instability, anger management problems, and substance abuse difficulties (Ford, Fisher, & Larson, 1997). These impairments are similar to those seen in severe personality disorders and suggest that personality patterns may prolong PTSD symptoms and impede recovery much more severely than comorbid Axis I disorders (Shea et al., 2004; Shea & Yen, 2003). Therefore, the association between PTSD features and certain core personality attributes suggests that Axis II comorbidity may be at the heart of intractable PTSD and its associated treatment resistance or failure (Bollinger, Riggs, Blake, & Ruzek, 2000; Dunn, et al., 2004; Ford, Fisher, & Larson, 1997; Gunderson & Sabo, 1993; Kamen, 2001; Shea et al., 2000; Southwick, Yehuda, & Giller, 1993).

Drawing on the connection between characterological integrity and treatment outcome, Ford et al. (1997) suggested that treatment resistant PTSD patients could be identified not by the amount of expressed PTSD symptoms, but through their relational capacity -- OR. Studying a sample of 75 Veterans with military trauma who received extensive (3 month) residential treatment, he found that level of object relations was related to treatment outcome. When patients were classified as having low levels of object relations, they failed to show improvement in both self-reported symptoms and social adjustment. On the other hand, when patients were classified as having moderate levels of object relations, they showed improvement in both symptoms and social adjustment. Thus, Ford et al. concluded that object relations was a robust predictor of treatment outcome in his sample (1997). However, the generalizability of his findings is unknown as there have been no large scale studies looking at object relations patterns in
PTSD patients and the normative patterns of object relations in those diagnosed with PTSD are unknown.

Taking Ford’s findings a step further, assessment of object relations may be potentially useful in triaging patients into appropriate treatments; for example, those exhibiting lower object relations levels could initially be exposed to reparative therapies before engaging in targeted PTSD treatment. To be used in this manner, assessment of object relations needs to be efficient, as well as psychometrically sound. However, until recently, determination of object relations typically has involved laborious, extensive and detailed clinical interviews and/or the administration of projective measures (Ford et al., 1997; Huprich & Greenberg, 2003; Piper et al., 2002). The level of effort required by such methods renders assessment of object relations a research endeavor and not easily incorporated into routine clinical care. A less involved assessment of object relations is therefore required to make object relations assessment feasible within the context of treatment needs. The Bell Object Relations and Reality Testing Inventory, BORRTI (Bell, 1995) may represent such an alternative assessment option. The BORRTI is a self-report measure that takes approximately 15-20 minutes and could thus provide a streamlined, reliable, valid and easily administered assessment of object relations, which, in turn, could be used to identify those patients ready to effectively engage in, and make use of, PTSD treatment.

The current study therefore had two goals: 1) to determine normative patterns for object relations as assessed by the BORRTI in combat PTSD Veterans and if/how patterns of object relations vary between PTSD-diagnosed Veterans seeking residential and outpatient treatment, and; 2) examine if object relations, as assessed by the BORRTI,
was related to PTSD symptom reduction following CPT treatment in a residential sample.

It is important to note that the focus of this study was not the efficacy of CPT, as CPT has been well validated (Chard, Weaver, & Resick, 1997; Owens & Chard, 2003; Owens, Pike, & Chard, 2001; Resick & Schnicke, 1996). Rather, the focus was on whether object relations influences Veterans’ capacity to make use of CPT treatment.

Specifically, it was hypothesized that lower levels of object relations would be related to less treatment response; further, it was hypothesized that this relationship would be mediated by the quality of the therapeutic bond.

**Method**

This study had two goals: 1) the establishment of PTSD norms on the Bell Object Relations and Reality Testing Inventory (BORRTI); and 2) investigation of the relationships between object relations, treatment alliance and capacity to benefit from PTSD treatment among PTSD Residential Rehabilitation Program (PRRP) participants.

**Participants**

Participants in this study were 163 PTSD-diagnosed male Veterans (87 residential, 76 outpatient) and 17 Therapists, who provided individual therapy to the residential Veterans. All participants were recruited through the PTSD and Anxiety Disorders Clinic (PTSDADC) at the Cincinnati VAMC; the inclusion criteria for this study were acceptance for PTSD services at the Clinic following assessment. There were no exclusion criteria. The average age of all participating Veterans was 48.19 years; on average the full sample reported 13.2 years of education. The Veteran sample was predominantly Caucasian (77%), had primarily served in the Army (64%) and was married (49%). The majority of participants (54%) were unemployed or disabled and the
average amount of PTSD-related Service Connection was 28%. As a whole, the sample was most likely to have served in the Vietnam (47%) or the Iraq/Persian Gulf (37%) eras. Significant differences emerged between the residential and outpatient samples on several dimensions. The Residential sample was more likely older, African-American, divorced, and greater than 50% service connected for PTSD. Tables 1 and 2 provide detailed demographic information regarding the full sample and the residential and outpatient subsamples.

The therapists in this study were mostly Female (64%) and Caucasian (88%). The majority of therapists (64%) were doctoral level psychologists or psychologists-in-training serving as interns or practicum students. The remaining therapists included a physician, four nurse practitioners, and a social worker. No other demographic information was collected about the therapists as they were not the focus of this study.

Measures

The following assessment instruments were used during this study.

Primary Outcome Measure.

Clinician Administered PTSD Scale (CAPS).

The Clinician Administered PTSD Scale - Week version (CAPS) is a structured clinical interview instrument developed to assess the presence and severity of symptoms of PTSD (Appendix A). The CAPS was created to provide a comprehensive, psychometrically sound interview and is currently the accepted standard for assessing traumatic stress. The CAPS was originally developed in 1989 and has been revised three times (1990, 1994, and 1998). The 1998 revision is identical to the past versions except it uses a one-week rather than one-month time frame.
The CAPS assesses PTSD diagnostic criteria as outlined in the DMS-IV. Its administration consists of a series of questions that assessed the frequency and severity of 17 PTSD symptoms. Summary scale scores for the PTSD symptoms of re-experiencing (DSM – IV Criterion B), avoidance and numbing (DSM – IV Criterion C), and hyperarousal (DSM – IV Criterion D) are computed. These three scales are then summed to provide a total PTSD severity score which can range from 0 to 136 (Blanchard et al., 1995). Scores at or above 45 are classified as reflecting the presence of diagnosable PTSD (K. M. Chard, personal communication, August 4, 2006; Weathers, Keane, and Davidson, 2001).

The CAPS is a psychometrically sound instrument. Past studies have shown good test-retest reliability (kappa ranging from .89 to 1.00) and high interrater reliability scores, ranging from .86 - .87 for frequency, .86 - .92 for intensity, and .92 for overall severity (Weathers, Ruscio, & Keane, 1999). Other PTSD measures correlate well with the CAPS including the Mississippi Scale for Combat Related PTSD \((r = .97)\) (Keane, Caddell, & Taylor, 1988), the PTSD subscale (PK) of the Minnesota Multiphasic Inventory \((r = .82)\) (Keane, Malloy, & Fairbank, 1984), and the Combat Exposure Scale with a Pearson product-moment statistic, \(r = .25, p < .0001\) (Keane et al., 1988).

**Primary Predictor Measure.**

*Bell Object Relations and Reality Testing Inventory (BORRTI).*

The Bell Object Relations and Reality Testing Inventory (BORRTI) is a 90 statement true - false paper and pencil inventory designed to test ego functioning in an efficient manner (Appendix B). There are 45 statements related to object relations and 45 statements related to reality testing. The BORRTI is intended for use with individuals 18
years and older. There are four subscales generated for Object Relations: Alienation (sample item: I may withdraw and not speak to anyone for weeks at a time); Insecure Attachment (sample item: It is hard for me to get close to anyone); Egocentricity (sample item: Exercising power over other people is a secret pleasure of mine); and, Social Incompetence (sample item: Others frequently try to humiliate me). Three subscales are generated for Reality Testing: Reality Distortion, Uncertainty of Perception, and Hallucinations and Delusions (Bell, 1995).

Internal consistencies for each subscale have been found to be adequate-to-good according to Bell’s earlier work (1995). Cronbach’s alpha and Spearman split-half reliability estimates are as follows: Alienation (.90 and .90); Insecure Attachment (.82 and .81); Egocentricity (.78 and .78); Social Incompetence (.79 and .82); Reality Distortion (.87 and .85); Uncertainty of Perception (.82 and .77), and; Hallucinations and Delusions (.85 and .83). The BORRTI has shown adequate-to-good test-retest reliability across all subscales, ranging from .58 to .90 over four weeks and from .63 to .81 over 13 weeks in a mixed diagnoses sample. The test-retest reliability over 26 weeks for a Schizophrenic sample ranged from .58 to .78 (Bell, 1995).

The BORRTI has displayed excellent discriminative validity among patient groups of Axis II (Borderline), Axis I (Affective, Schizophrenia), and nonclinical (college/university students, community active adults). The object relations data “distinguished pathological groups from community active adults” and provided “distinct profile patterns... for each criterion group” (Bell, 1995, p. 32). Convergent and divergent validity is challenging with the BORRTI in that there are “no comparable scales” but some scales “measure related phenomena” (Bell, 1995, p. 37). Comparisons made to
these measures, frequently used in psychiatric disorders, included the Brief Psychiatric Rating Scale (BPRS), Global Assessment Scale (GAS), Positive and Negative Syndrome Scale (PANSS), Symptom Checklist 90 Revised (SCL-90-R), Eysenck Personality Inventory Subscales (Eysenck), Millon Clinical Multiaxial Inventory (MCMI), Minnesota Multiphasic Personality Inventory-2 (MMPI-2), and Earliest Memory technique. The overall summary of each of these measures revealed a convergent pattern of relationship with specific subscales of each measure to each BORRTI subscales (see Bell, 1995, pp. 45-46 for specifics). Each of the relationships provides insight into the “general domain of personality of which each subscale is a part” (Bell, 1995, p. 44). The value of these relationships is thought to provide enhanced clinical understanding and treatment guidance.

For Goal II of this study (prediction of treatment utilization), the four object relations scales were used. The Reality Testing data was collected and used for Goal 1 (establishment of norms) only.

**Secondary Prediction Measures.**

*Structured Clinical Interview for Axis I Disorders.*

The Structured Clinical Interview for Axis I Disorders (SCID I) is a semi-structured interview that identifies DSM-IV Axis I disorders (APA, 1994) (Appendix C). It can be used with both psychiatric and general medical patients and contains language appropriate for patients 18 years or older. The SCID I is employed by both clinicians and researchers. The SCID-I covers all subcategories within the diagnostic areas of Mood Disorders, Anxiety Disorders, Psychotic Disorders, Substance Use Disorders, Somatoform Disorders, Eating Disorders, and Adjustment Disorders. Administration
typically takes from 60-90 minutes. Patients answer questions about symptoms reflective of the diagnostic areas and the clinician rates their responses on a four point scale (? = Inadequate information to code the criterion and as 1, 2, or 3; where 1 = Absent or False; 2 = Subthreshold; 3 = Threshold or True). Examples of SCID-I questions are: What was your energy like? (Tired all the time? Nearly every day?); Do periods of [Depressed Mood] mostly seem to happen at the same time of the year, like fall or winter?, and; Do you think that you were more afraid of (Phobic Activity) than you should have been (or than made sense)? The interview results are reviewed again in summary form before a final determination is made regarding the presence of a disorder. For this study, one point was assigned for the presence of each disorder and the sum of all disorders were used to create a single variable which ranged from 0 to 14.

Since the SCID-I is dependent upon the clinical judgment of the interviewer, the kappa statistic is typically used as a reliability estimate. Studies have produced kappas in the range of .70 to 1.00 by using either joint or videotaped interviews, thereby removing some of the variability in observation (Strakowski, Keck, McElroy, Lonczak, & West, 1995; Stukenberg, Dura, & Kiecolt-Glaser, 1990).

**Chart Review.**

A review of the electronic medical record was performed for each patient in this study to obtain demographic information and presence of clinically diagnosed Axis I and Axis II psychopathology.

**Structured Clinical Interview for DSM-IV Axis II Personality Questionnaire.**

The SCID-II Personality Questionnaire (SCID-II PQ) is a 119-item true/false assessment of personality functioning covering the 11 DSM-IV (APA, 1994) Personality...
Disorders, including Personality Disorder Not Otherwise Specified (NOS) (Appendix D). The SCID-II PQ was developed to be used in conjunction with the SCID-II Clinical Interview as a screening tool to shorten the time required by the clinician to administer the SCID-II. The SCID-II PQ typically takes about 20 minutes and was designed to identify areas requiring in-depth examination through the full Clinical Interview. Studies have shown that endorsed items hold considerable information but denied items have limited utility due to very low rates of false negatives (Ekselius et al., 1994; Jacobsberg, Perry, & Frances, 1995). The questions within the SCID-II-PQ are grouped by personality disorder. The presence of a disorder is determined by exceeding an empirically derived threshold score. The SCID-II is normed for adults (18+ years of age). Examples of questions from the Dependent and Passive scales of the SCID-II Personality Questionnaire are respectively: Do you usually feel uncomfortable when you are by yourself? Are you often grumpy and likely to get into arguments?

Although the SCID-II Personality Questionnaire was not designed to be used as a stand-alone instrument, its threshold scores have an overall kappa of agreement with the SCID-II interview of 0.78 (Jacobsberg, Perry, & Frances, 1995). It has also been found to display reasonable internal consistency coefficients, ranging from 0.76 for the avoidant and borderline scales to 0.33 for the schizoid scale (Jacobsberg et al). For this study, the SCID II-PQ was used to obtain an estimate of overall Axis-II comorbidity. The obtained scores were collapsed into a single continuous variable (range 0 – 11), reflecting the total number of disorders which reached diagnostic threshold.
The Patient Characteristics Questionnaire.

The Patient Characteristics Questionnaire (PCQ) (Appendix E) was specifically created for this study. It was intended to capture the therapist’s experience of the patient’s ability to connect during therapy as compared to the therapist’s experience of other clients. Thus, the scores have an ipsative nature and the client’s attachment capacity per se is not being quantified. The questionnaire consisted of six statements that the therapist rated using a five point Likert-type scale (1 = Much Less to 5 = Much More). Example statements were: “Compared to my other patients, this patient displayed a demanding and manipulative attitude toward me”; and, “Compared to my other patients, I felt connected with this patient”. Item scores were summed to create an overall score which could range from 6 – 30. The coefficient alpha for this measure was .85 for this sample of Veterans and is therefore considered reliable.

Procedure

Data collection for both Goals 1 and 2 began after approval by the R&D Committee of the Cincinnati Veterans Administration Medical Center (VAMC) and the IRBs of the University of Cincinnati and Xavier University (Appendix F). The study approval was renewed by these organizations during the course of data collection as required. Upon admission to either the outpatient or residential programs, Veterans were recruited for the study and provided, orally and in writing, with a Participant Informed Consent form to read and sign (Appendix G). Therapist-participants, who provided the individual Cognitive Processing Therapy (CPT) to residential Veterans, were given a Therapist Informed Consent Form to read and sign (Appendix G). Over the course of the
study, approximately 66% of residential and 82% of outpatient Veterans refused to participate or consented but did not return or fully complete the assessment instruments.

For Study Goal 1, all residential and outpatient Veterans enrolled in this study were asked to complete the BORRTI as an additional instrument after completion of their routine clinic intake materials. Residential participants were primarily recruited during group evening meetings orienting them to the program and treatment requirements after formal intake measures had been administered. Outpatients were individually recruited following their intake battery or later during one of the first three CPT individual sessions.

For Study Goal 2, all residential participants were involved in standard treatment at the PTSD clinic. Standard treatment was comprised of 13 sessions of intense Cognitive Processing Therapy (CPT), in addition to various psychoeducational group sessions on the topics of Anger Management, Sleep Management, Assertiveness, Distress Tolerance, Interpersonal Effectiveness, Mindfulness, Communication Training, and Health Issues. At the end of treatment, the residential participants' CPT therapists completed the Patient Characteristics Questionnaire (PCQ). These participants were administered an end-of-treatment CAPS in keeping with standard procedures.

Results

Study Goal 1: Derivation of BORRTI Norms in a military PTSD population

This study goal was to obtain normative data for PTSD-diagnosed Veterans on the BORRTI. No predictions were made regarding the patterns or profiles that would emerge. However, the obtained results were compared to known (Bell, 1995, p. 34)
BORRTI profiles for other populations – both clinical and community – to assess for similarities and differences.

The Total PTSD sample showed elevated T scores on 3 BORRTI subscales (Alienation, Reality Distortion, Uncertainty of Perception). When examined by subgroup, it was found that residential participants produced elevated T scores on 5 subscales (Alienation, Insecure Attachment, Egocentricity, Reality Distortion, Uncertainty of Perception), while outpatients showed T score elevations on 2 subscales (Alienation, Uncertainty of Perception). The residential sample showed significantly higher elevations on all subscales except Hallucinations and Delusions when compared to the outpatient sample. Overall, results indicated that those Veterans who sought residential treatment showed significantly more impairment of object relations as assessed by the BORRTI than those who opted for outpatient care (See Table 3).

Following identification of the Veteran profiles, three sets of comparison analyses were conducted: 1) comparison of the Veteran Total (VT) sample to non-clinical community active adults; to clinical borderline personality disordered patients; to clinical affective disordered patients, and to clinical schizophrenia patients; 2) comparison of the Veteran Residential (VR) sample to the same groups and 3) comparison of the Veteran Outpatient (VO) sample to the same groups. The comparisons were conducted using a series of one-sample t-tests. As seen in Figure 1, results indicated significant differences between the VT sample group and each comparison group. Overall, the VT sample profiles were significantly higher than the community population across all BORRTI subscales. In contrast, the VT sample profiles were significantly lower than clinical borderline patients across 5 BORRTI subscales. The VT sample profile was significantly
higher than clinical affective patient sample on six BORRTI subscales and finally, was significantly higher than the clinical schizophrenia patient profile on three subscales and significantly lower on two subscales of the BORRTI. These results indicate that the VT sample showed a distinct pattern of object relations impairment. While the Veterans as a whole showed less impairment than the Axis II borderline patient group, they showed more impairment than either Axis I groups.

In contrast, the VR sample showed some profile differences. As shown in Figure 2, while again the VR was significantly higher on all 7 BORRTI subscales compared to the community sample, the VR sample was significantly lower on only two subscales (Reality Distortion, Hallucinations and Delusions) when compared to clinical borderline patients. The VR group was significantly higher on six subscales when compared to the clinical affective patients. Finally, the VR sample was significantly higher on four subscales and significantly lower on 2 subscales when tested against a clinical schizophrenia sample.

The comparisons of the VO sample yielded highly similar results to those found with the VT sample. As shown in Figure 3, compared to a community sample, the VO sample was significantly higher on 6 BORRTI subscales. The VO sample was significantly lower on all 7 BORRTI subscales compared to clinical borderline patients. The VO sample was significantly higher on 3 subscales and significantly lower on 1 subscale when compared to clinical affective patients and when compared to clinical schizophrenia patients, the VO sample was significantly lower on two subscales and higher on three subscales.
Study Goal 2: Examination of Object Relations to PTSD symptom reduction following CPT treatment in a Residential sample

Analytic Strategy.

The following analytic strategy was used for Study Goal 2. Prior to any analysis, all variables were examined for normalcy and no violations were observed. It was hypothesized that impaired object relations, operationally defined as higher elevations on the BORRTI object relations scales, would be associated with a poor therapeutic connection and, as a result, with the failure to make treatment gains (operationally defined as end-of-treatment CAPS score). As such, the hypothesis specifies a mediational model. Following the requirements of mediation outlined by Baron & Kenny (1986), mediation requires that the predictor variable (PV) -- in this case the object relations scales -- be significantly related to both the outcome variable (OV) -- in this case end-of-treatment CAPS score-- and the hypothesized mediational variable (MV) -- in this case the therapeutic connection; the meditational variable must also show a significant relationship with the outcome variable. This mediational model was tested in four steps. The first step involved assessing the relationship of each individual BORRTI object relations scale with treatment gains; the second step involved testing the relationship of the therapeutic connection with treatment gains; the third step involved testing the relationship of each individual BORRTI object relations scale with the therapeutic connection; the final step involved testing the relationship of each BORRTI object relations scale with treatment gains, after accounting for the influence of the therapeutic connection. For all analyses treatment gains were operationally defined as total end-of-treatment CAPS score (CAPS-2), with higher scores being reflective of less
treatment gain; the treatment relationship was operationally defined as the total score on the Patient Characteristics Questionnaire (PCQ). In order to control for individual differences in initial symptom severity, the baseline CAPS total score (CAPS-1) was entered as a control variable in all analyses. Additionally, while no specific hypotheses were made regarding the relative importance of the various dimensions of object relations as assessed by the BORRTI, it was predicted that the scales would possess differential predictive power. As such, the identification of a prediction model containing only significant object relations elements was planned, using multiple regression and the interactive removal of non-significant object relations factors until only significant elements remained.

Specific Hypotheses Results.

The ability of the BORRTI subscales to predict end-of-treatment symptom severity (CAPS-2) was tested using a series of hierarchical linear regression equations, where baseline CAPS was entered on the first step and each BORRTI object relations scale was entered on the second step. The hypothesis that higher BORRTI scores would be associated with lower treatment gains was not supported. Results indicated that none of the BORRTI scales were significantly related to treatment gains. The regression results for each BORRTI object relations subscale are shown in Table 4.

The second step of the mediational model assessed the ability of the PCQ to predict end-of-treatment symptom severity (CAPS-2) and was tested using a hierarchical linear regression equation, where baseline CAPS was entered on the first step and PCQ was entered on the second step. This regression was significant and indicated the value of the PCQ in predicting treatment outcome after controlling for initial symptom severity,
\[ \beta = -0.25, t = -2.48, p = .02. \] Higher scores on the PCQ were associated with greater treatment gains. However, while the PCQ was shown to be related to treatment outcome, as indicated none of the BORRTI object relations scales showed a significant relationship with outcome, so the mediational properties of the PCQ could not be tested. Nonetheless, the relationship of the BORRTI object relations scales with the PCQ was tested; no significant results emerged.

As none of the BORRTI object relations scales showed any significant relation with treatment outcome, a prediction model could not be built.

**Supplemental Analyses.**

Given that the BORRTI scales showed no relation to symptom change (e.g., end-of-treatment symptoms after controlling for baseline severity), we decided to test the relationship of the BORRTI object relations scales to end-of-treatment PTSD severity levels in a univariate manner. This was done by regressing the CAPS-2 on each BORRTI object relations subscale. These analyses again produced no significant results. None of the BORRTI object relations scales showed any association with PTSD symptoms as assessed by the CAPS Total 2 (Table 5).

Next, the relationship between a more global object relations measure and treatment gains was tested through three multiple linear regressions, all controlling for baseline symptom severity. This was done to determine if an integrated, rather than fractionated, model of object relations might have more predictive utility. The first regression tested the relationship between the average of the four object relations subscales and treatment gains; results showed no significant relationship \[ \beta = -.05, t = -.44, p = .66. \] The second regression tested the relationship between the average of the
three Reality Testing subscales and treatment gains; results showed no significant relationship $\beta = .15, t = 1.41, p = .16$. Finally, the relationship between the average of all seven BORRTI scales and treatment gains was tested; results showed no significant relationship with $\beta = .04, t = 3.7, p = .71$.

As a final check, the primary hypotheses were rerun after removing all BORRTI profiles of questionable validity due to elevations on the Inconsistency Responding (INC) scale and Validity Indexes (FREQ and INFREQ) ($n = 3$). Results paralleled those found in the primary analyses; none of the BORRTI scales showed any association with treatment outcome.

**Discussion**

The primary purposes of this study were to: 1) establish norms for the Bell Object Relations and Reality Testing Inventory among male Veterans diagnosed with PTSD, and; 2) to evaluate the utility of this assessment instrument to predict treatment gains in Residential Veterans receiving PTSD treatment. The BORRTI was selected for study as it is a quick, easy to administer, self-report inventory that has shown adequate validity in other populations (Bell, 1995). The focus on object relations was prompted by past work which showed a strong association between object relations and PTSD treatment outcome. Specifically, Ford et al. (1997) observed that higher levels of object relations were a robust predictor of positive PTSD Residential treatment outcome. He attributed this to these patients' ability to withstand the rigors of the therapeutic encounter and the stresses of working through their trauma. However, despite his findings, assessment of object relations did not become a routine part of clinical intake due, at least in part, to the time consuming and laborious nature of this task. As such, the current study focused on
the BORRTI as it offered considerable promise in these areas. It was hypothesized that
the BORRTI would capture the salient aspects of object relations and that individuals
with less object relations impairment would show more treatment gains and those with
more impairment would make less movement. However, this hypothesis was not
supported and level of object relations as measured by the BORRTI showed no
relationship with treatment gains following Cognitive Processing Therapy in a
Residential setting.

While the hypothesized relationship between the BORRTI scales and treatment
gains was not supported, the current study results do indicate that PTSD Veterans
produce a distinct profile on the BORRTI. For example, compared to a community
population, the Total PTSD Sample and the Residential and Outpatient subsamples were
significantly higher on all BORRTI scales. Additionally, the overall PTSD sample
demonstrated a distinct object relations pattern of less impairment than Axis II borderline
patients but more impairment than Axis I affective or schizophrenia patients. Finally, the
Residential and Outpatient Veteran samples showed several significant differences across
the BORRTI scales, with more impairment emerging in the residential sample. The
clinic from which the sample was recruited allows Veterans to self-select their treatment
venue and does not triage Veterans into a particular treatment setting. As such, the
current results suggest that Veterans who opt for residential PTSD treatment may be
more interpersonally impaired than their outpatient counterparts and, as a result,
motivated to self-select more structured and contained treatments. However, the present
results also suggest that once treatment is initiated, object relations impairment does not
affect therapy outcome.
The failure of the object relations scales to show a relationship with treatment gains can be considered from several perspectives. First, perhaps the way that treatment gains were operationalized in this study was too narrow and symptom focused. For instance, in Ford's 1997 study, outcome was examined not only as symptom reduction but also from the perspective of treatment service utilization and vocational progress. However, it is important to note that the primary purpose of PTSD treatment is the reduction of PTSD symptoms so that defining treatment gains in terms tertiary to the disorder itself may be a questionable decision. Second, what is captured by the BORRTI scales may not be the same as what Ford's object relations assessment process captured. Ford used extensive clinical interviews to assess four interpersonal domains: 1) complexity of representations of people; 2) affect tone of relationship paradigms; 3) capacity for emotional investment in relationships and moral standards, and; 4) understanding social causality. Raters coded the interviews with the final object relations classification based on the clinician's perceptions of object relations development. In contrast, the BORRTI is a self-report measure that assesses respondents' own perceptions of their relationships. It may be that the salient function of object relations for treatment outcome is not how an individual perceives his or her relational capacity but how others view it. Some support for this is seen in the current study when examining the therapist ratings of the therapeutic connection. While therapists' perception of client connection was unrelated to all the self-report object relations scales, it was related to treatment outcome. Veterans who were perceived by their therapists as more relationally comfortable and competent showed greater treatment gains. Lastly, Ford's assessment of object relations could be described as being a more holistic and inclusive measure while
the BORRTI might be described as more focused and therefore more limited in its scope of the object relations construct.

Finally, the type of therapy offered in this study is very different from that offered in the 1997 Ford study. Treatment for PTSD has changed considerably in the years since Ford's inquiry and the long-term, milieu-based models targeting dynamic and existential issues, such as the one he studied, are no longer used as they failed to show the efficacy that more focal treatments have demonstrated. For example, in Ford's sample, across both symptom measures and community outcomes, between 62 and 87 percent of patients were classified as failing to show reliable progress by end-of treatment; in contrast, in the current study fully 46 percent of patients no longer showed clinical levels of PTSD symptoms by treatment end as measured by a CAPS-2 Total Score <45. The Cognitive Processing Therapy used in this study is very structured and time-limited and focuses on directly addressing PTSD symptoms and the cognitive distortions that perpetuate the disorder. Unlike in dynamic treatment models, process issues such as transference are not addressed. As such, object relations may not be a salient factor in treatment as the interpersonal and intrapsychic conflicts central to dynamic psychotherapies are avoided. It may be that individuals with significant object relations impairment are able to engage with and benefit from the CPT treatment modality independent of their impairment because their conflicts and relational issues are not activated. As such, the current study's null findings may actually contribute to our understanding of the efficacy of CPT and offer additional support for the applicability of this treatment for those with significant relational impairment.
However, the current study does have one significant limitation. While the overall number of participants provides adequate power to test the hypotheses, the refusal rate among the residential cohort was very high. Approximately 66% of Veterans approached for the study declined. It is not known if those who refused to participate differed in important ways from those who agreed. Specifically, it was noted that refusal was often prompted by suspicion and accompanied by what appeared to be interpersonal trust deficits. As such, it may be that those Veterans who refused had more impaired object relations than those who complied. However, while this is a possibility, examination of the cohort results showed no restriction in range on the study indices.

This study spawns several avenues of future research. First, future studies assessing the construct validity of the BORRTI appear warranted. The lack of relationship between the BORRTI scales and the therapist ratings of the therapeutic connection suggest that the BORRTI is not capturing important aspects of interpersonal functioning. Second, research could continue to investigate the relevance of object relations in PTSD treatment by identifying object relations assessment strategies that are efficient but do not rely upon self-report. Finally, it may be that the importance of object relations differs for men and women. It could be that object relations is more important when treating female Veterans due to the stronger therapeutic alliance often formed by women during therapy (Puschner, Bauer, Horowitz, & Kody, 2005).
References


Table 1

**Participant Demographics in the Current Study**

<table>
<thead>
<tr>
<th>Sociodemographics</th>
<th>Total (N=163)</th>
<th>Outpatient (N=76)</th>
<th>Residential (N=87)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (SD)</td>
<td>48.19 (13.47)</td>
<td>45.49* (15.42)</td>
<td>50.55* (11.05)</td>
</tr>
<tr>
<td>Ethnicity, %</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>77.3</td>
<td>88.2*</td>
<td>67.8*</td>
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<tr>
<td>African-American</td>
<td>19.6</td>
<td>9.2*</td>
<td>28.7*</td>
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<tr>
<td>Hispanic/Latino</td>
<td>1.8</td>
<td>1.3</td>
<td>2.3</td>
</tr>
<tr>
<td>Native-American</td>
<td>1.2</td>
<td>1.3</td>
<td>1.1</td>
</tr>
<tr>
<td>Marital Status, %</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>49.1</td>
<td>60.5*</td>
<td>39.1*</td>
</tr>
<tr>
<td>Divorced</td>
<td>30.7</td>
<td>22.4*</td>
<td>37.9*</td>
</tr>
<tr>
<td>Separated</td>
<td>5.5</td>
<td>2.6*</td>
<td>8.0*</td>
</tr>
<tr>
<td>Never Married</td>
<td>13.5</td>
<td>14.5</td>
<td>12.6</td>
</tr>
<tr>
<td>Widowed</td>
<td>1.2</td>
<td>0.0</td>
<td>2.3</td>
</tr>
<tr>
<td>Years of education</td>
<td>13.2</td>
<td>13.1</td>
<td>13.3</td>
</tr>
<tr>
<td>Employment Status,%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>30.7</td>
<td>48.7*</td>
<td>14.9*</td>
</tr>
<tr>
<td>Unemployed</td>
<td>30.7</td>
<td>23.7*</td>
<td>36.8*</td>
</tr>
<tr>
<td>Disabled</td>
<td>23.3</td>
<td>9.2*</td>
<td>35.6*</td>
</tr>
<tr>
<td>Retired</td>
<td>12.9</td>
<td>14.5</td>
<td>11.5</td>
</tr>
<tr>
<td>Student</td>
<td>2.5</td>
<td>3.9</td>
<td>1.1</td>
</tr>
<tr>
<td>Index Trauma¹, %</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combat</td>
<td>61.3</td>
<td>75.0*</td>
<td>49.4*</td>
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<tr>
<td>Sexual assault</td>
<td>9.2</td>
<td>0.0*</td>
<td>17.2*</td>
</tr>
<tr>
<td>Unexpected death</td>
<td>9.2</td>
<td>13.2*</td>
<td>5.7*</td>
</tr>
<tr>
<td>Childhood sexual abuse</td>
<td>5.5</td>
<td>3.9</td>
<td>6.8</td>
</tr>
<tr>
<td>Childhood physical abuse</td>
<td>5.5</td>
<td>2.6</td>
<td>6.9</td>
</tr>
<tr>
<td>Witness to death</td>
<td>5.5</td>
<td>7.9</td>
<td>3.4</td>
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<tr>
<td>Physical assault</td>
<td>4.3</td>
<td>1.3</td>
<td>6.9</td>
</tr>
<tr>
<td>Serious accident</td>
<td>4.3</td>
<td>7.9</td>
<td>1.1</td>
</tr>
<tr>
<td>Fire or explosion</td>
<td>4.3</td>
<td>1.3</td>
<td>6.8</td>
</tr>
<tr>
<td>Assault with weapon</td>
<td>4.3</td>
<td>1.3</td>
<td>6.8</td>
</tr>
<tr>
<td>Transportation accident</td>
<td>3.1</td>
<td>2.6</td>
<td>3.4</td>
</tr>
</tbody>
</table>

¹ The sum of the percentages is greater than 100% within each group due to multiple Index traumas.

*= values differ at p <.05
Table 2

*Participant Military-related Demographics in the Current Study*

<table>
<thead>
<tr>
<th>Sociodemographics</th>
<th>Total (N=163)</th>
<th>Outpatient (N=76)</th>
<th>Residential (N=87)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vietnam</td>
<td>47.2</td>
<td>42.1*</td>
<td>51.7*</td>
</tr>
<tr>
<td>Iraq</td>
<td>24.5</td>
<td>31.6*</td>
<td>18.4*</td>
</tr>
<tr>
<td>Post-Vietnam</td>
<td>16.3</td>
<td>10.5*</td>
<td>19.5*</td>
</tr>
<tr>
<td>Persian Gulf</td>
<td>12.9</td>
<td>14.5</td>
<td>11.4</td>
</tr>
<tr>
<td>Lebanon</td>
<td>2.5</td>
<td>2.6</td>
<td>2.3</td>
</tr>
<tr>
<td>Korea</td>
<td>0.6</td>
<td>1.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Kosovo</td>
<td>0.6</td>
<td>1.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Somalia</td>
<td>0.6</td>
<td>0.0</td>
<td>1.1</td>
</tr>
<tr>
<td>Other</td>
<td>0.6</td>
<td>1.3</td>
<td>0.0</td>
</tr>
</tbody>
</table>

1 The sum of the percentages are greater than 100% within each group because some Veterans served in multiple Service Eras.

<table>
<thead>
<tr>
<th>Combat Exposure, % Yes</th>
<th>78.5</th>
<th>85.5*</th>
<th>72.4*</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD Service Connection, % Mean</td>
<td>27.6</td>
<td>19.9*</td>
<td>34.3*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Branch, %</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Army</td>
<td>64.4</td>
<td>68.4</td>
<td>60.9</td>
</tr>
<tr>
<td>Marines</td>
<td>20.9</td>
<td>26.3*</td>
<td>16.1*</td>
</tr>
<tr>
<td>Navy</td>
<td>9.2</td>
<td>2.6*</td>
<td>14.9*</td>
</tr>
<tr>
<td>Air Force</td>
<td>5.5</td>
<td>2.6*</td>
<td>8.0*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-Treatment CAPS</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPS-B 1, mean</td>
<td>18.3</td>
<td>16.9*</td>
<td>19.6*</td>
</tr>
<tr>
<td>CAPS-C 1, mean</td>
<td>27.9</td>
<td>25.6*</td>
<td>29.9*</td>
</tr>
<tr>
<td>CAPS-D 1, mean</td>
<td>26.7</td>
<td>23.5</td>
<td>23.8</td>
</tr>
<tr>
<td>CAPS-Total 1, mean</td>
<td>70.0</td>
<td>66.0*</td>
<td>73.4*</td>
</tr>
</tbody>
</table>

* = values differ at p < .05

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Table 3

BORRTI Subscale T scores measured for PTSD-diagnosed Veterans

<table>
<thead>
<tr>
<th>BORRTI Subscales</th>
<th>Total (N=163)</th>
<th>Outpatient (N=76)</th>
<th>Residential (N=87)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alienation (ALN)</td>
<td>67</td>
<td>64*</td>
<td>70*</td>
</tr>
<tr>
<td>Insecure Attachment (IA)</td>
<td>57</td>
<td>54*</td>
<td>60*</td>
</tr>
<tr>
<td>Egocentricity (EGC)</td>
<td>59</td>
<td>57*</td>
<td>62*</td>
</tr>
<tr>
<td>Social Incompetence (SI)</td>
<td>54</td>
<td>52*</td>
<td>56*</td>
</tr>
<tr>
<td>Reality Distortion (RD)</td>
<td>60</td>
<td>58*</td>
<td>62*</td>
</tr>
<tr>
<td>Uncertainty of Perception (UP)</td>
<td>63</td>
<td>60*</td>
<td>66*</td>
</tr>
<tr>
<td>Hallucination &amp; Delusion (HD)</td>
<td>59</td>
<td>57</td>
<td>60</td>
</tr>
</tbody>
</table>

1 BORRTI HD score classified as elevated at nonstandard T>65

* values differ at p<.05
Table 4

Hierarchical Regression Analysis for BORRTI Subscales Predicting Treatment Response in PTSD-diagnosed Residential Veterans accounting for initial symptoms (N=87)

<table>
<thead>
<tr>
<th>BORRTI Subscale</th>
<th>β</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alienation</td>
<td>.04</td>
<td>.32</td>
<td>.75</td>
</tr>
<tr>
<td>Insecure Attachment</td>
<td>-.08</td>
<td>-.72</td>
<td>.47</td>
</tr>
<tr>
<td>Egocentricity</td>
<td>-.00</td>
<td>-.04</td>
<td>.97</td>
</tr>
<tr>
<td>Social Incompetence</td>
<td>-.09</td>
<td>-.84</td>
<td>.41</td>
</tr>
<tr>
<td>Reality Distortion</td>
<td>-.00</td>
<td>-.00</td>
<td>.99</td>
</tr>
<tr>
<td>Uncertainty of Perception</td>
<td>.11</td>
<td>1.01</td>
<td>.32</td>
</tr>
<tr>
<td>Hallucinations &amp; Delusions</td>
<td>.19</td>
<td>1.85</td>
<td>.07</td>
</tr>
</tbody>
</table>
Table 5

*Hierarchical Regression Analysis for BORRTI Object Relations Subscales Predicting Treatment Response in PTSD-diagnosed Residential Veterans (N=87)*

<table>
<thead>
<tr>
<th>Object Relations BORRTI Subscale</th>
<th>β</th>
<th>t</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alienation</td>
<td>.17</td>
<td>1.54</td>
<td>.13</td>
</tr>
<tr>
<td>Insecure Attachment</td>
<td>-.12</td>
<td>-1.07</td>
<td>.29</td>
</tr>
<tr>
<td>Egocentricity</td>
<td>.08</td>
<td>.74</td>
<td>.46</td>
</tr>
<tr>
<td>Social Incompetence</td>
<td>-.08</td>
<td>-.68</td>
<td>.50</td>
</tr>
</tbody>
</table>
Figure 1. BORRTI Subscales Comparison among Total Veterans (N=163), Community Active Adults (N=60), Clinical Borderline (N=37), Clinical Affective (N=29), Clinical Schizophrenia (N=21).

*p < .05
Figure 2. BORRTI Subscales Comparison among Residential Veterans (N=87), Community Active Adults (N=60), Clinical Borderline (N=37), Clinical Affective (N=29), Clinical Schizophrenia (N=21).

*p < .05
AN INVESTIGATION OF TRAUMA

BORRTI Subscales

Figure 3. BORRTI Subscales Comparison among Outpatient Veterans (N=76), Community Active Adults (N=60), Clinical Borderline (N=37), Clinical Affective (N=29), Clinical Schizophrenia (N=21).
*p < .05
Appendix A

Clinician-Administered PTSD Scale for DSM-IV (CAPS)
Clinician-Administered PTSD Scale for DSM-IV (One Week Version) is available from the National Center for Posttraumatic Stress Disorder, Behavioral Science Division-Boston VA Medical Center and Neurosciences Division-West Haven VA Medical Center.
Appendix B
Bell Object Relations and Reality Testing Inventory (BORRTI)
The Bell Object Relations and Reality Testing Inventory (BORRTI) is available for purchase from Western Psychological Service, 12031 Wilshire Boulevard, Los Angeles, California 90025-1251.
Appendix C

The Structured Clinical Interview for Axis I Disorders (SCID I)
The Structured Clinical Interview for Axis I Disorders (SCID I) is available from Biometrics Research Department at Columbia University, 1051 Riverside Drive – Unit 60, New York, NY 10032.
Appendix D

The Structured Clinical Interview for DSM-IV Axis II Personality Questionnaire (SCID-II PQ)
Appendix E

The Patient Characteristic Questionnaire (PCQ)
**The Patient Characteristics Questionnaire**

Please provide your professional evaluation regarding your experience in working with this patient across the following domains.

1. Compared to my other patients, this patient displayed the ability to form relationships with me.
   - **Much Less**
   - **Less**
   - **Neutral**
   - **More**
   - **Much More**

2. Compared to my other patients, this patient displayed fear, shyness, and anxiety in their interactions with me.
   - **Much Less**
   - **Less**
   - **Neutral**
   - **More**
   - **Much More**

3. Compared to my other patients, this patient displayed trust and confidence in their interactions with me.
   - **Much Less**
   - **Less**
   - **Neutral**
   - **More**
   - **Much More**

4. Compared to my other patients, this patient displayed a demanding and manipulative attitude toward me.
   - **Much Less**
   - **Less**
   - **Neutral**
   - **More**
   - **Much More**

5. Compared to my other patients, this patient displayed the tendency to withdraw from me and to adopt an antisocial attitude.
   - **Much Less**
   - **Less**
   - **Neutral**
   - **More**
   - **Much More**

6. Compared to my other patients, I felt connected with this patient.
   - **Much Less**
   - **Less**
   - **Neutral**
   - **More**
   - **Much More**

7. Any other comments concerning your work with this patient that are noteworthy or striking.
   ______________________________________________________________
   ______________________________________________________________
   ______________________________________________________________
   ______________________________________________________________
Appendix F

Institutional Review Boards and R&D Committee Approvals
AN INVESTIGATION OF TRAUMA

MEDICAL INSTITUTIONAL REVIEW BOARD PROTOCOL APPROVAL NOTIFICATION
FOR STUDIES GRANTED EXPEDITED APPROVAL

PRINCIPAL INVESTIGATOR: Barbara Beimesch, MA
SUB-INVESTIGATOR(S): Kathleen Chard, MD

PROTOCOL: IRB #06-4-6-4EE—Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes Using Cognitive Processing Therapy in a Sample of Inpatient Veterans

Includes informed consent Yes
Includes advertising Yes
Informed consent requirement waived No
Survey materials constitute abbreviated consent No
Includes HIPAA Waiver No

Sponsor: 

DATE: June 6, 2006

The approval for this research activity expires on: June 6, 2007

1. The federal regulations at 45 CFR 46.110 which allow for the expedited review procedure, require that the IRB adopt a method for keeping all members advised of research proposals which have been approved under this procedure. The full Board will be notified of the expedited approval status of your study at its next convened meeting. You will be notified in writing in the event the Board disagrees with this expedited approval decision.

2. You are required to immediately report to the Institutional Review Board: 1) any death/serious adverse event, or 2) any non-serious event which is both related to the study and is unexpected. For adult, non-treatment studies with minimal risk; e.g., chart reviews, rosters, questionnaires, the UC IRBs only require reporting of SERIOUS adverse events that are RELATED to the study.

3. The period of approval of this research project is stated above. In order for a project to continue with IRB approval beyond the expiration date, a progress report form must be filed with the Institutional Review Board on at least an annual basis, and sometimes more frequently at the discretion of the Board.

4. There may be no change or addition to the project, or changes of the investigators involved, without prior approval of the IRB.

5. You are required to modify this study, subject to IRB approval, if subsequent information regarding any drug, device or procedure utilized in the study is received from the manufacturer or any other reliable source that could reasonably increase or alter potential harm to subjects. The informed consent statement must be modified to include this new information or an addendum must be prepared as a means to assure subject notification. In cases where the subject has completed the study, the modification or addendum is only necessary if the additional information received could impact the subjects in the future.

Chairperson (or designee) Institutional Review Board

*The attached consent is stamped with the period of IRB approval. Please copy this ICS document and use for all subjects entered into the study.

University of Cincinnati Institutional Review Board Office
G-08 Wherry Hall, ML #0567, Cincinnati, Ohio 45267-0567
Telephone 513-558-5259, Fax 513-558-4111

http://www.med.uc.edu/irb/
FWA #3152 (8/28/02-9/15/08)
MEMORANDUM

TO: Barbara Beimesch  
Barbara Beimesch  
2470 Legends Way Crestview Hills Kentucky 41017  
M/L: 

FROM: Michael Linke, M.D., Chairperson  
University of Cincinnati Medical Center  
Institutional Review Board  

DATE: May 30, 2007  

PROTOCOL #: 06-04-06-04-EE  

RE: TITLE Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes Using Cognitive Processing Therapy in a Sample of Inpatient Veterans

Pleased be advised that the University of Cincinnati Medical Center Institutional Review Board reapproved the above referenced protocol at its meeting on 5/30/2007.

This approval expires on 5/30/2008.

This protocol has been approved for the following subject population:

☑ Adult Subjects  ☐ Minors

☐ Adult and Children
TO: Barbara Beimesch  
FROM: Mike Linke, Ph.D., Chairperson  
Institutional Review Board #1  
University of Cincinnati  
Carolyn West, Program Manager  
Institutional Review Board #1  
University of Cincinnati  

Date: April 15, 2008  
Re: IRB #06-4-6-4EE--Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes Using Cognitive Processing Therapy in a Sample of Inpatient Veterans  
Modification: Add SCID-II Personality Questionnaire  

Please be advised the request to modify the study referenced above as outlined in your April 11, 2008 correspondence has been approved. The modification was determined to qualify for approval under the expedited review procedure as outlined in the federal regulations governing expedited review of minor changes in approved research. The members of Medical Institutional Review Board #1 will be notified of the Chairman's decision at the April 30, 2008 meeting.

The revised consent must be used when new subjects are enrolled. A copy of the revised consent is attached. The revised consent is stamped with the modification approval date and date the annual approval expires.

The Chairman determined re-consent is not necessary for currently enrolled subjects.

Please contact Carolyn West at westch@uc.edu if you have any questions. Thank you for your continued cooperation with the Board's regulations with regard to changes in your research activities.
TO: Barbara Bolling Beimesch  
Barbara Beimesch  
2470 Legends Way Crestd view Hills Kentucky 41017

FROM: Michael Linke, Ph.D., Chairperson  
University of Cincinnati Medical Center  
Institutional Review Board

DATE: May 15, 2008

PROTOCOL #: 06-04-06-04-EE

RE: TITLE Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes Using Cognitive Processing Therapy in a Sample of Inpatient Veterans

Pleased be advised that the University of Cincinnati Medical Center Institutional Review Board reapproved the above referenced protocol at its meeting on 5/14/2008.

This approval expires on 5/14/2009.

This protocol has been approved for the following subject population:

☑ Adult Subjects  ☐ Minors

☐ Adult and Children

/mcn
MEMORANDUM

TO: Barbara Bolling Beimesch
Barbara Beimesch
2470 Legends Way Crestview Hills Kentucky 41017

FROM: Michael Linke, Ph.D., Chairperson
University of Cincinnati Medical Center
Institutional Review Board

DATE: May 13, 2009

PROTOCOL #: 06-04-06-04-EE

RE: TITLE Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes Using Cognitive Processing Therapy in a Sample of Inpatient Veterans

Pleased be advised that the University of Cincinnati Medical Center Institutional Review Board reapproved the above referenced protocol at its meeting on 5/13/2009.

This approval expires on 5/13/2010.

This protocol has been approved for the following subject population:

☑ Adult Subjects ☐ Minors
☐ Adult and Children

/AN
DEPARTMENT OF VETERANS AFFAIRS MEMORANDUM

Date: January 22, 2007
From: Chair, Research & Development Committee (R&D)
Subj: Research & Development Committee Review for Research Protocols
To: Barbara Beimesch, M.A.

1. The purpose of this memorandum is to notify you that the protocol entitled “Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes Using Cognitive Processing Therapy in a Sample of Inpatient Veterans” was reviewed by the Research and Development Committee (R&D) on May 9, 2006. A motion was made and seconded to accept the protocol pending resolution of stated concerns. As of the date of this letter, all requirements have been met. This protocol now has full R&D Committee approval.

2. In order to conduct successful human subject research, the principal investigator must meet the following requirements:
   • The principal investigator or his/her designee must obtain a signed informed consent from each subject on an IRB stamped, dated, signed, approved informed consent statement. The VA informed consent form 10-1086 must be used. Please see the attached guidelines on informed consent for more specific direction. When obtaining informed consent, the PI or person delegated by the PI must provide the prospective subject (or the legally authorized representative) sufficient opportunity to consider whether or not to participate. The prospective subject (or the legally authorized representative) must give consent without coercion or undue influence.
   • If your protocol involves investigational drugs, it is required that an electronic flag be placed on the patient’s medical record indicating that the patient is participating in a research protocol and who to contact in an emergency situation. This flag provide information to other health practitioners on a “need to know” basis only.
   • Furthermore, it is required that if investigational drugs are used, these drugs and a list of the principal investigator’s authorized designees prescribing the drug be placed in the Research Pharmacy prior to the initiation of your study by completing VA Form 10-9112 with your submission packet.

3. The approval of this protocol is contingent on the related activity or activities not adversely affecting, displacing, or otherwise occupying priorities that would exclude the developing of VA-funded and approved activities.

4. If we may be of any further assistance to you, please feel free to call the Research Office at 475-6403.

Francisco Gomez, M.D.
DEPARTMENT OF
VETERANS AFFAIRS

MEMORANDUM

Date: April 24, 2008

From: Chairman, Research & Development Committee

Subj: Expedited Review of a modification for the protocol #06-04-06-04-EE
"Norms for Object Relations and the Relationship of Object Relations
to PTSD Treatment Outcomes Using Cognitive Processing Therapy
in a Sample of Inpatient Veterans"

To: Barbara Beimesch, M.A.

1. After careful review, it has been determined that the request for approval
of revised Participant Informed Consent to include the administration of
the SCID-II Personality Questionnaire for Residential Patients to the
above referenced study qualifies for approval status under the expedited
review procedure as outlined in the Code of Federal Regulations at
46.110. This decision will be presented to the R&D Committee at its
meeting on May 13, 2008 for information purposes only.

2. If your protocol involves human subjects, VA policy requires that signed
information consent statements be made a permanent part of their
medical records. Furthermore, it is required that if investigational drugs
are used these drugs and a list of the principal investigator's authorized
designees prescribing the drug be placed in the Pharmacy prior to the
initiation of your study (this requires the completion of form VA 10-9012).

3. The approval of this protocol is contingent on the related activity or
activities not adversely affecting, displacing, or otherwise occupying
priorities that would exclude the developing of VA-funded and approved
activities.

4. If we may be of any further assistance to you, please feel free to call the
Research Office at 475-6403.

Francisco Gomez, M.D.
DEPARTMENT OF VETERANS AFFAIRS

MEMORANDUM

Date: July 18, 2008

From: Chair, R&D Committee

Subj: Research Protocol

To: Barbara Beimesch, M.A.

1. Research Service is in receipt of the IRB approval letter for the continuing review of the protocol #06-04-06-04-EE entitled “Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes Using Cognitive Processing Therapy in a Sample of Inpatient Veterans” dated May 15, 2008. This continuing review item was reviewed at the Research & Development Committee meeting on July 8, 2008. A motion was made and seconded to approve the progress report.

2. This approval will expire on May 14, 2009.

3. If we may be of any further assistance to you, please feel free to call Research Service (513) 475-6414.

Francisco Gomez, M.D.
MEMORANDUM

Date: May 13, 2009

From: Chairman, R&D Committee

Subj: Research Protocol

To: Barbara Beimesch, Ph.D.

1. Research Service is in receipt of the IRB progress report materials for the 5/14/08 to 5/14/09 reporting period requesting continuing review of the protocol #06-04-06-04 entitled "Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes Using Cognitive Processing Therapy in a Sample of Inpatient Veterans". This continuing review item was reviewed at the Research & Development Committee meeting on April 14, 2009. A motion was made and seconded to accept the progress report pending resolution of stated concerns. The progress report now has R&DC approval.

2. This protocol expires on May 13, 2010.

3. If we may be of any further assistance to you, please feel free to call Research Service (513) 475-6414.

Francisco Gomez, M.D.
July 23, 2007

Barbara Bolling Beimesch, M.A.
2470 Legends Way
Crestview Hills, KY 41017

Dear Ms Beimesch:

The IRB has reviewed your study #0460-3, An Investigation of Trauma and PTSD. Your study is approved in the Expedited Review category. Approval expires 7/23/08. A progress report must be filed with XU’s IRB by the expiration date. The form is enclosed for your convenience and is also available at www.xu.edu/IRB/IRBforms.htm.

If there are any adverse events or modifications to the study, please notify the IRB immediately.

We wish you success with your research!

Sincerely,

Kathleen J. Hart, Ph.D., ABPP
Interim Chair

Enclosures: Approval-stamped Informed Consent Forms
Progress Report Form

C: Dr. Susan Kenford, Faculty Advisor, ML 6411
April 28, 2008

Barbara Bolling Beimesch, M.A.
2470 Legends Way
Crestview Hills, KY 41017

Dear Ms Beimesch:

The IRB has reviewed the modification request for your study #0460-3, An Investigation of Trauma and PTSD. Your modification is approved in the Expedited Review category. Approval expires 7/23/08. A progress report must be filed with XU’s IRB by the expiration date. The form is enclosed for your convenience and is also available at www.xu.edu/IRB/forms.cfm.

If there are any adverse events or modifications to the study, please notify the IRB immediately.

We wish you success with your research!

Sincerely,

Charles J. Grossman
Interim Chair

CJG:mm

Enclosures: Approval-stamped Informed Consent Forms
Progress Report Form

C: Dr. Susan Kenford, Faculty Advisor, ML 6411
May 1, 2008

Barbara B. Beimesch, M.A.
2470 Legends Way
Crestview Hills, KY 41017

Dear Ms Beimesch:

The IRB received a progress report for your study #0460-3, An Investigation of Trauma and PTSD. Your study is approved for an additional year. Approval expires 4/28/09. A progress report must be filed with XU’s IRB by the expiration date. The form is available at www.xu.edu/IRB/forms.cfm.

If there are any adverse events or modifications to the study, please notify the IRB immediately.

We wish you success with your research!

Sincerely,

Charles J. Grossman
Interim Chair

C: Dr. Susan Kenford, Faculty Advisor, ML 6411
May 15, 2009

Barbara B. Beimesch, M.A.
2470 Legends Way
Crestview Hills, KY 41017

Dear Ms Beimesch:

The IRB has reviewed your progress report and the appropriate approvals from University of Cincinnati and the Department of Veterans Affairs for Xavier’s IRB study #0460-3, An Investigation of Trauma and PTSD. Based on your continued compliance and receipt of these items, we are pleased to grant you continued approval for your study under the Expedited Review category. Approval expires 5/15/2010. A progress report must be filed with XU’s IRB by the expiration date.

If there are any adverse events or modifications to the study, please notify the IRB immediately.

We wish you continued success with your research!

Sincerely,

Kathleen J. Hart, Ph.D., ABPP
Interim Chair

C: Dr. Susan Kenford, Faculty Advisor, ML 6411
Appendix G
Informed Consents
AN INVESTIGATION OF TRAUMA

VA RESEARCH CONSENT FORM

Subject Name: __________________________ Date: ______________

Title of Study: Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

Principal Investigator: Barbara B Beimesch MA VAMC: Cincinnati (539)

Consent Version Date: October 8, 2005

STUDY TITLE: Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

UC IRB Study # 06-4-6-4EE

INVESTIGATOR INFORMATION:

<table>
<thead>
<tr>
<th>Principal Investigator Name</th>
<th>Telephone Number</th>
<th>24 hr Emergency Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbara B Beimesch</td>
<td>859-801-2732</td>
<td>N/A</td>
</tr>
</tbody>
</table>

INTRODUCTION:
Before you agree to participate in this research study, it is important that you be told the purpose, procedures, benefits, risks, discomforts and precautions of the research. You should also be told what alternative procedures are available to you if you do not participate in the research study.

Your participation in this research study is entirely voluntary. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without unfairness to you or your medical care. The investigator does not promise that you will receive any benefits from this study.

This informed consent document is a brief written summary of what the researcher is telling you. Be sure to ask questions while you read this if there is anything that is not clear.

WHY HAVE YOU BEEN ASKED TO TAKE PART IN THIS RESEARCH STUDY?
You are being asked to take part in this research study because you are a participant in the residential or outpatient Posttraumatic Stress Disorder (PTSD) program at the Ft. Thomas VA. PTSD is a psychological disorder that arises following experience or witness of a traumatic event. People with PTSD commonly experience the symptoms of re-experiencing the trauma, avoidance of things associated with the trauma, and hyperarousal.

HOW LONG WILL YOU BE IN THE RESEARCH STUDY?
You will be in the research study for approximately 15-20 minutes. The researcher may decide to take you off this research study at any time if doing so should be deemed in your best interests.

I have received a copy of this consent form

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**VA RESEARCH CONSENT FORM**

<table>
<thead>
<tr>
<th>Subject Name: ___________________________</th>
<th>Date: ________________</th>
</tr>
</thead>
</table>

**Title of Study:** Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

**Principal Investigator:** Barbara B Beimesch MA  
**VAMC:** Cincinnati (539)  
**Consent Version Date:** October 8, 2005

**WHY IS THIS RESEARCH BEING DONE?**

The purpose of this research study is to find out what personality traits, if any, are related to one's PTSD and their response to treatment.

**WHO IS CONDUCTING THE RESEARCH STUDY?**

The study is directed by Barbara B Beimesch MA, a researcher at the Ft. Thomas VA.

**HOW MANY PEOPLE WILL TAKE PART IN THE RESEARCH STUDY?**

200 people will take part in this study at the VA in Ft. Thomas and Cincinnati Hospital.

**WHAT IS INVOLVED IN THE RESEARCH STUDY?**

If you take part in this study, you will complete the following questionnaire:

1. You will fill out the Bell Object Relations and Reality Testing Inventory

This will take you 15-20 minutes.

**WHAT ARE THE RISKS AND DISCOMFORTS OF THE RESEARCH STUDY?**

To the best of our knowledge, participation in this study has no more risk of harm than you would experience in everyday life.

**ARE THERE BENEFITS TO TAKING PART IN THE RESEARCH STUDY?**

You will not receive any benefits for your participation in this study, although you might find some of the questionnaires interesting.

**WHAT OTHER CHOICES FOR CARE ARE THERE?**

You can choose to decline participation in this study.

**HOW WILL INFORMATION ABOUT YOU BE KEPT PRIVATE AND CONFIDENTIAL?**

Every effort will be made to maintain the confidentiality of your study records. Agents of the University of Cincinnati, Xavier University and the Department of Veterans Affairs will be allowed to inspect section of your research records related to this study. The data from the study may be published; however, you will not be identified by name. Your identity will remain confidential unless disclosure is required by law.

I have received a copy of this consent form

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AN INVESTIGATION OF TRAUMA

VA RESEARCH CONSENT FORM

Subject Name: ___________________________ Date: ________________

Title of Study: Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

Principal Investigator: Barbara B Beimesch MA VAMC: Cincinnati (539)

Consent Version Date: October 8, 2005

WHAT ARE YOUR COSTS TO BE IN THIS STUDY?
There are no costs for taking part in this study. Department of Veterans Affairs Medical Center (VA) patients may be financially responsible for care at the Department of Veterans Affairs Medical Center. Financial responsibility is individually determined based upon legislative criteria.

WILL YOU BE PAID TO PARTICIPATE IN THIS RESEARCH STUDY?
No monetary compensation is offered for participating in this study.

WHAT ARE YOUR RIGHTS AS A PARTICIPANT?
You may choose either to take part or not take part in this research study. If you decide to take part, you may decide to leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to you. The investigators will tell you about new information that may affect your health, welfare, or willingness to stay in this study.

If you have questions about the study, you will have the chance to talk to one of the study staff. Do not sign this form unless you have had the chance to ask questions and have received satisfactory answers.

Nothing in this consent form waives any legal rights you may have nor does it release the investigator, the institution, or its agents from liability for negligence.

WHO DO YOU CALL IF YOU HAVE QUESTIONS OR PROBLEMS?
If you have questions about this research study or to report a research-related injury, you can contact the researcher, Barbara B Beimesch, 859-801-2732.

If you have general questions about giving consent or your rights as a research participant in this research study, you can call the University of Cincinnati Medical Institutional Review Board at 513-558-5259.

VA FORM 10-1086 April 1991
(CVAMC revised 07-2005)
VA RESEARCH CONSENT FORM

Subject Name: ___________________________ Date: ______________

Title of Study: Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

Principal Investigator: Barbara B Beimesch MA VAMC: Cincinnati (539)
Consent Version Date: October 8, 2005

PERSON OBTAINING CONSENT:

I have reviewed this form with the participant. An explanation of the research was given and questions from the subject were solicited and answered to the subject's satisfaction. In my judgment, the subject has demonstrated comprehension of the information.

Signature and Title of Person Obtaining Consent and Identification of Role in the Study ___________________________ Date ______________

UCMCIRBICS revised 09/2003

VA FORM 10-1086 April 1991 (CVAMC revised 07-2005)

I have received a copy of this consent form ___________________________
VA RESEARCH CONSENT FORM

Subject Name: _______________________________ Date: ____________________

Title of Study: Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

Principal Investigator: Barbara B Beimesch MA VAMC: Cincinnati (539)

Consent Version Date: October 8, 2006

UNIVERSITY OF CINCINNATI AND THE CINCINNATI VA MEDICAL CENTER

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

STUDY TITLE: Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

UC IRB Study # 06-4-6-4EE

INVESTIGATOR INFORMATION:

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<td>Barbara B Beimesch</td>
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</table>

INTRODUCTION:
Before you agree to participate in this research study, it is important that you be told the purpose, procedures, benefits, risks, discomforts and precautions of the research.

Your participation in this research study is entirely voluntary. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time. The investigator does not promise that you will receive any benefits from this study.

This informed consent document is a brief written summary of what the researcher is telling you. Be sure to ask questions while you read this if there is anything that is not clear.

WHY HAVE YOU BEEN ASKED TO TAKE PART IN THIS RESEARCH STUDY?
You are being asked to take part in this research study because you are a therapist in the residential or outpatient Posttraumatic Stress Disorder (PTSD) program at the Ft. Thomas VA and have first hand knowledge of patients who are receiving treatment for their PTSD symptoms. PTSD is a psychological disorder that arises following experience or witness of a traumatic event. People with PTSD commonly experience the symptoms of re-experiencing the trauma, avoidance of things associated with the trauma, and hyperarousal. You are being asked to comment using a brief questionnaire on the personality traits you observed in your clients who are participating in this study.

HOW LONG WILL YOU BE IN THE RESEARCH STUDY?
You will be in the research study for approximately 5 minutes. The researcher may decide to take you off this research study at any time if doing so should be deemed in your best interests.

VA FORM 10-1086 April 1991
(CVAMC revised 07-2005)

I have received a copy of this consent form

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WHY IS THIS RESEARCH BEING DONE?
The purpose of this research study is to find out what personality traits, if any, are related to one's PTSD and their response to treatment.

WHO IS CONDUCTING THE RESEARCH STUDY?
The study is directed by Barbara B Beimesch MA, a researcher at the Ft. Thomas VA.

HOW MANY PEOPLE WILL TAKE PART IN THE RESEARCH STUDY?
20 therapists will take part in this study at the VA in Ft. Thomas and Cincinnati Hospital.

WHAT IS INVOLVED IN THE RESEARCH STUDY?
If you take part in this study, you will complete the following questionnaire:

1. You will fill out the Therapist Evaluation Questionnaire
   This will take you 5 minutes.

WHAT ARE THE RISKS AND DISCOMFORTS OF THE RESEARCH STUDY?
To the best of our knowledge, participation in this study has no more risk of harm than you would experience in everyday life.

ARE THERE BENEFITS TO TAKING PART IN THE RESEARCH STUDY?
You will not receive any benefits for your participation in this study, although you might find some of the questionnaire interesting.

WHAT OTHER CHOICES FOR CARE ARE THERE?
You can choose to decline participation in this study.

HOW WILL INFORMATION ABOUT YOU BE KEPT PRIVATE AND CONFIDENTIAL?
Every effort will be made to maintain the confidentiality of your study records. Agents of the University of Cincinnati, Xavier University and the Department of Veterans Affairs will be allowed to inspect section of your research records related to this study. The data from the study may be published; however, you will not be identified by name. Your identity will remain confidential unless disclosure is required by law.

WHAT ARE YOUR COSTS TO BE IN THIS STUDY?

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## VA RESEARCH CONSENT FORM

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</tr>
<tr>
<td>Consent Version Date: October 8, 2006</td>
</tr>
</tbody>
</table>

There are no monetary payments for participation in the study.

**WILL YOU BE PAID TO PARTICIPATE IN THIS RESEARCH STUDY?**
No monetary compensation is offered for participating in this study.

**WHAT ARE YOUR RIGHTS AS A PARTICIPANT?**
You may choose either to take part or not take part in this research study.

If you have questions about the study, you may talk to investigator at any time. Do not sign this form unless you have had the chance to ask questions and have received satisfactory answers.

**WHO DO YOU CALL IF YOU HAVE QUESTIONS OR PROBLEMS?**
If you have questions about this research study or to report a research-related injury, you can contact the researcher, Barbara B Beimesch, 859-801-2732.

If you have general questions about giving consent or your rights as a research participant in this research study, you can call the University of Cincinnati Medical Institutional Review Board at 513-558-5259.

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UNIVERSITY OF CINCINNATI
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

STUDY TITLE: Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

INVESTIGATOR INFORMATION:
Barbara B Beimesch 859-801-2732 N/A
Principal Investigator Name Telephone Number 24 hr Emergency Contact

SIGNATURES

I have read or someone has read to me, this Informed Consent Document which describes the purpose and nature of this research. I have had time to review this information and have been encouraged to ask questions. I have received answers to my questions. If I do not participate My participation in this research is completely voluntary. I give my consent to participate in this study. I have received (or will receive) a copy of this form for my records and future reference.

Participant Date

WITNESS TO THE CONSENT PROCESS Date

PERSON OBTAINING CONSENT:

I have reviewed this form with the participant. An explanation of the research was given and questions from the subject were solicited and answered to the subject's satisfaction. In my judgment, the subject has demonstrated comprehension of the information.

Signature and Title of Person Obtaining Consent and Identification of Role in the Study

Date

I have received a copy of this consent form
AN INVESTIGATION OF TRAUMA

Subject Name: _______________________________ Date: ________________

Title of Study: Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

Principal Investigator: Barbara B Beimesch MA VAMC: Cincinnati (539)

Consent Version Date: October 8, 2006

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**STUDY TITLE:** Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

**UC IRB Study #**: 06-4-6-4EE

**INVESTIGATOR INFORMATION:**

Barbara B Beimesch 859-801-2732 N/A

**INTRODUCTION:**

Before you agree to participate in this research study, it is important that you be told the purpose, procedures, benefits, risks, discomforts and precautions of the research. You should also be told what alternative procedures are available to you if you do not participate in the research study.

Your participation in this research study is entirely voluntary. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without unfairness to you or your medical care. The investigator does not promise that you will receive any benefits from this study.

This informed consent document is a brief written summary of what the researcher is telling you. Be sure to ask questions while you read this if there is anything that is not clear.

**WHY HAVE YOU BEEN ASKED TO TAKE PART IN THIS RESEARCH STUDY?**

You are being asked to take part in this research study because you are a participant in the residential or outpatient Posttraumatic Stress Disorder (PTSD) program at the Ft. Thomas VA. PTSD is a psychological disorder that arises following experience or witness of a traumatic event. People with PTSD commonly experience the symptoms of re-experiencing the trauma, avoidance of things associated with the trauma, and hyperarousal.

**HOW LONG WILL YOU BE IN THE RESEARCH STUDY?**

You will be in the research study for approximately 15-25 minutes. The researcher may decide to take you off this research study at any time if doing so should be deemed in your best interests.
# VA Department of Veterans Affairs

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<tr>
<td><strong>Subject Name:</strong></td>
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<tr>
<td><strong>Title of Study:</strong> Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans</td>
</tr>
<tr>
<td><strong>Principal Investigator:</strong> Barbara B Beimesch MA</td>
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<tr>
<td><strong>Consent Version Date:</strong> April 11, 2008</td>
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</tbody>
</table>

## WHY IS THIS RESEARCH BEING DONE?

The purpose of this research study is to find out what personality traits, if any, are related to one's PTSD and their response to treatment.

## WHO IS CONDUCTING THE RESEARCH STUDY?

The study is directed by Barbara B Beimesch MA, a researcher at the Ft. Thomas VA.

## HOW MANY PEOPLE WILL TAKE PART IN THE RESEARCH STUDY?

200 people will take part in this study at the VA in Ft. Thomas and Cincinnati Hospital.

## WHAT IS INVOLVED IN THE RESEARCH STUDY?

If you take part in this study, you will complete the following questionnaire or questionnaires:

1. You will fill out the Bell Object Relations and Reality Testing Inventory if you are an Outpatient
2. You will fill out both the Bell Object Relations and Reality Testing Inventory and the SCID-II Personality Questionnaire if you are a Residential Patient

This will take you 15-25 minutes.

## WHAT ARE THE RISKS AND DISCOMFORTS OF THE RESEARCH STUDY?

To the best of our knowledge, participation in this study has no more risk of harm than you would experience in everyday life.

## ARE THERE BENEFITS TO TAKING PART IN THE RESEARCH STUDY?

You will not receive any benefits for your participation in this study, although you might find some of the questionnaires interesting.

## WHAT OTHER CHOICES FOR CARE ARE THERE?

You can choose to decline participation in this study.

## HOW WILL INFORMATION ABOUT YOU BE KEPT PRIVATE AND CONFIDENTIAL?

Every effort will be made to maintain the confidentiality of your study records. Agents of the University of Cincinnati, Xavier University and the Department of Veterans Affairs will be allowed to inspect section of your research records related to this study. The data from the study may be published; however, you will not be identified by name. Your identity will remain confidential unless disclosure is required by law.

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WHAT ARE YOUR COSTS TO BE IN THIS STUDY?
There are no costs for taking part in this study. Department of Veterans Affairs Medical Center (VA) patients may be financially responsible for care at the Department of Veterans Affairs Medical Center. Financial responsibility is individually determined based upon legislative criteria.

WILL YOU BE PAID TO PARTICIPATE IN THIS RESEARCH STUDY?
No monetary compensation is offered for participating in this study.

WHAT ARE YOUR RIGHTS AS A PARTICIPANT?
You may choose either to take part or not take part in this research study. If you decide to take part, you may decide to leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to you. The investigators will tell you about new information that may affect your health, welfare, or willingness to stay in this study.

If you have questions about the study, you will have the chance to talk to one of the study staff. Do not sign this form unless you have had the chance to ask questions and have received satisfactory answers.

Nothing in this consent form waives any legal rights you may have nor does it release the investigator, the institution, or its agents from liability for negligence.

WHO DO YOU CALL IF YOU HAVE QUESTIONS OR PROBLEMS?
If you have questions about this research study or to report a research-related injury, you can contact the researcher, Barbara B Beimesch, 859-801-2732.

If you have general questions about giving consent or your rights as a research participant in this research study, you can call the University of Cincinnati Medical Institutional Review Board at 513-558-5259.
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

STUDY TITLE: Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

INVESTIGATOR INFORMATION:
Barbara B Beimesch 859-801-2732 N/A
Principal Investigator Name Telephone Number 24 hr Emergency Contact

SIGNATURES

I have read or someone has read to me, this Informed Consent Document that describes the purpose and nature of this research. I have had time to review this information and have been encouraged to ask questions. I have received answers to my questions. If I do not participate or if I discontinue my participation, I will not lose any benefits. I will not lose any legal rights if I discontinue. My participation in this research is completely voluntary. I give my consent to participate in this study. I have received (or will receive) a copy of this form for my records and future reference.

Participant Date

WITNESS TO THE CONSENT PROCESS Date

PERSON OBTAINING CONSENT:

I have reviewed this form with the participant. An explanation of the research was given and questions from the subject were solicited and answered to the subject’s satisfaction. In my judgment, the subject has demonstrated comprehension of the information.

Signature and Title of Person Obtaining Consent and Identification of Role in the Study
UCMCIRBICS revised 09/2003

APPROVED MAY 28 2008 XUER UNIVERSITY IRB

I have received a copy of this consent form
INTRODUCTION:
Before you agree to participate in this research study, it is important that you be told the purpose, procedures, benefits, risks, discomforts and precautions of the research.

Your participation in this research study is entirely voluntary. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time. The investigator does not promise that you will receive any benefits from this study.

This informed consent document is a brief written summary of what the researcher is telling you. Be sure to ask questions while you read this if there is anything that is not clear.

WHY HAVE YOU BEEN ASKED TO TAKE PART IN THIS RESEARCH STUDY?
You are being asked to take part in this research study because you are a therapist in the residential or outpatient Posttraumatic Stress Disorder (PTSD) program at the Ft. Thomas VA and have first hand knowledge of patients who are receiving treatment for their PTSD symptoms. PTSD is a psychological disorder that arises following experience or witness of a traumatic event. People with PTSD commonly experience the symptoms of re-experiencing the trauma, avoidance of things associated with the trauma, and hyperarousal. You are being asked to comment using a brief questionnaire on the personality traits you observed in your clients who are participating in this study.

HOW LONG WILL YOU BE IN THE RESEARCH STUDY?
You will be in the research study for approximately 5 minutes. The researcher may decide to take you off this research study at any time if doing so should be deemed in your best interests.
WHY IS THIS RESEARCH BEING DONE?
The purpose of this research study is to find out what personality traits, if any, are related to one’s PTSD and their response to treatment.

WHO IS CONDUCTING THE RESEARCH STUDY?
The study is directed by Barbara B Beimesch MA, a researcher at the Ft. Thomas VA.

HOW MANY PEOPLE WILL TAKE PART IN THE RESEARCH STUDY?
20 therapists will take part in this study at the VA in Ft. Thomas and Cincinnati Hospital.

WHAT IS INVOLVED IN THE RESEARCH STUDY?
If you take part in this study, you will complete the following questionnaire:

1. You will fill out the Therapist Evaluation Questionnaire

This will take you 5 minutes.

WHAT ARE THE RISKS AND DISCOMFORTS OF THE RESEARCH STUDY?
To the best of our knowledge, participation in this study has no more risk of harm than you would experience in everyday life.

ARE THERE BENEFITS TO TAKING PART IN THE RESEARCH STUDY?
You will not receive any benefits for your participation in this study, although you might find some of the questionnaire interesting.

WHAT OTHER CHOICES FOR CARE ARE THERE?
You can choose to decline participation in this study.

HOW WILL INFORMATION ABOUT YOU BE KEPT PRIVATE AND CONFIDENTIAL?
Every effort will be made to maintain the confidentiality of your study records. Agents of the University of Cincinnati, Xavier University and the Department of Veterans Affairs will be allowed to inspect section of your research records related to this study. The data from the study may be published; however, you will not be identified by name. Your identity will remain confidential unless disclosure is required by law.

WHAT ARE YOUR COSTS TO BE IN THIS STUDY?
There are no costs for taking part in this study.

VA FORM 10-1258
(CVAMC revised APR 1991)
Page 2 of 4
WILL YOU BE PAID TO PARTICIPATE IN THIS RESEARCH STUDY?
No monetary compensation is offered for participating in this study.

WHAT ARE YOUR RIGHTS AS A PARTICIPANT?
You may choose either to take part or not take part in this research study.

If you have questions about the study, you may talk to investigator at any time. Do not sign this form unless you have had the chance to ask questions and have received satisfactory answers.

WHO DO YOU CALL IF YOU HAVE QUESTIONS OR PROBLEMS?
If you have questions about this research study or to report a research-related injury, you can contact the researcher, Barbara B Beimesch, 859-801-2732.

If you have general questions about giving consent or your rights as a research participant in this research study, you can call the University of Cincinnati Medical Institutional Review Board at 513-558-5259.
AN INVESTIGATION OF TRAUMA

VA Department of Veterans Affairs

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<th>VA RESEARCH CONSENT FORM</th>
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<td>Subject Name: ___________________________ Date: __________________</td>
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<tr>
<td>Title of Study: Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans</td>
</tr>
<tr>
<td>Principal Investigator: Barbara B Beimesch MA VAMC: Cincinnati (539)</td>
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<tr>
<td>Consent Version Date: October 8, 2006</td>
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CONSENT TO PARTICIPATE IN A RESEARCH STUDY

STUDY TITLE: Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

INVESTIGATOR INFORMATION:
Barbara B Beimesch 859-801-2732 N/A
Principal Investigator Name Telephone Number 24 hr Emergency Contact

SIGNATURES

I have read or someone has read to me, this Informed Consent Document which describes the purpose and nature of this research. I have had time to review this information and have been encouraged to ask questions. I have received answers to my questions. If I do not participate My participation in this research is completely voluntary. I give my consent to participate in this study. I have received (or will receive) a copy of this form for my records and future reference.

Participant ___________________________ Date __________________

WITNESS TO THE CONSENT PROCESS ___________________________ Date __________________

PERSON OBTAINING CONSENT:

I have reviewed this form with the participant. An explanation of the research was given and questions from the subject were solicited and answered to the subject’s satisfaction. In my judgment, the subject has demonstrated comprehension of the information.

Signature and Title of Person Obtaining Consent and Identification of Role in the Study
UCMCIRB/CS revised 09/2003

APPROVED MAY 2 8 2008
Xavier University IRB

IRB # 06-04-06-077
R&D Approval 5/27/08
Signed X. Mueller

VA FORM 10-1086 April 1991 (CVAMC revised 07-2005)
Page 4 of 4

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AN INVESTIGATION OF TRAUMA

VA RESEARCH CONSENT FORM

Subject Name: __________________________ Date: ____________

Title of Study: Normal for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

Principal Investigator: Barbara B. Beimesch MA VAMC: Cincinnati (539)

Consort: Version Date: April 1, 2009

Sponsor Name: Department of Psychology, Xavier University.

UC IRB Study #: 06-04-06-04-EE

INVESTIGATOR INFORMATION:

Barbara B. Beimesch MA 859-801-2732 NA

Principal Investigator Name Telephone Number 24 hr Emergency Contact

INTRODUCTION:

Before you agree to participate in this research study, it is important that you be told the purpose, procedures, benefits, risks, discomforts and precautions of the research. You should also be told what alternative procedures are available to you if you do not participate in the research study.

Your participation in this research study is entirely voluntary. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without unfairness to you or your medical care. The study researcher(s) do not promise that you will receive any benefits from this study.

This informed consent document is a brief written summary of what your study researcher is telling you. Be sure to ask questions while you read this if there is anything that is not clear.

WHY HAVE YOU BEEN ASKED TO TAKE PART IN THIS RESEARCH STUDY?

You are being asked to take part in this research study because you have been diagnosed with PTSD (Posttraumatic Stress Disorder). PTSD can result when a person is exposed to a traumatic event which involves actual or threatened death or serious injury and the person's response involves intense fear, helplessness or horror. As a result, a person with PTSD will persistently re-experience the traumatic event, display persistent avoidance of thoughts, feelings or conversations associated with the trauma, and have persistent symptoms of increased arousal such as difficulty sleeping, outbursts of anger, difficulty concentrating, being hypervigilant or having an exaggerated startle response.

HOW LONG WILL YOU BE IN THE RESEARCH STUDY?

You will be in the research study for approximately 15-25 minutes which is the estimated amount of time required to complete the questionnaire(s) which constitute the study. The researcher may decide to take you off this research study at any time if doing so should be deemed in your best interest.

I have received a copy of this consent form.
VA RESEARCH CONSENT FORM

Subject Name: ____________________________ Date: ________________

Title of Study: ____________Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans________________________

Principal Investigator: ____________________________ VAMC: Cincinnati (839)

Consent Version Date: ________________

* WHY IS THIS RESEARCH BEING DONE?

The purpose of this research study is to find out what personality traits, if any, are related to a person’s PTSD and their response to the therapy you will receive at the PTSD and Anxiety Clinic.

WHO IS CONDUCTING THE RESEARCH STUDY?

This study is sponsored by Department of Psychology, Xavier University. The study is directed by Barbara B. Beimesch MA, a graduate student at Xavier University, Cincinnati, Ohio. Supervision for the study is provided by Drs. Kate Chard, Cincinnati VAMC and Susan Kenford, Department of Psychology, Xavier University.

HOW MANY PEOPLE WILL TAKE PART IN THE RESEARCH STUDY?

A total of 200 people will take part in this study at the VAMC in Ft Thomas and the Cincinnati Hospital. 100 Outpatients Veterans and 100 Residential Veterans from the PTSD Clinic will take part.

* WHAT IS INVOLVED IN THE RESEARCH STUDY?

If you choose to take part in this study, you will be asked to complete the following questionnaire or questionnaires depending on whether you are an Outpatient or a Residential PTSD Veteran:

1) You will fill out the Bell Object Relations and Reality Testing Inventory if you are an Outpatient Veteran, or;

2) You will fill out the Bell Object Relations and Reality Testing Inventory and the SCID-II Personality Questionnaire if you are a Residential Veteran.

* WHAT ARE THE RISKS AND DISCOMFORTS OF THE RESEARCH STUDY?

To the best of our knowledge, there are no known risks or discomforts, beyond what you currently experience in everyday life, associated with participation in this research study.

WHAT ARE THE REPRODUCTION RISKS?

This study does not involve any drug(s) and poses no reproductive risks.

* ARE THERE BENEFITS TO TAKING PART IN THE RESEARCH STUDY?

If you agree to take part in this research study, there may not be a direct benefit to you. The investigators hope the information learned from this research study will benefit future PTSD patients through increased knowledge about PTSD among veterans.
Subject Name: ___________________________ Date: ________________________________

Title of Study: _ Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

Principal Investigator: Barbara B. Reimisch MA VAMC: Cincinnati (539)

Consent Version Date: April 1, 2009

* WHAT OTHER CHOICES FOR CARE ARE THERE?

You may choose to decline participating in this study.

* HOW WILL INFORMATION ABOUT YOU BE KEPT PRIVATE AND CONFIDENTIAL?

Every effort will be made to maintain the confidentiality of your study records. The Department of Veterans Affairs, the University of Cincinnati, and Xavier University, will be allowed to inspect sections of your medical and research records related to this study. The data from the study may be published; however, you will not be identified by name. Your identity will remain confidential unless disclosure is required by law. Release of data will be in accordance with VHA regulations and policies. Data will be controlled so that reuse of the data is within an approved research protocol and in compliance with VHA procedures.

* WHAT ARE YOUR COSTS TO BE IN THIS STUDY?

There are no costs to participants who choose to take part in this study. Department of Veterans Affairs patients may be financially responsible for care at the Department of Veterans Affairs. Financial responsibility is individually determined based upon legislative criteria. Some veterans are required to pay co-payments for medical care and services; these co-payment requirements will continue to apply to medical care and services provided by the Department of Veterans Affairs that are not part of this study.

* WILL YOU BE PAID TO PARTICIPATE IN THIS RESEARCH STUDY?

No monetary compensation is offered to you for your participation in this study.

* WHAT COMPENSATION IS AVAILABLE IN CASE OF INJURY?

The Department of Veterans Affairs will provide necessary medical treatment to you as a research subject if you are injured by participation in this research project, at no cost to you. This requirement does not apply to treatment for injuries that result from non-compliance by you with study procedures. The Department of Veterans Affairs does not normally provide any other form of compensation for injury. You have not released this institution from liability for negligence.

* WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

You may choose either to take part or not to take part in this research study. If you decide to take part, you may decide to leave the study at any time. Leaving the study will not result in any penalty or loss of...

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APPROVED

May 13, 2009

Barbara Reimisch

APPROVED

Page 3 of 6

I have received a copy of this consent form

[Signature]

UC - IRB

Institutional Review Board

[Signature]

May 13, 2009

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 benefits to you. The investigators will tell you about new information that may affect your health, welfare, or willingness to stay in this study.

If you have questions about the study, you will have a chance to talk to one of the study staff. Do not sign this form unless you have had the chance to ask questions and have received satisfactory answers.

Nothing in this consent form waives any legal rights you may have nor does it release the investigator, the sponsor, the institution, or its agents from liability for negligence.

WHO DO YOU CALL IF YOU HAVE QUESTIONS OR PROBLEMS?

If you have any questions regarding this study, if you experience side effects or to report a research-related injury or illness, or if you have any additional concerns or complaints while you are participating in this study, you can contact the researcher Barbara B. Beimesch at 859-801-2732.

Please call the University of Cincinnati Medical Institutional Review Board at 513-558-5258 (Monday – Friday 8 am to 5 pm) if you:
- Think the research has hurt you.
- Have general questions about giving consent or your rights as a research participant in this research study.
- Have questions, concerns, or complaints about the research.
- Cannot reach the research team or you want to talk to someone else.

To report complaints or concerns to an independent agency in an anonymous and confidential manner, please call the Research Compliance Hotline at 1-800-889-1547.

If you want to check to be sure this study is approved and the researchers are authorized to do this study please contact the Cincinnati Department of Veterans Affairs Research Service at 513-475-6488. Information can also be found at the internet at http://www.clinicaltrials.gov

I have received a copy of this consent form.
Subject Name: 

Title of Study: 

Principal Investigator: 

Consent Version Date: April 1, 2009

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

STUDY TITLE: Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

INVESTIGATOR INFORMATION:

Principal Investigator Name: Barbara B. Beimesch MA

Telephone Number: 859-801-2732

SIGNATURES

I have read or someone has read to me, this Informed Consent Document which describes the purpose and nature of this research. I have had time to review this information and have been encouraged to ask questions. I have received answers to my questions. If I do not participate or if I discontinue my participation, I will not lose any benefits. I will not lose any legal rights if I discontinue. My participation in this research is completely voluntary. I give my consent to participate in this study. I have received (or will receive) a copy of this form for my records and future reference.

Participant (or Parent, if signing for a minor)

Next of Kin (state relationship to participant)

Date

SIGNATURES

WITNESS TO THE CONSENT PROCESS

All consent forms used at the Department of Veterans Affairs require this signature.

PERSON OBTAINING CONSENT:

I have reviewed this form with the participant and/or representative. An explanation of the research was given and questions from the subject were solicited and answered to the subject's satisfaction. In my judgment, the subject has demonstrated comprehension of the information.

Signature and Title of Person Obtaining Consent and Identification of Role in the Study

Date

Page 5 of 5

R&D Approval 5/13/09

I have received a copy of this consent form

APPROVED

Xavier University

Institutional Review Board

Date: 5/13/09
VA RESEARCH CONSENT FORM

Subject Name: _______________________________   Date: ________________

Title of Study: _Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans_

Principal Investigator: Barbara B. Beimesch MA  VAMC: Cincinnati (539)

Consent Version Date: __April 1, 2009__

Sponsor Name: Department of Psychology, Xavier University.

UC IRB Study # _06-04-06-04-EE_

INVESTIGATOR INFORMATION:

Barbara B. Beimesch MA  859-801-2732  NA

Principal Investigator Name  Telephone Number  24 hr Emergency Contact

INTRODUCTION:

Before you agree to participate in this research study, it is important that you be told the purpose, procedures, benefits, risks, discomforts and precautions of the research. You should also be told what alternative procedures are available to you if you do not participate in the research study.

Your participation in this research study is entirely voluntary. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without unfairness to you or your medical care. The study doctor(s) do not promise that you will receive any benefits from this study.

This informed consent document is a brief written summary of what the researcher is telling you. Be sure to ask questions while you read this if there is anything that is not clear.

WHY HAVE YOU BEEN ASKED TO TAKE PART IN THIS RESEARCH STUDY?

You are being asked to take part in this research study because you are a therapist in the Residential or Residential and Outpatient PTSD and Anxiety Clinic at the Cincinnati VAMC Ft. Thomas location and have first-hand knowledge of patients who are receiving residential treatment for their PTSD symptoms. PTSD can result when a person is exposed to a traumatic event which involves actual or threatened death or serious injury and the person's response involves intense fear, helplessness or horror. As a result, a person with PTSD will persistently re-experience the traumatic event, display persistent avoidance of thoughts, feelings or conversations associated with the trauma, and have persistent symptoms of increased arousal such as difficulty sleeping, outbursts of anger, difficulty concentrating, being hypervigilant or experiencing an exaggerated startle response.

HOW LONG WILL YOU BE IN THE RESEARCH STUDY?

You will be in the research study for approximately 5 minutes which is the estimated amount of time required to complete the questionnaire(s) which constitutes the study. The researcher may decide to take you off this research study at any time if doing so should be deemed in your best interest.

I have received a copy of this consent form

APPROVED

Xavier University Institutional Review Board
Date: __5/13/09__

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AN INVESTIGATION OF TRAUMA

VA RESEARCH CONSENT FORM

Subject Name: ______________________________________________ Date: _________________

Title of Study: __ Norms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

Principal Investigator: Barbara B. Beimesch MA _______________ VAMC: Cincinnati (539)

Consent Version Date: April 1, 2009

* WHY IS THIS RESEARCH BEING DONE?

The purpose of this research study is to find out what personality traits, if any, are related to a person's PTSD and their response to residential treatment at the Cincinnati VAMC PTSD and Anxiety Clinic.

* WHO IS CONDUCTING THE RESEARCH STUDY?

This study is sponsored by Department of Psychology, Xavier University. The study is directed by Barbara B. Beimesch MA, a graduate student at Xavier University, Cincinnati, Ohio. Supervision for the study is provided by Drs. Kate Chard, Cincinnati VAMC and Susan Kenford, Department of Psychology, Xavier University.

* HOW MANY PEOPLE WILL TAKE PART IN THE RESEARCH STUDY?

All residential individual therapists at the Cincinnati VAMC who see patients in the VAMC PTSD and Anxiety Clinic at the Ft Thomas location will take part in the study. Approximately 40 Individual Therapists could take part in this study depending on the length of time required to collect data from 100 Residential veterans at the VAMC PTSD and Anxiety Clinic.

* WHAT IS INVOLVED IN THE RESEARCH STUDY?

If you choose to take part in this study, you will be asked to complete the following questionnaire(s) for your Residential PTSD Veteran(s):

- Therapist Evaluation Questionnaire

* WHAT ARE THE RISKS AND DISCOMFORTS OF THE RESEARCH STUDY?

To the best of our knowledge, there are no known risks or discomforts, beyond what you currently experience in everyday life, associated with participation in this research study.

* WHAT ARE THE REPRODUCTION RISKS?

This study does not involve any drug(s) and poses no reproductive risks.

* ARE THERE BENEFITS TO TAKING PART IN THE RESEARCH STUDY?

If you agree to take part in this research study, there may not be a direct benefit to you. The researchers hope the information learned from this research study will benefit other future PTSD patients through increased knowledge about PTSD among veterans.

(CVAMC revised 9-2008)

VA FORM 10-1086 April 1994

Page 2 of 5

I have received a copy of this consent form.

Barbara Beimesch

APPROVED

MAY 13 2009

APPROVED

Xavier University

Institutional Review Board

Date: 5/13/09

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* WHAT OTHER CHOICES FOR CARE ARE THERE? 

You may choose to decline participating in this study.

* HOW WILL INFORMATION ABOUT YOU BE KEPT PRIVATE AND CONFIDENTIAL? 

Every effort will be made to maintain the confidentiality of your study records. The Department of Veterans Affairs, the University of Cincinnati, and Xavier University, will be allowed to inspect sections of your research record related to this study. The data from the study may be published; however, you will not be identified by name. Your identity will remain confidential unless disclosure is required by law. Release of data will be in accordance with VHA regulations and policies. Data will be controlled so that reuse of the data is within an approved research protocol and in compliance with VHA procedures.

WHAT ARE YOUR COSTS TO BE IN THIS STUDY? 

There are no costs to participants who choose to take part in this study. Department of Veterans Affairs residential patients may be financially responsible for care at the Department of Veterans Affairs. Financial responsibility is individually determined based upon legislative criteria. Some veterans are required to pay co-payments for medical care and services; these co-payment requirements will continue to apply to medical care and services provided by the Department of Veterans Affairs that are not part of this study.

WILL YOU BE PAID TO PARTICIPATE IN THIS RESEARCH STUDY? 

No monetary compensation is offered to you for your participation in this study.

* WHAT COMPENSATION IS AVAILABLE IN CASE OF INJURY? 

The Department of Veterans Affairs will provide necessary medical treatment to you as a research subject if you are injured by participation in this research project, at no cost to you. This requirement does not apply to treatment for injuries that result from non-compliance by you with study procedures. The Department of Veterans Affairs does not normally provide any other form of compensation for injury. You have not released this institution from liability for negligence.

WHAT ARE YOUR RIGHTS AS A PARTICIPANT? 

You may choose either to take part or not to take part in this research study. If you decide to take part, you may decide to leave the study at any time. Leaving the study will not result in any penalty or loss of

I have received a copy of this consent form

Barbara Reines MA

VAMC Cincinnati (539)

Consent Version Date: April 1, 2009

APPROVED

MAY 13 2009

UC-IRB

Institutional Review Board

Date: 5/13/09

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AN INVESTIGATION OF TRAUMA

VA RESEARCH CONSENT FORM

Subject Name: ___________________________ Date: ___________________

Title of Study: N o t e s f o r O b j e c t R e l a t i o n s a n d t h e R e l a t i o n s h i p o f O b j e c t R e l a t i o n s t o P T S D T r e a t m e n t O u t c o m e s u s i n g C o g n i t i v e P r o c e s s i n g T h e r a p y i n a s a m p l e o f I m p a t e n t V e t e r a n s

Principal Investigator: Barbara B. Beimesch MA VAMC: Cincinnati (539)

Consent Version Date: April 1, 2009

benefits to you. The investigators will tell you about new information that may affect your health, welfare, or willingness to stay in this study.

If you have questions about the study, you will have a chance to talk to the researcher. Do not sign this form unless you have had the chance to ask questions and have received satisfactory answers.

Nothing in this consent form waives any legal rights you may have nor does it release the investigator, the sponsor, the institution, or its agents from liability for negligence.

* WHO DO YOU CALL IF YOU HAVE QUESTIONS OR PROBLEMS?

If you have any questions regarding this study, if you experience side effects or to report a research-related injury or illness, or if you have any additional concerns or complaints while you are participating in this study, you can contact the researcher Barbara B. Beimesch at 859-801-2732.

Please call the University of Cincinnati Medical Institutional Review Board at 513-558-5259 (Monday - Friday 8 am to 5 pm) if you:

- Think the research has hurt you.
- Have general questions about giving consent or your rights as a research participant in this research study.
- Have questions, concerns, or complaints about the research.
- Cannot reach the research team or you want to talk to someone else.

To report complaints or concerns to an independent agency in an anonymous and confidential manner, please call the Research Compliance Hotline at 1-800-889-1547.

If you want to check to be sure this study is approved and the researchers are authorized to do this study please contact the Cincinnati Department of Veterans Affairs Research Service at 513-475-6498. Information can also be found at the internet at http://www.clinicaltrials.gov.
Subject Name: __________________________________________ .  Date: ______________

Title of Study: N oms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

Principal Investigator: Barbara B. Beimesch MA  VAMC: Cincinnati (539)

Consent Version Date: April 1, 2009

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

STUDY TITLE: N oms for Object Relations and the Relationship of Object Relations to PTSD Treatment Outcomes using Cognitive Processing Therapy in a sample of Inpatient Veterans

Sponsor Name: Department of Psychology, Xavier University

INVESTIGATOR INFORMATION:

Barbara B. Beimesch MA  859-801-2732  NA

Principal Investigator Name  Telephone Number 24 hr Emergency Contact

SIGNATURES

I have read or someone has read to me, this Informed Consent Document which describes the purpose and nature of this research. I have had time to review this information and have been encouraged to ask questions. I have received answers to my questions. If I do not participate or if I discontinue my participation, I will not lose any benefits. I will not lose any legal rights if I discontinue. My participation in this research is completely voluntary. I give my consent to participate in this study. I have received (or will receive) a copy of this form for my records and future reference.

Participant (or Parent, if signing for a minor) Date

Next of Kin (state relationship to participant) Date

or Subject’s Representative (only required if subject not competent to consent)

WITNESS TO THE CONSENT PROCESS Date

All consent forms used at the Department of Veterans Affairs require this signature.

PERSON OBTAINING CONSENT:

I have reviewed this form with the participant and/or representative. An explanation of the research was given and questions from the subject were solicited and answered to the subject's satisfaction. In my judgment, the subject has demonstrated comprehension of the information.

Signature and Title of Person Obtaining Consent and Identification of Role in the Study Date

(CVAMC revised 9-2006)

PROTOCOL NO. 5-13-10
APPROVED
EXPRESSES ON MAY 18, 2009

I have received a copy of this consent form.

APPROVED
Xavier University Institutional Review Board
Date: 5/13/09

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