RPRS Manual

Recovery-Promoting Relationships Scale

The development of the RPRS instrument was supported by the National Institute on Disability and Rehabilitation Research and the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration

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self-acceptance

empowerment

hope

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Acknowledgements

The development of the RPRS instrument was supported by the National Institute on Disability and Rehabilitation Research and the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration (grant # H133B90023).

We wish to acknowledge the contributions of Michelle Mullen, MS, and Su-Ting Hsu, MD, ScD, who participated in the analysis of qualitative data which informed the development of the initial set of items for the RPRS instrument, Marjorie DeLong, BA, who took part in the cognitive interviews testing the RPRS items, Karon Cook, PhD, who conducted the Item Response Theory analyses, Asya Lyass, PhD (Cand.), who conducted the Classical Test Theory analyses, and Ralph D'Agostino, PhD, who provided consultation on the psychometric properties of the RPRS instrument and the integration of the Classical Test Theory and Item Response Theory analyses.

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The Center for Psychiatric Rehabilitation is partially funded by the National Institute on Disability and Rehabilitation Research and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

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Mental health and rehabilitation professionals represent an important factor that can either facilitate or hinder the recovery process of people with psychiatric disabilities. Practitioners can inspire hope and empower mental health consumers in their efforts to overcome the disabling effects of a mental illness or they can instill hopelessness, dependence, and helplessness.

Several authors have described the negative attitudes among mental health and rehabilitation professionals toward people with serious mental illnesses (Minkoff, 1987; Minkoff & Stern, 1985; Degen & Nasper, 1996). Working with people who have a mental illness is often considered unrewarding, non-prestigious, and hopeless; these feelings become major barriers that interfere with treatment of and service provision to this population. Practitioners, faced with serving clients with severe problems and multiple needs, may experience feelings of despair that prevent them from bringing a more hopeful perspective to the treatment of their clients. Yet, a hopeful perspective is considered a critical ingredient in rehabilitation and recovery (Anthony, 1993; Russinova, 1999).

Numerous first-person accounts by consumers describe interactions with mental health professionals that have left them feeling disrespected, discouraged, and hopeless. These accounts provide significant anecdotal evidence about the detrimental impact that practitioners' negative attitudes can have on people with psychiatric disabilities. Deegan (1990) eloquently describes this phenomenon of "spirit breaking": "the experience of breaking occurs as a result of those cumulative experiences in which we are humiliated and made to feel less than human, in which our will to live is deeply shaken or broken, in which our hopes are shattered and in which giving up, apathy, and indifference become a way of surviving and protecting the last vestiges of the wounded self" (p. 352). This phenomenon also explains the development of learned helplessness among mental health consumers that has been identified as one of the major barriers to recovery (Deegan, 1992; Kramer & Gagne, 1997; Weingarten, 1994).

At the same time, people in recovery and practitioners have both emphasized the invaluable role that practitioners can have in influencing the recovery process (Deegan, 1997; Minkoff, 1987; Orrin, 1996). There is also a considerable body of research on how the therapeutic relationship (e.g., Horvath, 2005; McCabe & Priebe, 2004; Strupp, 1996; Watson & Geller, 2005), the core conditions of the helping relationship (e.g., Aubry et al., 2005; Barrett-Leonard, 1986), and empowering medical practices (Ellison, 1996), all have an important effect on the outcomes experienced by people in recovery. Based on a survey conducted with persons with psychiatric disabilities, Coursey and his colleagues (1995) observed a positive correlation between the extent clients felt empowered by

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their therapist and the process of their recovery: clients who felt more empowered in therapy spent less time in hospitals, expected a shorter stay in therapy, and knew more about their problems.

The recovery paradigm, which has become the guiding principle in the delivery of services to people with psychiatric disabilities (New Freedom Commission on Mental Health, 2003), requires an understanding of the impact practitioners can have on their clients. (Coursey et al., 2000a; Coursey et al., 2000b; Hoge, Tondora, & Marrelli, 2005; Young, Forquer, Tran, Starzynski, & Shatkin, 2000). From this perspective, the professional competence of mental health and rehabilitation providers needs to be reexamined in the context of the current understanding about the nature and the dimensions of the process of recovery. There have been a few recent attempts to define the core competencies of mental health providers working with persons in recovery (Coursey et al., 2000a; Coursey et al., 2000b; Hoge et al., 2005; Young et al., 2000).

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The development of the RPRS instrument focused on identifying and reliably measuring the competencies of mental health providers that have a particular impact on the recovery process beyond the management of psychiatric symptoms. Its development was informed by a new conceptual model about the structure of providers' competencies titled "the pyramid model of recovery-promoting professional competence" (Russinova, Rogers, & Ellison, 2006).

This conceptual model examines providers' recovery-promoting competence as a complex set of attitudes, skills and strategies that facilitate the recovery process of persons with serious mental illnesses. It identifies three key components in the structure of mental health providers' professional competence.

1) The first component is represented by the provider's core interpersonal skills necessary to acknowledge the client's personhood and maintain an ongoing positive regard toward this person. In addition to the skills that have been traditionally acknowledged as essential in establishing and maintaining a therapeutic alliance with the client, this component also includes skills that are specific to working with individuals who have been affected by the most disabling mental illnesses, including the provider's ability to identify and relate to the core personhood of a client who might be overwhelmed by psychiatric symptoms and ability to maintain and convey a personal confidence in the potential for a given client to pursue and achieve recovery.

2) The second component includes the competencies that are specific to the different modalities of services provided to persons with serious mental illnesses such as psychopharmacological management, psychotherapy, case management, rehabilitation counseling, peer support, etc. These competencies are developed in the context of the discipline-specific training of mental health providers. They are also acquired through undergraduate and post-graduate training in specific discipline-related interventions.

3) The third component of mental health providers' professional competencies is comprised of a complex set of skills that specifically target the recovery process of clients with serious mental illnesses. These skills determine providers' ability to use a variety of strategies that promote clients' hopefulness, empowerment and self-acceptance. The development of providers' skills in utilizing various recovery-promoting strategies is a relatively new trend in defining and assessing the professional qualifications of mental health professionals while the professional skills relevant to the first two components of the presented conceptual model have been all along part of the traditional state-of-the art mental health education.

Although all three components of mental health providers' professional competence are essential for the effective delivery of services to persons with serious mental illnesses, their relative importance to the optimal unfolding of the

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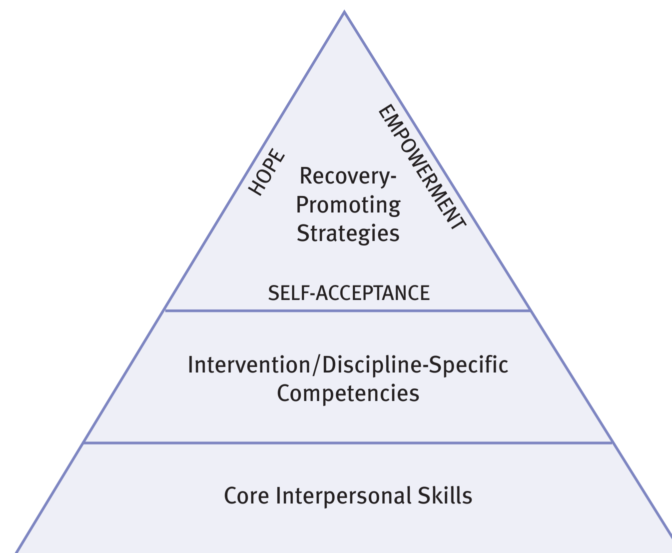
treatment process can be presented in a hierarchical way (Figure 1). Providers' core interpersonal skills constitute the basis for the effective delivery of any mental health intervention specific to a given treatment modality. At the same time, the delivery of specific interventions needs to be permeated by the use of relevant strategies that enhance the hopefulness, empowerment and sense of self-acceptance of clients. Without the provider's ability to acknowledge the personhood of the client and establish a solid therapeutic alliance, treatment would be severely compromised especially in services for which the provider-client relationship is essential. Without the use of recovery-promoting strategies, treatment would be less than optimal. Providers' skills in acknowledging the client's personhood and in promoting his/her hope, empowerment and self-acceptance should constitute the fabric of any intervention delivered to persons with serious mental illnesses. They may be incorporated in the context of newer recovery-oriented interventions or may need to be added as an adjustable module to established services.

Figure 1. Pyramid Model of Recovery-Oriented Professional Competencies



The first and third components of this model represent the *generic components* of mental health providers' recovery-promoting competence that need to be integrated with the professional skills relevant to different treatment modalities or specific clinical or rehabilitative interventions. Although the frequency and intensity of the use of specific recovery-promoting strategies may vary across different treatment modalities and interventions, the enhancement of clients' hopefulness, empowerment and self-acceptance is essential for achieving desired treatment outcomes and ultimately for promoting the recovery process of clients with serious mental illnesses.

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The RPRS instrument is a 24-item scale that measures the *generic components* of mental health providers' recovery-promoting professional competence: a) the core interpersonal skills and b) skills to utilize recovery-promoting strategies. It provides a total score indicating the level of overall manifestation of these generic components of providers' recovery-promoting competence as well as specific scores for each of these two generic components. For measurement purposes, the generic components of providers' recovery-promoting competence have been operationalized as two separate indices, namely the Core Relationship Index and the Recovery-Promoting Strategies Index. In addition, the RPRS instrument provides scores for the three sub-components of the Recovery-Promoting Strategies Index representing providers' skills to enhance clients' hopefulness, empowerment and self-acceptance. These three sub-components which constitute the content of the Recovery-Promoting Strategies Index have been operationalized as the following three subscales: Hopefulness, Empowerment, and Self-Acceptance.

The RPRS instrument assesses mental health providers' recovery-promoting competence from the point of view of their clients with serious mental illnesses. The instrument provides scores about the level of a given practitioner's core interpersonal skills and skills to utilize recovery-promoting strategies as manifested in a specific provider-client relationship. The level of a given practitioner's overall recovery-promoting competence can be established based on average scores obtained through the administration of the RPRS instrument across this provider's caseload at a certain time.

The items constituting the two indices and the three subscales of the RPRS instrument are as follows in Figure 2:

Figure 2. Structure of the RPRS Instrument

Indices	**Items**
Core Relationship	5, 10, 13, 16, 17, 18, 21, 24
Recovery-Promoting Strategies	1, 2, 3, 4, 6, 7, 8, 9, 11, 12, 14, 15, 19, 20, 22, 23
Subscales	
Hopefulness	2, 3, 4, 8, 11, 12, 19
Empowerment	1, 9, 20, 22, 23
Self-Acceptance	6, 7, 14, 15

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The RPRS instrument was developed based on findings from an anonymous Internet survey inquiring about mental health providers' attitudes, skills and techniques that have a particular relevance to the recovery process of clients with serious mental illnesses. Quantitative and qualitative data about the professional competencies that enhance the recovery process beyond symptom management were collected from 603 consumers, 153 consumer-providers and 239 providers of mental health and rehabilitation services. These findings informed the development of the initial pool of items for the RPRS instrument. Consequently, these items were tested and reduced through several rounds of cognitive interviews conducted with persons with serious mental illnesses.

The final 24-item version of the RPRS instrument was developed with a mixed approach combining Classical Test Theory and Item Response Theory of instrument development. The RPRS instrument, including indices and subscales, has acceptable fit statistics established based on the Item Response Theory principles. The scale has demonstrated a high level of internal consistency (0.981, 0.976 and 0.953 for the total scale and respectively two indices), good test-retest reliability (inter-class correlation coefficients of 0.72, 0.72 and 0.75 for the total scale and two indices) and acceptable concurrent, criterion and known groups validity. The internal consistency coefficients for the three subscales were 0.945 for the Hope Subscale, 0.925 for the Empowerment Subscale, and 0.885 for the Self-Acceptance Subscale. The intra-class correlation coefficients for the test-retest reliability of the three subscales were respectively 0.69 for the Hope Subscale, 0.72 for the Empowerment Subscale, and 0.61 for the Acceptance Subscale.

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Since the RPRS instrument measures the generic components of mental health providers' recovery-promoting competence, it can be administered in the context of any treatment modality or specific clinical intervention. The instrument provides a template of administration instructions that can be flexibly modified based on the specific context and purposes for which the instrument is used.

The administration of the RPRS instrument needs to account for the duration of the provider-client relationship in which context the practitioner's recovery-promoting competence is assessed. The items constituting the Core Relationship Index can be administered at any time-point during service delivery, including after the first encounter with the client, since providers' core interpersonal skills are essential for any segment of the treatment process. At the same time, the score for the Recovery-Promoting Strategies Index is sensitive to the duration of the provider-client relationship. A certain "dose" or duration of treatment intervention is necessary to allow for the optimal utilization of various recovery-promoting strategies. The minimum treatment dose allowing the use of hopefulness, empowerment and self-acceptance enhancing strategies needs to be determined based on the specificity of the intervention in which context the RPRS instrument is administered. For example, at least four sessions of individual psychotherapy might be necessary prior to administering the items of the Recovery-Promoting Strategies Index. We expect that further testing of the RPRS instrument will allow the minimal treatment dose specific to different clinical interventions to be determined empirically. Meanwhile, we recommend that the intervention specific minimal treatment dose be determined based on clinical judgment.

Items are assessed based on a 4-point Agree/Disagree Likert scale. The scale allows for a "Not Applicable" response to allow for adjustment of the instrument to the specificity of different treatment modalities and interventions. Conceptually, the "Not Applicable Response" is not relevant to the items of the Core Relationship Index. Higher occurrence of "Not Applicable" responses across the subscales of the Recovery-Promoting Strategies Index might invalidate the use of certain subscales or the whole index since such responses are counted as missing values. Guidelines for acceptable level of missing data are provided below in the scoring instructions. Higher number of "Not Applicable" responses beyond the acceptable level of missing data requires a clinical examination to determine if this occurrence is client-specific or intervention-specific. If the intervention-specific occurrence of a higher number of "Not Applicable" responses is ruled out, the presence of such responses might reflect clients' reluctance to evaluate their providers in a negative way. A high number of intervention-specific "Not Applicable" responses may be associated with the duration of the provider-client relationship and requires further clinical consideration of the minimal treatment dose needed prior to the administration of the RPRS instrument.

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The scoring for the RPRS instrument follows several steps in order to account for missing data as well as for the Item Response Theory principles which require raw scores to be converted into scaled scores through the use of concordance tables. Separate concordance tables exist for the RPRS total score, two indices and three subscales.

Step One:
Identify level of missing data and usefulness of collected data per respondent.

Skipped items and "Not Applicable" responses are considered missing data. Calculate the number of missing items for the total scale, two indices and three subscales. If any of these scores have more than 25% of the items missing, they should not be used in further analyses. For example, if the total RPRS score for a given respondent has more than 25% of all items on the scale missing, it cannot be used. However, if in this case the missing items were primarily associated with the Recovery-Promoting Strategies Index and the Core Relationship Index had less than 25% missing items, the score for the latter index is still usable. Below are the numbers of missing items per type of score that constitute the 25% cut off point of data usefulness.

Figure 3. Guidelines for Acceptable Level of Missing Data

RPRS Total Score	If 6 items are missing, the total score should be considered as missing.
Recovery-Promoting Strategies Index	If 4 items are missing, the score for this index should be considered as missing.
Core Relationship Index	If 2 items are missing, the score for this index should be considered as missing.
Hopefulness Subscale	If 2 items are missing, the score for this subscale should be considered as missing.
Empowerment Subscale	If 1 item is missing, the score for this subscale should be considered as missing.
Self-Acceptance Subscale	If 1 item is missing, the score for this subscale should be considered as missing.

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If no data are missing for any of the items constituting the RPRS indices and/or subscales, add up the values of these items. These sums will be the raw scores corresponding to either the RPRS total score, two indices or three subscale. Proceed with Step Four as described below in order to convert these raw scores into scaled scores.

Step Two:
Prorate scores for missing data.

In case you identify missing data for any of the RPRS two indices and/or three subscales, you need to generate prorated scores for the missing data prior to calculating the scores for the whole scale, indices and subscales. After identifying which components of the scale (indices or subscales) contain missing data, conduct the following calculations separately for each component with missing data (Reminder: missing responses are both the "Not Applicable" or blank responses.) First, add up all the non-missing items that belong to the given index or subscale and then, divide that sum by the number of items with non-missing responses. This will give you the mean of the non-missing items for the given RPRS component. Second, multiply the mean of the non-missing items by the total number of items in the index or subscale for which you are calculating a prorated score. The result of these computations is your prorated score for the given component of the RPRS. Repeat these calculations for the remaining RPRS components with missing data.

Figure 4. Number of Items per RPRS Component

RPRS Component	Number of Items
Recovery-Promoting Strategies Index	16
Core Relationship Index	8
Hopefulness Subscale	7
Empowerment Subscale	5
Self-Acceptance Subscale	4

Step Three:
Rounding prorated scores.

You need to round the prorated scores for the whole RPRS scale, two indices and three subscales to the whole number.

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Step Four:
Conversion of raw scores into scaled scores.

The Item Response Theory (IRT) method of test development requires the raw RPRS scores (either prorated or original if no data are missing) to be converted into scaled score. Convert raw scores into scaled scores using the IRT concordance tables developed for the RPRS instrument. The scaled scores you obtain from the corresponding concordance table are your final scores. The concordance tables for the total RPRS scale, each of the two indices and three subscales are presented in following Tables 1–6.

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Table 1. Concordance Table for the Total RPRS Score

Raw Score	Scaled Score	Raw Score	Scaled Score
24	0	61	48
25	10	62	48
26	16	63	49
27	20	64	49
28	22	65	50
29	24	66	50
30	26	67	51
31	27	68	52
32	29	69	52
33	30	70	53
34	31	71	53
35	32	72	54
36	33	73	55
37	33	74	55
38	34	75	56
39	35	76	57
40	36	77	58
41	36	78	58
42	37	79	59
43	38	80	60
44	38	81	61
45	39	82	62
46	40	83	63
47	40	84	64
48	41	85	65
49	41	86	66
50	42	87	67
51	42	88	69
52	43	89	70
53	43	90	72
54	44	91	74
55	44	92	76
56	45	93	79
57	46	94	83
58	46	95	89
59	47	96	100
60	47		

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Table 2. Concordance Table for the Core Relationship Index

Raw Score	Scaled Score	Raw Score	Scaled Score
8	0	21	47
9	12	22	50
10	19	23	52
11	24	24	55
12	27	25	58
13	30	26	61
14	32	27	65
15	35	28	68
16	37	29	73
17	39	30	79
18	41	31	87
19	43	32	100
20	45		

Table 3. Concordance Table for the Recovery-Promoting Strategies Index

Raw Score	Scaled Score	Raw Score	Scaled Score
16	0	41	48
17	11	42	48
18	18	43	49
19	22	44	50
20	24	45	51
21	26	46	52
22	28	47	53
23	30	48	54
24	31	49	56
25	33	50	57
26	34	51	58
27	35	52	59
28	36	53	61
29	37	54	62
30	38	55	64
31	39	56	65
32	40	57	67
33	41	58	69
34	41	59	71
35	42	60	74
36	43	61	77
37	44	62	81
38	45	63	88
39	46	64	100
40	47		

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Table 4. Concordance Table for the Hopefulness Subscale

Raw Score	Scaled Score	Raw Score	Scaled Score
7	0	18	46
8	12	19	49
9	20	20	52
10	24	21	55
11	28	22	59
12	31	23	63
13	34	24	67
14	36	25	72
15	38	26	78
16	41	27	86
17	43	28	100

Table 5. Concordance Table for the Empowerment Subscale

Raw Score	Scaled Score	Raw Score	Scaled Score
5	0	13	48
6	14	14	52
7	23	15	57
8	29	16	62
9	33	17	68
10	37	18	75
11	41	19	85
12	44	20	100

Table 6. Concordance Table for the Self-Acceptance Subscale

Raw Score	Scaled Score	Raw Score	Scaled Score
4	0	11	52
5	15	12	58
6	24	13	65
7	31	14	73
8	36	15	84
9	42	16	100
10	47		

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We recommend the use of conceptually derived norms for determining the level of mental health providers' recovery-promoting competence as measured by the RPRS instrument. These prescriptive norms are based on the understanding that practitioners working with individuals with serious mental illnesses need to have an acceptable level of both core interpersonal skills and skills to use various hope, empowerment and self-acceptance promoting strategies. Since the acceptable level of recovery-promoting competence is achieved through professional education, the recommended prescriptive norms for the RPRS instrument are justifiable.

We propose that an acceptable level of practitioners' recovery-promoting competence is associated with manifestation of the skills represented by the various RPRS items. Such levels of manifestation will correspond to clients endorsing either the "Somewhat Agree" or "Agree" answers for the RPRS items. At the current stage of development of the RPRS instrument, we do not recommend a distinction between "acceptable level" and "advanced level" of providers' recovery-promoting competence. However, we anticipate that further testing of the RPRS instrument will allow such norms to be developed empirically.

The prescriptive norms for an acceptable level of mental health practitioners' recovery-promoting competence based on the scaled scores for the different components of the RPRS instrument are presented below:

Figure 5. RPRS Prescriptive Norms

RPRS Total Score	A scaled score of 54 or above.
Core Relationship Index	A scaled score of 55 or above.
Recovery-Promoting Strategies Index	A scaled score of 54 or above.
Hopefulness Subscale	A scaled score of 55 or above.
Empowerment Subscale	A scaled score of 57 or above.
Self-Acceptance Subscale	A scaled score of 58 or above.

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Contact Information

Specific questions about the use and administration of the RPRS instrument can be addressed to the attention of:

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For further help with the scoring and statistical analyses of RPRS data, the Center offers negotiable technical assistance.

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Recovery-Promoting Relationships Scale

The following statements describe different aspects of the relationship people with psychiatric conditions might have with a mental health or rehabilitation provider.

Please think of the relationship you have with ______________________________

Please check the box of the answer that best describes your relationship with this provider.

1. My provider helps me recognize my strengths.

   ☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

2. My provider tries to help me see the glass as “half-full” instead of “half-empty.”

   ☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

3. My provider helps me put things in perspective.

   ☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

4. My provider helps me feel I can have a meaningful life.

   ☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

5. I have a trusting relationship with my provider.

   ☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

6. My provider helps me not to feel ashamed about my psychiatric condition.

   ☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

7. My provider helps me recognize my limitations.

   ☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

8. My provider helps me find meaning in living with a psychiatric condition.

   ☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

9. My provider helps me learn how to stand up for myself.

   ☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

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10. My provider accepts my down times.

☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

11. My provider encourages me to take chances and try things.

☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

12. My provider reminds me of my achievements.

☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

13. My provider understands me.

☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

14. My provider tries to help me feel good about myself.

☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

15. My provider helps me learn from challenging experiences.

☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

16. My provider really listens to what I have to say.

☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

17. My provider cares about me as a person.

☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

18. My provider treats me with respect.

☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

19. My provider helps me feel hopeful about the future.

☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

20. My provider helps me build self-confidence.

☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

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21. My provider sees me as a person and not just a diagnosis.

☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

22. My provider helps me develop ways to live with my psychiatric condition.

☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

23. My provider has helped me understand the nature of my psychiatric condition.

☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

24. My provider believes in me.

☐ Disagree ☐ Somewhat Disagree ☐ Somewhat Agree ☐ Agree ☐ Not Applicable

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